

**Investigating the Stress-and-Coping Model of Self-
Forgiveness, Self-Compassion, Affect and
Psychological Health.**

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Abbreviations

BFI	Big Five Inventory
CFT	Compassionate Focused Therapy
CMT	Compassionate Mind Training
CSR	Compassionate Self-Responding
DASS-21	Depression Anxiety and Stress Scales (21-item)
DUREL	Duke University Religion index
HFS	Heartland Forgiveness Scale
FFM	Five Factor Model of personality
MCSDS	Marlowe-Crowne Social Desirability Scale
MSC	Mindfulness Self-Compassion
NZSEI-13	New Zealand Socioeconomic Index of occupational status criteria - 13
PANAS	Positive And Negative Affect Scales
PA	Positive affect
NA	Negative Affect
SCA	Safe Content Affect
SCS	Self-Compassion Scale
SCS-T	Self-Compassion Scale – Total score
SINS	Single Item Narcissism Scale
SSGS	State Shame and Guilt Scale
SSFS	State Self-Forgiveness Scale
SSFS-FA	State Self-Forgiveness Scale - Feeling and Actions
SSFS-SB	State Self-Forgiveness Scale – Self-Beliefs
TTPAS	Two-Types of Positive Affect Scale
USR	Uncompassionate Self-Responding

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published by another person, nor material which is to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Peter G. Maynard

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Abstract

Background

Historically many authors have written about the restorative influence that self-compassion and affect can have upon the process of self-forgiveness in promoting psychological health (e.g. Dalai Lama, & Chan, 2004; 2012; Tutu, 2000; 2015), but little empirical research exists into these relationships (Cornish & Wade, 2015b; Gilbert & Woodyatt, 2017). Worthington (2006) proposed a model of self-forgiveness from within a stress and coping paradigm (Lazarus & Folkman, 1984) to unify and guide future research, but this model does not account for the restorative influence of self-compassion. Drawing upon the work of Worthington (2006), Gilbert (2005; 2009; 2014) and Neff (2003a; 2012), the researcher proposed a new stress and coping model of self-forgiveness, self-compassion, affect and psychological health that was evaluated through undertaking three studies using a mixed-methods approach.

Methodology

Study 1 ($n = 141$) utilised a cross-sectional design with a mixed clinical and non-clinical sample to examine the researcher's model in addition to the influence of a range of potentially confounding socio-economic and personality variables. Study 2 ($n = 39$) utilised a longitudinal design to establish relationships between trait self-forgiveness, self-compassion, affect and a range of psychological health variables (psychological distress, shame and guilt) with a group of clinical participants who had chosen to take part in a 12-week Compassion Focused Therapy (CFT) intervention. Study 3 ($n = 44$) utilised the qualitative method of the focus group to provide more detailed understandings of participants' experiences of the CFT group and the processes of change. It was also expected that the findings would provide context to inform the interpretations derived from the quantitative data obtained from Study 1 and Study 2.

Results

In Study 1, reduced negative affect and the combined effects of the negative components of Neff's (2003a) model (uncompassionate self-responding) emerged as having a mediating effect upon the relationship between increased trait self-forgiveness

and reduced psychological distress. Whilst reduced negative affect and uncompassionate self-responding were found to partially mediate the relationship between trait self-forgiveness with shame and guilt. Neuroticism was found to have a significant confounding effect upon these results.

In Study 2, it was found that participating in the CFT group led to significant increases in trait and state self-forgiveness, compassionate self-responding, and positive and safe / content affect, and significant reductions in uncompassionate self-responding, negative affect, shame, guilt and psychological distress. Parallel mediations found that negative affect yielded a mediating effect upon the relationship between trait self-forgiveness with guilt, state self-forgiving self-beliefs with shame, and state self-forgiving feelings and actions with shame and guilt. In addition, uncompassionate self-responding was found to mediate the relationship between state self-forgiving self-beliefs with shame.

Study 3 identified two major themes: '*Becoming self-compassionate and self-forgiving*', and '*The CFT group was beneficial*'. Together, with the findings of Study 1 and 2, the results of Study 3 indicated the importance of assuming responsibility for changing thoughts and feelings around personal transgressions rather than adopting a position of self-condemnation. Generally, the process of self-forgiveness was found to be facilitated by learning CFT skills that assisted with the regulation of negative affect. This process included the development of more balanced thoughts about perceived transgressions, and reduced self-condemnation that promoted psychological health.

Conclusions

It was concluded that the proposed model has both theoretical and clinical utility, but that further research is needed to test the model using larger sample sizes. Participating in a CFT group and developing self-compassion skills facilitated reductions in negative affect and uncompassionate self-responding that mediated the relationship between increased self-forgiveness and reduced shame and guilt. The qualitative results provided more insight into the relationship between self-compassion and self-forgiveness. The clinical and theoretical implications of these three studies will be discussed.

CHAPTER 1.

1.0 Introduction

Who are we? How does the self develop? What can be done to offset some of the detrimental impacts of our personal upbringings? How can we better support the people we love and ourselves? How can we better cope with life stresses? How can we live life in a happier and healthy way and contribute to and preserve the world we live in? How can we be better human beings?

Like many of us who come to choose psychology as a career, I have always been curious about life and the process of living, and these are some of the questions that I feel guided and motivated me to undertake and complete my psychology degree twenty-five years ago. Having gained insights, obtained only partial answers, and developed further questions, my search continued. It was during this time that developed an interest in folk music and folklore and the green man, the significance of which only became apparent during the course of this research. Briefly, the Green Man is a symbol that can be found in art and literature in most cultures over the past 2-3,000 years of human history (Basford, 1978; Anderson, 1990). It has been suggested that the Green Man represents a symbol of fertility, life and nature, including the destructive and constructive tendencies that all human beings need to resolve (Araneo, 2008); core themes that will run through throughout this thesis and which informed the development of the researcher's model.

Over the next decade I undertook further training in clinical, counselling and health psychology that grew my awareness of the need for multiple theoretical perspectives (Rogerian, cognitive, behavioural, psychodynamic, attachment, transpersonal, systemic, stress and coping theories) as a basis for explaining human behaviour. These theories also helped me to begin to identify a personal way of being with clients as a basis for professional helping that formed a secure base from which to explore what it is to be a human being both personally, professionally, and psychotherapeutically.

Over the second decade my awareness of positive psychology, neuroscience, mindfulness and compassion grew as a balance to the dominant "deficit" models of

psychological health. What struck me was that many of the answers to the original questions that I had posed were probably to be found within our ‘roots’ and the contexts of our interpersonal and intrapersonal relationships past and present. But where should I be looking? During this time more and more research accumulated suggesting that the answers to my questions lay in the study of the natural and lifelong process of breaking, making, and maintaining affectionate bonds (Bowlby, 1988; Fonagy, Gergely, Jurist & Target, 2005; Sroufe & Siegel, 2011; Granquist, et al., 2017). In essence, psychological well-being appeared less linked to the fact that we are a clumsy often mindless species who transgress each other and ourselves on a daily basis, but more to do with the way that we try effect repairs to our relationships with others and ourselves in relation to the challenges of living. However, in order to answer my original questions I felt that I needed to better understand the apparent ease with which complicate and break our relationships as well as our resistances towards repairing our bonds with ourselves and others.

It was from these contexts, as well as the impetus from a subsequent personal loss, that my interests in self-compassion (Gilbert, 2005; 2010; Neff; 2003a; 2008) and then self-forgiveness (Hall & Fincham, 2005; Worthington, 2006) grew. Over the course of my study, what became clear was that there was a need for a theoretical model to unify these bodies of knowledge as a basis for psychological helping. What follows is the culmination of my thinking over the last 5 years that will begin with focusing on what it is to be human.

1.1 Being human

The experience of being human with all of its contrasts and complexities has been the subject of extensive writing and debate amongst philosophers, psychologists and religious / spiritual writers for centuries (Fromm, 1997; Gilbert, 2017a; Kagan, 2016; Van Prooijen, 2018). History tells us that human beings are complex, and their behaviours are conflictual. For example, whilst we are capable of extraordinary artistic, scientific, and prosocial achievements, the last few thousand years of recorded human history have been marked by slavery, wars, atrocities, genocide, and terrorist attacks, often in the name of religious faiths that place freedom, morality, love, compassion and forgiveness as some of their highest of virtues (Haidt, 2013).

Kagan (2016) points out some of the themes that have emerged from the literature to explain what it is to be human. They include the nature vs. nurture debate, where some believe that human nature is intrinsically neutral and a 'blank slate' upon which experience leaves its mark and from which the self emerges. Other debates include the good vs. evil, where there is a predisposition towards goodness, altruism, reflection, and consideration, together with a wish to care for others, whereas others believe that human beings are born with a capacity for being evil, uncaring for others, impulsivity and selfishness. There are of course those such as Descartes (1596–1650) who believed in a synergy between these positions. Descartes believed that human beings have the capacity for good and evil and that one of the tasks of being human is to use our capacity for volition and freewill to manage the conflicts between these two aspects of human nature.

The emergence of Darwinism (Darwin, 1859/2009) fundamentally undermined Cartesian thought by proposing the idea that; a) species evolve over time as a result of natural selection, that b), the human species is descended from within the animal kingdom, and c), that human behaviour is more instinctual than was thought. At the turn of the century, William James (James, 1890/2017) and early psychoanalytic thinkers such as Sigmund Freud (Freud, 1923/2010) and Carl Jung (Jung, 1981) placed great emphasis upon instinct as explaining human behavior. Where Jung departed from Freud was on the importance of balancing positive and negative emotions, and internal conflicts that he felt were collectively expressed within society in the form of archetypes such as the Green Man (Araneo, 2005).

This emphasis upon unresolved psychological conflicts became less of a focus from the 1930's to the 1960's through the influence of behaviourism (Skinner, 1976). Subsequently, the development of attachment theory (Bowlby, 1969; 1973; 1980), cognitive theory (Beck, 1976; 1987), and the evolutionary theories of Lorenz (1966), Morris (1967), and Dawkins (1976), led to the development of evolutionary psychology (Barkow, Cosmides & Tooby, 1992; Symons, 1979) that drew heavily upon the developing research into neuroscience (e.g., Dupue & Morone-Strupinsky, 2005; Panksepp, 1998).

Gilbert (2005) suggests that evolutionary psychology seeks to apply the theories of evolutionary biology and attachment theory (Bowlby, 1969/1982) in order to

understand human psychology and explain human behaviour and suffering and developed Social Mentality Theory (SMT) (1989; 2000; 2005). Gilbert proposes that SMT is a social evolutionary theory that has at its centre the proposition that perceptions of threat and safeness explain all forms of human behaviour. Gilbert (2000) defines a social mentality as “*patterns of cognition, affect and behavior that allow for the enactment of social roles*” (p. 120) that involve the solution of social challenges that are essential for human beings to survive. Gilbert goes on to explain that internal and external stimuli are scanned for threat and safety in relation to five main social mentalities (care-giving, care-eliciting, formation of alliances, social ranking, sexual) that motivate human beings to care, seek care, cooperate or compete with others with the overall aim of ensuring survival and reproduction (Huang & Bargh, 2014). In this way social mentalities direct our attention to pursue social alternatives such as seeking affiliation with others (e.g. caring for being cared for by others) or viewing others as competitors that guide and regulate human behaviour. Gilbert (2017) points out that in early human history, society comprised of small tribal groups who were usually related, and who lived according to an agreed system of social values, morals, roles and rank in order to survive (Barrett, Dunbar & Lycett, 2002). In contrast, in our modern environment we find ourselves amongst strangers with whom we need to compete with for scarce financial resources to support our families and ourselves. Gilbert (2017) and van Prooijen (2018) draw upon neuroscience and advance the position that we are hard-wired to compete with a tendency to punish if we, or others do not meet our expectations or the expectations of the cultures in which we live.

A full description of SMT is beyond the scope of this thesis (see Gilbert, 2005, 2005a), but in alliance with Attachment Theory, SMT not only provides an explanation of self-to-others relating, it also provides an explanation of how self-to-self relating is linked to psychological well-being. Gilbert (2005) asserts that just as in the relationship between mother and child (e.g. crying baby - caring mother), the care-seeking and care-giving social mentalities can be activated in relation to the self. In this way, self-compassion and self-reassurance are viewed as the care-giving mentality responding to signals of distress from the care-seeking mentality with the goal of reducing personal distress and improving well-being.

Paul Gilbert’s research group has found empirical evidence in support of SMT from both clinical and non-clinical populations, specifically, that when people’s social

comparisons do not meet their expectations they adopt maladaptive coping styles. These include viewing themselves as inferior, becoming submissive, shaming and self-critical (Gilbert, Clarke, Hempel, Miles, & Irons, 2004; Zuroff, Santor & Mongrian, 2005) in relation to others with whom they are competing resulting in depression (Allan & Gilbert, 1997; Gilbert & Allan, 1998; Gilbert, Allan, Brough, Melley & Miles, 2002). In contrast, there is developing evidence that more adaptive coping strategies such as compassionate self-soothing can be taught and can positively change individuals negative social comparisons, and reduce inferiority, shame, self-criticism and depression (Gilbert & Proctor, 2006; Judge, Cleghorn, McKewan & Gilbert, 2012). Furthermore, a recent review and study by Hermanto and Zuroff (2015) also appears to support the data that the degree to which we feel we have been compassionately responded to in childhood reflects our capacity to compassionately respond to others and ourselves in later life (Crocker & Canevello, 2008; Irons, Gilbert, Baldwin, & Palmer, 2006; Neff & Beretvas, 2012; Neff & McGehee, 2010; Neff & Pommier, 2011; Pepping, Davis, O'Donovan & Pal, 2015).

In reality, human beings try to manage the dialectics of living but inevitably fail because of tendencies to focus excessively upon matters of self-interest and competition with motives that may not correspond with their sense of social safety and well being (MacDonald & Leary, 2005). For example, discrepancies between the realities of performance and expectations can result in an increased capacity for social comparisons and the development of a sense of inferiority and inadequacy that yields a need for retribution through self-punishment, self-criticism and self-blame (McEwan, Gilbert & Duarte, 2012). This thesis will draw upon the theoretical and empirical evidence to assert that it is from such self-criticism and self-blaming that the need for more restorative approaches such as self-compassion and self-forgiveness arises.

From a position of SMT, the researcher suggests that self-compassion and self-forgiveness are adaptive and restorative processes that have evolved so that we can care for and repair our relationships and ourselves when confronted with our 'failures', mistakes and transgressions so that we can continue to compete and achieve both as individuals and social beings. Cooperation involves living in accordance with commonly held ideas of justice, rights and fairness. However, our need to compete means that it is not possible to live without committing interpersonal transgressions that can put us in conflict with these social conventions, actions that make it difficult to

always live according to our values and morals (Shabel & Nadler, 2015). In this way self-compassion and self-forgiveness are viewed as essential evolutionary capacities that are allied to our caring mentality. This mentality helps individuals, families and groups to remain caring and cooperative, and mitigates the negative effects of our competitive mentality that makes violence and social disintegration less likely and peace and well being more likely (Goetz, Keltner, & Simon-Thomas, 2010; Singer & Steinbeis, 2009). This also means that families and groups are more likely to remain intact in a way that supports the well being of the individual, the family, the wider social group and the human species (Gilbert, 2000).

Having introduced some of the main concepts and the theoretical and empirical research, in the next chapter (Chapter 2), the concepts of self-forgiveness, self-compassion will be introduced and linked to the stress and coping literature before examining further links between self-forgiveness, self-compassion, and psychological health. The evidence linking self-forgiveness and self-compassion with a range of psychological variables (positive, negative and safe/content affect, guilt and shame), and potentially confounding personality variables (neuroticism, agreeableness, narcissism and social desirability) and socio-cultural variables (age, gender, socio-economic status, ethnicity / culture, and religiosity / spirituality) will be explored and critiqued. Having identified gaps within the literature, the researcher's proposed stress and coping model of self-forgiveness, self-compassion, affect and psychological health will be introduced and described that will set the scene for testing the model both cross-sectionally (Study 1), longitudinally (Study 2) and qualitatively (Study 3).

Chapter 3 will outline these three studies and the chosen methodologies in detail. Chapter 4 will outline Study 1, which involved testing the model cross-sectionally using a combined clinical and non-clinical sample. Whilst Chapter 5 outlines Study 2 that aims to test the model longitudinally with a sample of clinical participants from Study 1 who elected to complete a 12-week Compassion Focused Therapy (CFT) group. Chapter 6 will outline Study 3, which involved Study 2 participants taking part in a focus group, the findings of which provided valuable qualitative data to provide finer detail about the process of change and the links between self-forgiveness, self-compassion and the other study variables. Chapter 7 will discuss the findings of the three studies together with their limitations, their theoretical and clinical implications, and the recommendations for future research. Finally, Chapter 8 will conclude this PhD

through highlighting the contribution that has been made to the study of self-forgiveness, self-compassion and CFT research as well as the direction that future studies could take in what is a key area of clinical research.

CHAPTER 2

2.0 Literature review

In this chapter the literature that examines the assessment of forgiveness and self-forgiveness will be reviewed and discussed. The similarities and distinguishing features of forgiveness and self-forgiveness will be introduced together with related constructs such as personality and pseudo-forgiveness. This review will inform subsequent discussions about the models of self-forgiveness and self-compassion that have been developed as well as the links between self-compassion and self-forgiveness.

2.1 Forgiveness and self-forgiveness

“Forgiveness is the answer to the child’s dream of a miracle by which what is broken is made whole again.” Dag Hammarskjöld (1964)

Recent reviews of forgiveness research (Woodyatt, Worthington, Wenzel & Griffin, 2017) highlight that philosophers and psychologists do not agree upon a clear definition of forgiveness, and that a consensus has yet to be reached about whether forgiveness truly occurs inter-personally or intra-personally, or whether forgiveness is more dispositional (trait) or situational (state) in nature (Thompson & Snyder, 2003). Thompson, et al., (2005) define a transgression as, *“an event that people perceive as violating their expectations and assumptions about how they, other people, or the world ‘ought’ to be”* (p.317). Thompson et al assert that following a transgression people become distressed and develop negative thoughts, feelings, and behavioural responses that are related to the person (the transgressor), the transgression (the act), or the associated consequences (the outcomes) that are in conflict with their values, morals and expectations (Janoff-Bulman, 1992; Janoff-Bulman & Frantz, 1997). Thompson et al., (2005) suggest that people are motivated to cope with such dissonance and distress through utilising forgiveness that helps them to transform their appraisals and negative responses through resolving the associated dissonance and distress that accompanies such negative life events.

Within such contexts, Thompson et al., (2005) define forgiveness as *“the framing of a perceived transgression such that one’s attachment to the transgressor,*

transgression, and sequelae of the transgression are transformed from negative to neutral or positive. The source of a transgression, and therefore the object of forgiveness, may be oneself, another person or persons, or a situation that one views as being beyond anyone's control (e.g. an illness, "fate," or a natural disaster)" (p. 302). This definition is useful as it integrates the possibility of feeling transgressed upon in both a personal and impersonal manner, and thus allows for the forgiveness of oneself, others or situations to exist as distinct and important aspects of dispositional (trait) forgiveness. Thompson et al's most compelling argument of forgiveness as a trait rather than a state (e.g., transgression specific) is the assertion that forgiveness itself is intrapersonal. In other words, it is the current (state-based) capacity, motivation and behaviour of the forgiver to forgive the self, others or the situation that exemplifies forgiveness as a disposition (Kamat, Jones & Row, 2006).

Hall and Fincham (2005) point out that self-forgiveness can apply to specific (state) transgressions as well as a range of cumulative (trait) transgressions across time. Hall and Fincham stress, *"although self-forgiveness across time is an important dispositional construct, it is also critical to examine how self-forgiveness may vary from offence to offence and to consider the emotional, social-cognitive, and offence-related factors that may facilitate self-forgiveness following a specific transgression"* (p. 629). Much as with interpersonal forgiveness, psychological researchers and philosophers have yet to reach a consensus on how to define self-forgiveness. However, there appears to be general agreement that trait and state forgiveness are related but that there are conceptual distinctions that will be explored in detail later. A recent review of empirical research by McConnell (2015) points out that measurement studies (Mauger, Perry, Freeman, & Grove, 1992; Thompson, et al., 2005) and correlational studies (e.g. Hodgson & Wertheim, 2007, Macaskill, 2012; Sternthal, Williams, Musick & Buck, 2010) indicate that self-forgiveness involves two processes that are complimentary and reflect interrelated processes. Specifically, self-forgiveness can both involve forgiving oneself for committing an interpersonal transgression either against another (e.g. committing a theft), as well as an intrapersonal transgression not living up to one's values and moral standards (e.g., stealing in morally wrong).

Recent philosophical and psychological reviews of the self-forgiveness literature (Cornish & Wade, 2015a; Holmgren, 2012; McConnell, 2015; Milam, 2015; Wohl & McLaughlin, 2014; Woodyatt, Worthington, Wenzel & Griffin, 2017) stress that trait

and state self-forgiveness involve a motivational shift away from anger, self-resentment and maleficence towards increasing benevolence towards the self involving kindness, compassion and a restoration of self-respect. These are core themes of the current study. Cornish and Wade (2015a; 2015b) highlight that the two definitions of self-forgiveness that most reflect this trend are those of Enright and the Human Development Study Group (1996) as well as Hall and Fincham, (2005). Enright et al., (1996) define self-forgiveness as, *“a willingness to abandon self-resentment in the face of one’s own acknowledged objective wrong, while fostering compassion, generosity, and love toward oneself”* (p.115). Hall and Fincham (2005) define self-forgiveness as, *“a set of motivational changes whereby one becomes decreasingly motivated to avoid stimuli associated with the offence, decreasingly motivated to retaliate against the self (e.g., punish the self, engage in self-destructive behaviours, etc.), and increasingly motivated to act benevolently to the self”* (p. 622).

Cornish and Wade (2015a) are critical of these definitions. They stress that whilst these definitions highlight some of the self-focused emotional, motivational, and behavioural components of self-forgiveness, they require the transgressor to repair the damage caused by the transgression and recommit to their values to reduce the chances of recommitting the same transgression in the future. They go on to define self-forgiveness as, *“a process in which a person, (a) accepts responsibility for having harmed another, (b) expresses remorse whilst reducing shame, (c) engages in restoration through reparative behaviours and a recommitment to values; and (d) thus achieves a renewal of self-respect, self-compassion, and self acceptance”* (p. 97). This thesis will endorse this definition of self-forgiveness with the addition of the view that self-forgiveness is a process that helps transgressors cope with the distress associated with committing an interpersonal or intrapersonal transgression.

Given that the focus of thesis is upon self-forgiveness, it is important to compare and contrast definitions of self-forgiveness with interpersonal forgiveness. Hall and Fincham (2005) stress that both types of forgiveness require a transgression to have been committed and require individual’s to consciously work through a process in order to reach forgiveness (Horsbrugh, 1974). Hall and Fincham (2005) point out that both self-forgiveness and interpersonal forgiveness focus upon the harm caused by behavioural transgressions, but they differ in the case of intrapersonal transgressions, as thoughts, desires and feelings in themselves can also be regarded as transgressions. For example,

perceived transgressions can be made through thinking about particular thoughts (e.g., racist, sexist thinking) that require self-forgiveness, whereas interpersonal forgiveness tends to involve the presence of unjust (racist, sexist) behavior against another. Hall and Fincham (2005) also assert that differences exist in the utility of empathy and need for reconciliation and outcome. For example, in order for interpersonal forgiveness to occur the transgressor must feel empathy with the person, but they suggest that excessive empathy with others can complicate the process of self-forgiveness through feelings of over-responsibility and guilt. This would lead to the transgressor experiencing guilt and remorse unless they reconcile themselves in relation to the transgression and the limits of their responsibility.

Hall and Fincham (2005) go on to point out that the process of self-forgiveness can be both conditional and unconditional upon meeting certain prerequisites. For example, someone who has been subject to fraud is likely to be angry and resentful towards his or her betrayer, and may also feel angry with themselves because of not being aware of the potential for betrayal. Under these circumstances, the victim of the crime may only feel able to forgive themselves if they make a resolution to behave differently in the future, such as seeking guidance from an independent party before making any future financial commitments. Alternatively, the victim may not set any conditions to self-forgiveness as they may view themselves as the innocent party and free of any wrongdoing. In the case of interpersonal forgiveness, Hall and Fincham suggest that complete interpersonal forgiveness or exoneration of the transgression is only possible when we don't set conditions for forgiveness (e.g., when a child makes a mistake), and that once given, forgiveness cannot be retracted (Horsbrugh, 1974).

As has been discussed, transgressions can cause tremendous distress for both the transgressor and the transgressed party and can be subjected to a range of responses such as avoidance, blame, revenge and benevolence. Hall and Fincham (2005) point out that each of these responses may yield different outcomes depending on whether the focus is on self-forgiveness or interpersonal forgiveness. For example, in the case of interpersonal forgiveness it may be possible for a transgressed person to feel less distressed through actively avoiding contact with or exacting revenge upon their transgressor. Alternatively they may continue to preserve their relationship until the forgiveness process is complete, a response that is linked with forbearance and the phrase, 'I forgive but I don't forget.'

When the transgression involves not acting in accordance with his or her personal values and morals (e.g. excessive gambling), then it becomes more difficult to avoid the associated distress, and blame or self-condemnation can take the place of revenge (Fischer & Exline, 2010). As has been suggested self-forgiveness is often linked to behavioural transgressions, but it is also possible that the self can feel injured through thinking thoughts, (e.g. racist or sadistic thoughts) that can cause self-condemnation, blame and distress (Fischer & Exline, 2006). If these thoughts persist then their presence may be associated with perceived characterological flaws (e.g., “I must be a bad person for thinking and feeling like this”), responses that are very common in clinical populations (Tangney, Mashek & Stuewig, 2007). Under these circumstances self-forgiveness involves adopting a very benevolent and understanding attitude towards the self, whilst interpersonal forgiveness requires the same for the transgressing other. Given the mind’s capacity for self-judgment and condemnation, and if benevolence is not forthcoming, then the consequences appear to be much greater for self than transgressing another, as self-to-self relating cannot be avoided (Woodyatt & Wenzel, 2013). Aside from the differences in terms of the focus of one’s motivation to forgive, blame, harm, seek revenge, or act benevolently, these targets are inter-related. For example, when one hurts another there is usually a negative impact on the transgressor and the victim (e.g., guilt, anger, sadness), but if the victim does not perceive that they are hurt by the action then does the transgressor need to self-forgive and repair the relationship? Similarly, because of feelings of over-responsibility and unresolved trauma, it is possible for transgressors and the transgressed to respond to relatively minor transgressions with distress that exceeds the severity of the actual transgression, such as showing excessive remorse, guilt, shame, or anger and resentment (Fischer & Exline, 2010). These examples highlight that in general it is the meaning of the hurt that is caused (e.g. I am a bad person) that defines the need for self-forgiveness rather than the behavior itself, although this premise can be challenged if the transgression is in opposition to cultural values, standards and laws (e.g. sexual or racial abuse).

Hall and Fincham (2005) highlight that discussions about self-forgiveness and forgiveness are incomplete without introducing the phenomena of pseudo-forgiveness. Pseudo-forgiveness involves a transgressor using self-forgiveness to reduce the discrepancy between their current behaviour and what their values tell them resulting in reduced guilt and shame (Wohl, Pychyl, & Bennett, 2010). For example, self-forgiveness can be used by transgressors to excuse themselves of their responsibilities,

perhaps through blaming another especially when transgressions are frequent, or when they feel socially excluded and rejected by the person they have transgressed (Woodyatt & Wenzel, 2013; Vitz & Meade, 2010). Such responses have been associated with personality variables such as neuroticism and narcissism (Tangney, Baumeister & Boone, 2004) and will be explored later. In contrast, genuine self-forgiveness requires the development of a positive attitudinal shift involving the development of pro-social attributes (e.g. understanding, sympathy, kindness) that leads to the reduction of negative affects (e.g. fear, anxiety, guilt) through taking responsibility to repair the damage associated with the transgression (Woodyatt & Wenzel, 2013).

In summary, this section has provided definitions of key concepts and terms (e.g., transgressions, interpersonal forgiveness, and self-forgiveness) that will be used throughout this thesis. The similarities and distinguishing features of these concepts have been introduced and discussed together with related constructs (e.g. personality and pseudo-forgiveness) that will inform subsequent discussions. In this next section, the key theoretical models of self-forgiveness (Hall and Fincham, 2005; McConnell, 2015), and Cornish and Wade's (2015a) clinical model of self-forgiveness will be discussed in relation to the empirical research (Woodyatt et al., 2017a).

2.2 Models of self-forgiveness.

Following the reviews of Strelan and Covic (2006) and Worthington (2006), the most recent review of self-forgiveness models by Cornish, Wade and Cikara, (2017) highlights continuing disagreements amongst researchers about how to define self-forgiveness, when self-forgiveness is complete, and how many phases make up the process models of self-forgiveness. For example, Worthington, (2006) describes five phases of self-forgiveness whilst Enright et al., (1996), Jacinto and Edwards, (2011), and Cornish & Wade, (2015a) outline four phases. These models are outlined in table 2.1 overleaf.

Table 2.1. Therapeutic models of self-forgiveness (taken from Cornish et al., 2017, p. 171)

Model	Stages, phases or components							
Enright et al., (1996)	1. Uncovering phase			2. Decision phase		3. Work phase		4. Outcome phase
Worthington (2006).	1. Recall the hurt		2. Empathise with oneself	3. Altruistic gift of self-forgiveness	4. Commit to self-forgiveness			5. Hold on to self-forgiveness
Jacinto and Edwards (2011)	1. Recognition	2. Responsibility	3. Expression			Expression (Cont)		4. Recreating
Cornish and Wade (2015a)		1. Responsibility	2. Remorse			Remorse (cont).	3. Restoration	4. Renewal

Cornish et al., (2017) compare these four models and highlight the similarities and differences between the models. In terms of similarities, Cornish et al point out that all models include cognitive and affective components and pay reference to the theme of responsibility, but that this is only made explicit in the case of Jacinto and Edward's (2011) and Cornish and Wade's (2015a) models. In contrast the models of Enright et al., (1996) and Worthington (2006) contain a phase highlighting the need for a decision to self-forgive, whereas Jacinto and Edward's (2011) and Cornish and Wade's (2015a) model do not. Furthermore, Cornish and Wade's (2015a) model is the only model that features a clear restoration phase as central to the process of self-forgiveness, whereas the other models pay looser references to the idea of resolution and restoration. For example, Worthington (2006) highlights the importance of living 'virtuously', Enright et al (1996) stresses the importance of developing a 'new purpose', whilst Jacinto and Edwards (2011) focus upon 're-envisioning' the future. Finally, Cornish et al., (2017) assert that all of the models emphasise the importance of self-acceptance and the capacity of self-compassion to transform negative affect into positive affect.

Given that Cornish and Wade's (2015a) model is also the only model that stresses the importance of restoration, which is a key theme in this thesis, it is asserted that Cornish and Wade's model provides the most comprehensive account of the process of self-forgiveness (Cornish et al., 2017). In this next section, Cornish and Wade's (2015a) model will be described in more detail and will be used as a framework through which to explore the empirical literature on self-forgiveness.

2.2.1. Cornish and Wade's (2015a) model of self-forgiveness

Cornish and Wade (2015a), identify four phases of self-forgiveness that they term: a) *Responsibility*, b) *Remorse*, c) *Repair* and d) *Renewal*. These phases will now be used as a basis through which to explore the process of self-forgiveness and the philosophical and psychological research on self-forgiveness.

Phase 1: Responsibility

Responsibility involves the need to acknowledge the role that one has in committing a transgression and is a key feature of all psychological and philosophical models of self-forgiveness (Bauer, et al., 1992; Enright et al., 1996; Hall & Fincham,

2005; Halling, 1994; Holmgren, 1998). Flanagan (1996) lists five categories of transgressions that require self-forgiveness:

1. Injuries caused by mistakes, misconduct, or limitations;
2. harm resulting in a person challenging his or her set of core assumptions;
3. apologies of others that do not seem to correct a hurtful situation;
4. personal fears that at the core of their being she or he is evil or cruel; and,
5. feelings of guilt, shame, regret or grief.

Necessarily, self-forgiveness can be complicated by the tendency of human beings to blame others, or minimise the negative impact that their interpersonal transgressions have on others. This is a phenomena termed ‘pseudo’ self-forgiveness” that has already been introduced and will be discussed at greater depth later in this chapter (Hall & Fincham, 2005; Woodyatt & Wenzel, 2013). Exline, Baumeister, Bushman, Campbell and Finkel, (2004) assert that whilst blaming others and denial have been shown to reduce distress associated with transgressions, the presence of over responsibility, guilt, shame, and self-blame as been found to decrease psychological health (Barber, Maltby, & Macaskill, 2005; Baumeister, Exline & Sommer, 1998; McCullough & Witvlet, 2002; Zachmeister & Romero, 2002).

In contrast, ‘genuine’ self-forgiveness involves both the awareness of an error (e.g., making a wrong choice, causing distress), and a willingness to accept responsibility for the part played in the transgression in violating group values (Holmgren, 2012). Luskin (2002) asserts that there are four types of motivations that encourage self-forgiveness:

1. Those who blame themselves for not succeeding at one of life’s important tasks;
2. those who blame themselves for not taking necessary actions to help themselves of someone else;
3. those who blame themselves for hurting another person; and,
4. those who blame themselves for self-destructive behaviours (e.g. addiction, recklessness, self-harm).

Woodyatt, Wenzel and de Vel-Palumbo, (2017) assert that self-forgiveness involves both cognitive and affective components such as remorse and regret together with guilt and shame, together with two key social cognitions: communion and agency.

Drawing upon the work of Shnabel and Nadler (2008, 2015), they argue that committing a transgression involves the violation of personal and culturally bound beliefs, morals, values, standards or ethics that represent a threat to one's socio-moral identity and social acceptance. Woodyatt et al., (2017) point out that such reactions are distressing and threatening to one's self-identity as they are in conflict with principals of justice and fairness thus creating an *injustice gap* (Worthington, 2006). Justice and fairness are important to human beings as they provide a consistent framework that affords a sense of security, power, control, and agency through buffering the existential concerns associated with living in world that can be uncertain world and unfair (Siman Tov-Nachleli, Shnabel & Halabi, 2016; Siman Tov-Nachleli, Shnabel & Mori-Hoffman, 2017) . Within the context of a self-forgiveness, the injustice gap emerges as a consequence of discrepancies between an individual's socio-moral identity and their actions that conflict with the expectations about their principles of personal justice creating discomfort, anxiety, shame and guilt that needs to be assuaged (Fischer & Exline, 2010; Exline, Root, Yadivali, Martin & Fischer, 2011). Gilbert and Woodyatt (2017) assert that such motivation appears partly to do with a fear of social exclusion, but also because of a threat to individual agency involving potential loss of status, power and control (Okimoto, Wenzel & Hendrick, 2013; Wenzel, Okimoto, Feather & Platow, 2008).

Responses to the transgression can be both maladaptive and adaptive according to one's personal beliefs, attributions, wish for fairness and justice, as well as how motivated one is to make amends for one's actions (Exline, Worthington, Hill & McCulloch, 2003). Drawing upon the literature, Gilbert (2010) distinguishes two types of justice; retributive and restorative justice, both of which appear to seek to reduce the injustice gap (for reviews see Armour & Umbreit, 2005; Darley, 2002; Wenzel, et al., 2008). Gilbert (2010) points out that the motive behind retributive justice is to punish the perpetrator for their transgression through the use of shame, condemnation, and blame to ensure they suffer to a degree that is commensurate with their perceived wrongdoing (Carlsmith, 2006). In contrast, restorative justice is based upon a wish to heal and transform the hurt caused by the transgression through fostering a dialogue between perpetrator and the victim (for recent review see Lacey & Pickard, 2015).

To date only one study has examined links between justice, interpersonal forgiveness and coping (Witvliet, Worthington, Root, Sato, Ludwig & Exline, 2008). Witvliet, et al., examined self-report, physiological data in response to a common crime

(burglary), in relation to justice (retributive justice, restorative justice, no justice) and forgiveness (forgiveness, no forgiveness). They found that justice, and especially restorative justice, decreased negative emotion (anger, fear) and increased prosocial emotions (gratitude, empathy) and unforgiveness, more effectively than no justice. The results of the physiological data found that restorative justice reduced the sweat response in comparison to no justice and retributive justice, and reduced the cardiovascular response to no justice. In conclusion, Witvliet et al., proposed that seeking justice is a problem-focused strategy to reduce the injustice gap, whereas forgiveness is an emotion-focused strategy that makes it easier to cope with the associated distress of injustice. The authors go on to suggest that seeking justice may be a favourable option in the first instance but that forgiveness may be more effective if justice is not obtained.

Subsequently, Strelan and van Prooljen (2013) undertook a series of studies and found that victims who punished their offenders are more likely to forgive. Strelan and Prooljen went on to suggest that the victim's desire for punishment appeared related to their need for justice, which if obtained increases security and safety through clarifying issues of personal responsibility and promoting forgiveness. However, the authors acknowledged that the absence of a control group meant that it was not possible to say whether punishment increases forgiveness, or a lack of punishment decreases forgiveness

Whilst it is possible to envisage this process facilitating interpersonal forgiveness, within self-forgiveness the target of punishment is the self, and defensive tendencies towards over-responsibility, self-blame, self-hate, guilt and shame that are so common in trauma tend to complicate the internal search for justice ensuring that individuals often remain on the hook of unforgiveness. A clinical example of this would be a client who rightly takes their abuser to court, gains a conviction, but who then continues to self-blame and deny themselves self-forgiveness because they still feel guilty and at least partly responsible for their abuse. In these circumstances, Woodyatt et al., (2017) suggest that self-punishment represents an attempt at regaining a sense of agency through purging the self of guilt, yet such retribution does not repair any of the harm caused by their abuser, their family, their community and themselves (Bastian, Jetten & Fasoli, 2011; Inbar, Pizarro, Gilovich & Ariely, 2013; van Bunderen & Bastian, 2014). In so doing, such action would complicate their attempts at making amends towards themselves through maintaining their distorted socio-moral identities and their sense of social stigma and isolation that is so common in survivors of sexual abuse (Browne & Finkelhor, 1986; Beitchman, Zucker, Hood, Dacosta, Akman & Cassavia, 1993). It would be expected that

reductions in retribution and self-punishment and negative affect would be key factors in facilitating the process of self-forgiveness. Woodyatt et al., (2017b) tested this proposition within the context of an interpersonal transgression in relation to the eudemonic pathway (via the reaffirmation of transgressed values) and the hedonic pathway (via self-compassion) using two studies. Woodyatt et al., (2017b) found that both the self-compassionate and values-affirming pathways led to reduced self-punitiveness and increased self-forgiveness, but they suggested that each may have different benefits depending on the context in which they are applied. For example, they concluded that becoming self-compassionate appeared to be helpful in relation to feelings of self-blame and stigmatisation, but that this approach was less helpful when a person feels responsible for the transgression, and in these cases pursuing a values-affirming pathway response may be more beneficial. Alternatively, it may be that participant's fear of self-forgiveness complicated the process of self-forgiveness. As yet the author is unaware of any empirical research into these linkages and it is hoped that this research will advance knowledge within this area.

Phase 2: Remorse

The second phase of self-forgiveness is remorse, and as with responsibility, is generally accepted to be a key component of psychological and philosophical models of self-forgiveness (Bauer et al., 1992; Enright et al., 1996; Hall & Fincham, 2005; Halling, 1994; Holmgren, 1998; McConnell, 2015). Remorse involves the recognition that one has damaged our socio-moral identities through causing harm and injustice to ourselves or another human being, (Shnabel & Nadler, 2008; 2015). The resolution of which includes developing empathy for the impact of our actions. Recent reviews of the empathy literature (Decty & Cowell, 2014; Zaki, 2014) highlight that empathy is a powerful motivator of empathic concern that can promote prosocial behaviours such as compassion and care for oneself and others. However, much more research needs to be undertaken into the influence of proposed mediators such as empathy and other prosocial responses such as self-compassion. Empathy is a process that is facilitated through an ability to understand the emotions, motivations and perspectives of others (others-empathy) or oneself (self-empathy) that usually lead to a transgression. The two emotions that appear most associated with remorse are guilt and shame that have been termed the 'moral emotions', both of which have different functions.

Guilt alerts us to behaviour that has caused hurt to others and motivates us to repair the damage we have caused and therefore has a prosocial adaptive function (Hall & Fincham, 2008). Shame is more associated with self-evaluations (e.g. beliefs, thoughts) that reflect our social and cultural mores and values (Leach, 2017). For example, shame alerts us to the threat of social rejection if we engage in behaviours that are in opposition to these values (e.g. men don't cry). Shame is a very threatening emotion and tends to be used as a tool of self-punishment and self-condemnation in order to penalise ourselves to ensure that we act once more as moral agents and that justice is perceived to be done. Enduring shame and guilt tend to be linked with generalised self-beliefs (e.g. I'm bad) that are very damaging and are linked with trauma (e.g. childhood sexual abuse), and a wide range of psychological disorders such as anxiety and depression (Kim, Thibodeau & Jorgensen, 2011; Matos, Pinto-Gouveia & Duarte, 2012).

There is also some evidence suggesting that people who report higher levels of guilt and remorse also report a greater sensitivity and empathy towards others and a desire to change their interpersonal behaviour through reducing the risk of further transgressions (Ranggandhan & Todorov, 2010), but that the lower levels of levels of distress can also reduce feelings of remorse and motivation to repair the damaged caused, either through passive rumination or blaming others (Tangney & Dearing, 2002). In contrast, there is some evidence to suggest that higher levels of shame and regret have been associated with greater self-concern and a desire for personal change (Lickel, Kushlev, Savalei, Matta, & Schmader, 2014). Shame and guilt will be further explored later in this chapter but these findings suggest that experiencing a level of shame and guilt can be adaptive in promoting self-forgiveness and may provide us with self-affirmation, especially if we are not defined by our offences (Dillon, 2001). Furthermore, the remorse associated with guilt and the injustice gap can motivate us to be appropriately responsible for the part that we play in our transgressions (Behrendt & Ben-Ari, 2012; Fischer & Exline, 2006). However, in order for self-forgiveness to occur, it would be important to reduce the discomfort and threat associated with this process through blending restorative justice strategies such as empathy and self-compassion to help us to understand and accept that we are imperfect and fallible human beings (Fischer & Exline, 2006; Halling, 1994; Janoff-Bulman, 1992). Whilst it would be possible to continue to be retributive and remain on the hook of unforgiveness through seeing oneself as the exception to the rule of fallibility, if blended with empathy, compassion and kindness, the sense of injustice and outrage that this may create could be used to motivate a shift towards pursuing

restorative justice for the self.

In summary, there appears to be universal agreement that remorse appears to be a key component of the self-forgiveness. Remorse in alliance with empathy and the moral emotions of guilt and shame is distressing and alerts us that we have done something unjust that is against our personal values or the values of the society in which we live. In response we have a choice to either adopt a retributive stance that runs the risks of injustice through denying our fallibility, or adopting a more restorative approach in the expectation that this will yield better learning and psychological health outcomes.

Phase 3: Restoration.

Restoration is the third phase of self-forgiveness and is once more a key feature in most definitions of self-forgiveness (Cornish, 2014; Enright et al., 1996; Hall & Fincham, 2005; Thompson et al., 2005). Aside from the hurt and injustice perpetrated towards ourselves and others, the desire for self-forgiveness involves a genuine wish to repair, transform and restore the damage to one's socio-moral identity as a result of not living according to one's values, and beliefs (Shnabel & Nadler, 2008, 2015; Holmgren, 2002). This is termed genuine forgiveness and has been found to be associated with positive restorative outcomes (Woodyatt & Wenzel, 2013). Models of forgiveness and self-forgiveness highlight that this process can be complicated by setting conditions to behavioural changes. These conditions tend to be in the form of affect (e.g., fear, anger) together with beliefs and assumptions that can act as barriers to making a commitment to responding differently in the future. For example, someone who has committed a transgression is likely to be angry and resentful towards themselves and may feel that forgiving themselves may equate with condoning their behaviour. This may complicate the self-forgiveness process through creating a fear that becoming self-forgiving could lead to committing further transgressions.

Models of self-forgiveness also highlight the importance of setting preconditions to becoming self-forgiving, such as making a commitment to change attitudes and beliefs to reduce the risk of future transgressions, and or offering to repair the damage to the person for the hurt caused. Exline et al., (2011) proposed that reparation involves three phases involving; 1) an acknowledgment of the wrong caused; 2) the adoption of a vulnerable and submissive posture, and 3), the expression of a wish to effect a repair because of the

person's value to the transgressor. Reparations can take the form of an apology or may need to be specific and can involve asking the offended party to describe how and what form the reparation must take.

Sometimes, making direct reparations is not possible such as when the offended party is deceased, or when they do not want to meet with the transgressor. These are often the most challenging and difficult (e.g. causing the death of a loved one by drink driving) because of a wish not to cause further offence and the grief caused by the loss. Under these circumstances, it may be possible to indirectly make amends by improving the life of the offended party through endorsing a cause (e.g., making a donation), campaigning against drunk driving, or setting personal conditions for self-forgiveness. For example, a drunk driver who accidentally killed a child may set their continuing sobriety as a condition for beginning the process of genuine self-forgiveness. Without undertaking such a commitment, the likelihood of repairing the damage caused by not acting in accordance with one's ethics and values, as well as the risk for further transgressions may remain high.

In summary, it appears that restoration is an important part of the self-forgiveness process, and if commitments to change are backed up with emotional, attributional, and behavioural changes, then it is possible to repair at least in part the interpersonal damage that we cause as well as progress the process of self-forgiveness. However, there are some individuals who will continue to be denied (or deny themselves) forgiveness, because their offences are so severe that their attempts at reparation may be felt to be insufficient. As a result they may be left with ongoing feelings of guilt, shame and sadness. In these cases, self-forgiveness continues to remain a possibility through releasing the self from the binds of pain and suffering. For example, most models of self-forgiveness stress the importance of using the attributes of self-compassion such as understanding, self-kindness, empathy, sympathy to transform these problematic feelings and emotions into prosocial emotions and self-states such as love and self-acceptance that are viewed as integral to the final phase of forgiveness and self-forgiveness; renewal.

Phase 4: Renewal.

The final phase of self-forgiveness is renewal. The idea of renewal through reconciliation is a feature of many philosophical and psychological models of forgiveness

and self-forgiveness and highlights the importance of transforming how the transgressor feels about themselves and others (Dillon, 2001; Griswold, 2007; Enright et al., 1996; Hall & Fincham, 2005; Holmgren, 1998; 2012; Norlock, 2017; Thompson et al., 2005). There is agreement amongst these researchers that genuine self-forgiveness involves changes in beliefs, assumptions and thoughts about the transgressor and oneself that are of benefit, as they provide some relief from the guilt and shame through revaluating or acting more in alignment with socio-moral identity (Shnabel & Nadler, 2008, 2015; Holmgren, 2002). In this way, genuine self-forgiveness involves becoming motivated to act as a prosocial moral agent through the fulfillment of personal responsibilities, with beneficence and in adherence to principles of restorative justice (Janoff-Bulman & Sheikh, 2006; Wenzel, et al., 2008).

This process of rehabilitation and learning involves the transgressor committing to a difficult process that involves viewing the self and or others in a different way. This usually requires a sense of moral outrage against the injustice that is being perpetrated either by another against the self, or in the case of self-forgiveness, by the self against the self. Such anger can motivate the transgressor (or the transgressed) to overcome fears of developing prosocial responses (e.g. compassion, empathy, kindness) that foster perspective taking around the reasons behind the transgression (Decety, 2005; Goldstein, Vezich & Shapiro, 2014).

Vitz and Meade (2011) offer a critique of the prevailing psychotherapeutic model of self-forgiveness that involves clients splitting themselves into a “good self” that is the source of self-forgiveness, and a “bad self” that is “faulty” and in need of self-forgiveness. Reconciliation involves the integration of these two selves through utilising the “glue” of self-forgiveness that heals the divided self. Drawing upon the work of Enright (2002), Vitz and Meade (2011) propose that many transgressions do not involve splitting but involve the breaking of a standard or important rule based on their conscience. This leads to feeling angry with themselves and a sense of personal difference between themselves and others that is distressing. Relief is sought through seeking forgiveness from God (if they are religious) or themselves that involves reducing feelings of difference through re-identifying and accepting themselves as ‘faulty’ human beings whose ‘flaws’ reflect their uniqueness. For example, someone with perfectionistic tendencies may come to realise that their need for perfectionism comes from a historical need to please or appease others in order to obtain validation and avoid the pain of

disapproval. They may conclude that they are being unjust to themselves and others and become more open to adopting more realistic standards (e.g., the “good enough”). In so doing they may become less demanding of others and more able to provide themselves with unconditional validation and approval irrespective of the outcomes they achieve. Vitz and Meade (2001) assert that making a commitment to change becomes an ethical act based upon a wish to view oneself differently through renouncing one’s wrongs in an attempt to repair the damage that we cause to our relationships and more importantly ourselves (Strelan, McKee, Claic, Cook & Shaw, 2013).

Wohl and McLaughlin (2014) are also critical of the concept of self-forgiveness and outline circumstances where self-forgiveness can produce negative consequences. Firstly, they highlight that self-forgiveness can be used to promote unhealthy behaviours (e.g., smoking, gambling, and abuse of others) through alleviating the guilt and shame associated with these wrongdoings. Secondly, they highlight the phenomena of pseudo-self-forgiveness whereby the transgressor blames their unhealthy behaviours on others fostering self-acceptance thereby increasing the likelihood of committing further transgressions (Woodyatt & Wenzel, 2013; Woodyatt, Wenzel & Hedrick, 2012). Whilst blaming others and deferring personal responsibility can be seen at attempts to restore one’s socio-moral identity and agency by claiming that our actions are justified and perhaps linked to higher ideals, often such actions come at the expense of disconnecting from others who disagree with our actions and lead to increased connections with those who agree with our actions.

An important part of self-forgiveness therefore involves acknowledging that human beings are imperfect, and therefore will, despite their best wishes continue to make mistakes, transgressions and negative judgments that will need to be forgiven. Such a stance makes it possible to seek the ‘grain of truth’ that exists in all complaints and allegations, the acknowledgment of which makes it easier for us to be less defensive and more willing to accept responsibility for our errors and mistakes that promotes learning through the processes of self-forgiveness and self-acceptance. Dillon (2001) asserts that *“self-forgiveness does not require extinguishing all self-reproach, for it is really not about the presence or absence of negative feelings and judgments; it’s about their power. Forgiving oneself means not that one no longer experiences self-reproach but that one is no longer in bondage to it, no longer controlled or crippled by it, no longer alienated from oneself, so that one can now live well enough”* (p. 83).

Having reviewed the phases of self-forgiveness in some detail, it would be important to review the empirical evidence that supports these phases. Of the models of self-forgiveness that have been described, Hall and Fincham's (2005) model was the first theoretical model to lay out the process of self-forgiveness, and it is the only model that has been subjected to an extended program of empirical evaluation. Given that one of the goals of this study is to develop a model of self-forgiveness, in the next section I will describe Hall and Fincham's model in more detail in relation to the subsequent empirical literature and findings that emerged testing this model.

2.2.2. Hall and Fincham's (2005) model of self-forgiveness

Hall and Fincham (2005) proposed a theoretical model of self-forgiveness that is laid out in Figure 2.1. The model emphasises emotional (empathy, guilt, shame), social cognitive (attributions and perceived forgiveness from a higher power and the victim), behavioural (seeking forgiveness, apologising, making amends) and offence-related determinants (perceived severity and consequences of the transgression).

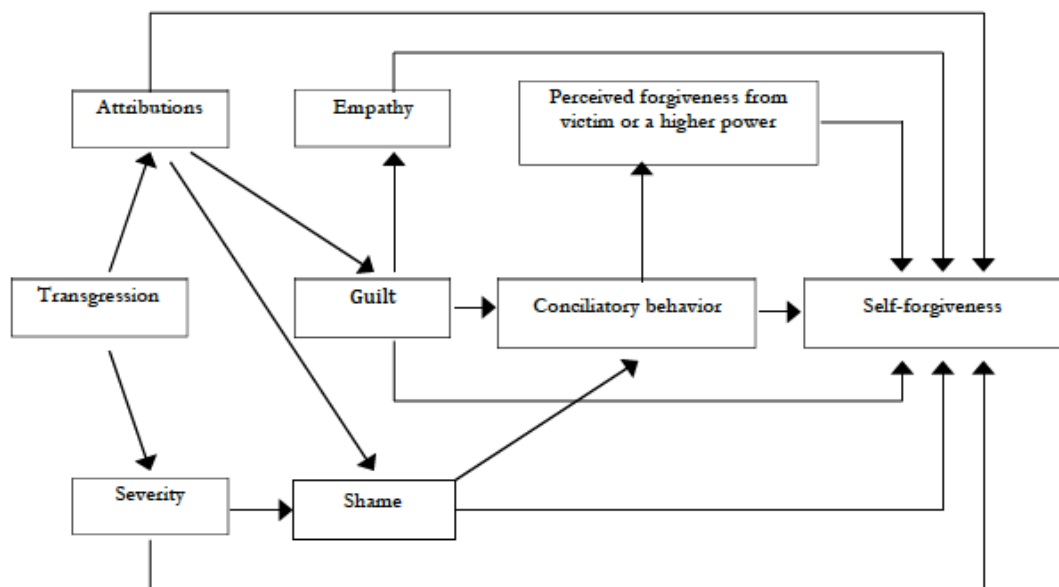


Figure 2.1: Hall and Fincham's model of self-forgiveness (taken from Hall & Fincham, 2005, p. 630).

Hall and Fincham (2008) subsequently tested their model and found that self-forgiveness was negatively associated with guilt, forgiveness-inhibiting attributions, perceived transgression severity, and was positively associated with perceived

forgiveness from the victim and a higher power (God). Self-forgiveness was associated with offering an apology and making amends toward the offended, and imagining the receipt of forgiveness from the victim of an interpersonal offence.

Following their publication, Hall and Fincham's (2005) model has only received partial empirical support, with attributions, shame, conciliatory behaviours and empathy having been found to be inconsistently related with self-forgiveness (Exline, DeShea, & Holeman, 2007; Fischer & Exline, 2006; Gueta, 2013; McConnell, Dixon and Holmes-Finch, 2012; Ragganadhan & Todorov, 2010; Terzino, 2010). Ragganadhan and Todorov (2010) found that shame and personal distress empathy predicted self-forgiveness, and guilt predicted conciliatory behaviour. Subsequently, McConnell, Dixon and Holmes-Finch (2012) tested Hall and Fincham's models (Hall & Fincham, 2005; 2008) and found that transgression severity, guilt, conciliatory behaviours and perceived forgiveness all play important roles in self-forgiveness. For example, they found that transgression severity positively predicted guilt, and that guilt accounted for 47.6% of the variance of self-forgiveness but that the relationship between guilt and self-forgiveness was mediated by conciliatory behaviour and perceived forgiveness from others.

An unpublished PhD study by Terzino (2010) also examined Hall and Fincham's (2008) model in relation to both interpersonal self-forgiveness (self-forgiveness of an interpersonal transgression) and intrapersonal self-forgiveness (self-forgiveness of transgressing a value, rule, or goal). Terzino (2010) also examined Hall and Fincham's model in relation to a range of other hypothesised variables. Regression analyses revealed that the emotion correlates (shame, rumination about mistreatment, and especially guilt) were strong predictors of both interpersonal and intrapersonal self-forgiveness. However, the personality correlates (neuroticism, narcissism, and self-compassion) did not remain significant, indicating that positive and negative affect may be mediating the association between these personality and self-forgiveness.

A subsequent study by McGaffin, Lyons and Deane (2013) drew upon the work of Hall and Fincham (2005) and Ragganadhan and Todorov (2010) and proposed a model of self-forgiveness for substance abusers with particular reference to guilt and shame proneness and acceptance. McGaffin et al., (2013) proposed that guilt proneness would affect empathy towards others, conciliatory behaviours and acceptance, whereas shame proneness would affect acceptance and personal distress empathy, all of which would

predict self-forgiveness. Upon testing their model they found that acceptance was the only significant mediator of the relationships between shame and guilt proneness and self-forgiveness, and that shame proneness was associated with reduced levels of acceptance and self-forgiveness, whereas guilt proneness was associated with greater acceptance and self-forgiveness.

2.2.3. McConnell's (2015) model of self-forgiveness

Most recently, McConnell (2015) has been critical of the empirical research that has tested Hall and Fincham's (2005) model. McConnell (2015) asserts that whilst researchers have made great conceptual advances in the study of self-forgiveness, Hall and Fincham's (2005) model has been driven by empirical research rather than theory. Drawing upon the work of Fawcett (1993), McConnell went on to propose the use of Conceptual-Theoretical-Empirical (CTE) framework that he hoped will provide a clearer and more comprehensive framework to drive research (Figure 2.2).

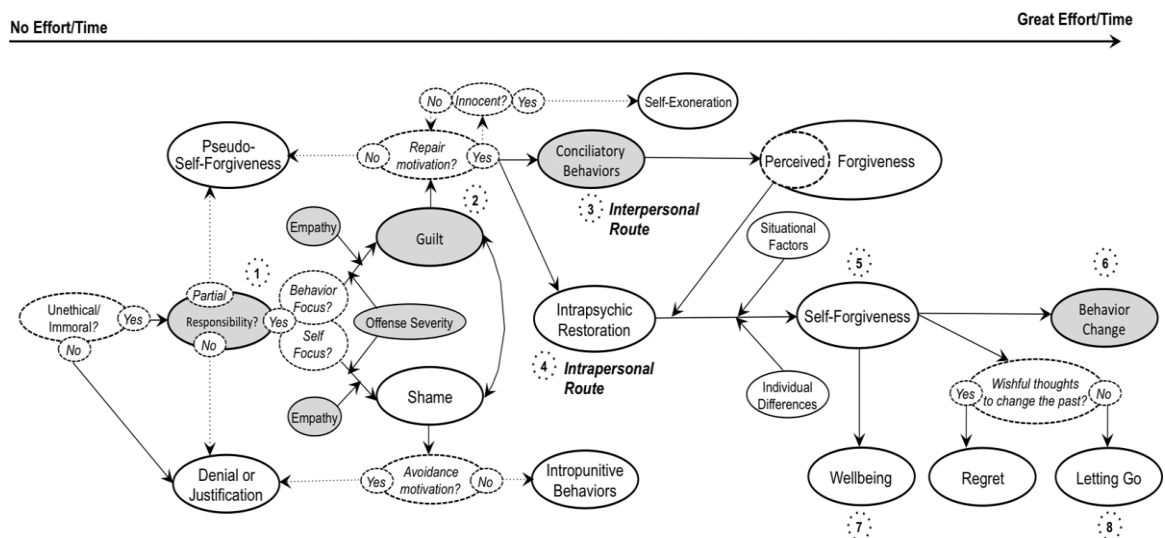


Figure 2.2. A Conceptual Theoretical Empirical (CTE) model of self-forgiveness. (Taken from McConnell, 2015, p. 155).

Note. Shaded areas indicate necessary, but insufficient, conditions to achieve the theoretical concept of genuine self-forgiveness

In outlining his model, McConnell (2015) makes eight points highlighted in Table 2.2 (overleaf), to explain how self-forgiveness occurs:

Table 2.2. Outlining McConnell's description of the process of self-forgiveness (taken from McConnell, 2015, pp. 155-156).

Key points	Description of self-forgiveness process
1.	<i>"Offenders consider their moral and ethical value systems and decipher their levels of responsibility. Through this process, offenders approach denial, justification, pseudo self-forgiveness, or self-conscious emotions. Having a behavioural focus leads to guilt and shame; however, offenders may vacillate between both self-conscious emotions. Offender's empathy and offence severity moderates the intensity of guilt and shame. If shame engenders and avoidance motivation, then offenders will deny or justify. Conversely if offenders do not avoid shame feelings, then they will punish themselves with interopunitive behaviours. If guilt does not stimulate and authentic repair motivation, then offenders will pseudo self-forgiveness (e.g., "It doesn't bother me anymore.")</i>
2.	<i>"However, if guilt produces a repair motivation, then they will move towards the process of genuine self-forgiveness, but self-exoneration may be relevant instead."</i>
3.	<i>"Offenders take an interpersonal route to self-forgiveness and then..."</i>
4.	<i>"an intrapersonal route via intrapsychic restoration. For offenders struggling with self-inflicted injuries devoid of harming others or higher power(s), they might skip the interpersonal route. However, these offenders may use similar processes such as confessing and seeking approval through other people or higher power(s)."</i>
5.	<i>"Through the interpersonal and intrapersonal routes offenders reach self-forgiveness, but this process may be accelerated or hindered by individual differences and situational factors."</i>
6.	<i>"This process includes and requires behavioural change and offenders experience.....",</i>
7.	<i>"increased well-being",</i>
8.	<i>"and diminished regret."</i>

In summary, considerable progress has been made in the study of self-forgiveness, since Hall and Fincham's (2005) seminal work, with several variables such as shame, guilt, transgression severity, positive and negative affect, perceived victim forgiveness and conciliatory behaviours being viewed as key in the study of self-forgiveness. However, much more research needs to be undertaken into the influence of proposed

mediators such as empathy and other prosocial responses such as self-compassion. Strelan and Covic (2006), Worthington (2006) and more recently Worthington and Sandage (2015) have also been critical of the absence of theory-driven empirical research, and advocate viewing forgiveness as a coping process to neutralise the distress and dissonance caused by transgressions. In the next section, the literature on coping will firstly be critically reviewed, secondly, the links between forgiveness, self-forgiveness and coping will be reviewed, and thirdly, the stress and coping research will be reviewed in relation to the forgiveness and self-forgiveness literature. Finally, the researcher's stress and coping model of self-forgiveness, self-compassion and psychological health will be introduced in relation to the supporting empirical literature.

2.3 Models of Coping

It has been suggested that forgiveness and self-forgiveness could be viewed as a coping response to neutralise the distress and dissonance caused by transgressions (Worthington, 2006; Strelan & Covic, 2006). It is for this reason that in this section, the literature on coping will now be reviewed.

Recent reviews of coping research (e.g. Mitrousi, Travlos, Koukia, & Zyga, 2013) highlight that research on psychological coping emerged out of a wish to better understand the impact of stress and mitigate the impact of stress-related aversive events. In commencing any discussion on stress and coping, the work of Lazarus and Folkman (1984) is salient. Lazarus and Folkman define coping as *"constantly changing cognitive and behavioural efforts to manage specific external and internal demands that are appraised as taxing or exceeding the resources of the person"*, (Lazarus & Folkman, 1984, p. 141). Mitrousi et al., (2013) outline the three main theoretical approaches that have emerged from coping research over the last four decades that include the psychoanalytic, personality, and the interactive model that will be briefly described and critiqued.

The psychoanalytic model (e.g., Valiant, 1977) emphasises the role of coping as a defence mechanism to manage psychopathology that is viewed to be a product of three developmental variables; the developmental stage that the trauma occurred, the conflicts associated with that stage, and the traits or temperament of the child. Lazarus (1981) criticised the psychoanalytic model because it associates coping with mastery over the

demands of the stressful situation, the process of coping therefore being confounded with outcome. For example, within the model the absence of stress-linked markers such as corticosteroids could be regarded as proof of a lack of a defensive response when this might be due to another process. The personality model (e.g. Kobasa, 1979) assumes that people with certain traits will behave in the same way irrespective of the environment that they find themselves. However, stressful situations are not static events, and different people respond to different kinds of stressful events in different ways at different times. Both the personality and psychoanalytic models of coping have been criticised on the basis of their one-dimensional simplicity as they do not account for the empirical evidence that indicates that coping is a multi-dimensional process. For example, coping with a physical illness is linked to broader environmental issues such as access to healthcare, the availability of medications, and the quality of medical care (Moos & Tsu, 1977).

The interactive model (Lazarus & Folkman, 1984) has become the dominant model of coping research (Mitrousi, et al., 2013). Within the interactive model, coping is not just a response to a stressful event, it also involves cognitive appraisals of these events that lead to the development of emotional responses. Lazarus and Folkman view coping as a dynamic process that involves two sets of separate cognitive appraisals. *Primary appraisals* are made about the significance of the stressful event from which meaning is derived, such as whether the event relevant or irrelevant, benign, positive, or stressful. Stressful events are categorised as threatening (the potential for harm or loss), challenging (potential for mastery, growth, gain) or harm-loss (when the injury or loss has already occurred). *Secondary appraisals* involve evaluations about what resources (psychologically, physically, socially, materially) the individual may have to reduce the stress associated with the situation and manage it better through increased self-efficacy or perceptions of personal control. If these responses are successful in reducing the stress, then coping can be said to have occurred that will motivate the individual to use these responses again. If the responses are perceived as ineffective or unmanageable, the situation will continue to be appraised as being stressful and these responses will be used less. Therefore, coping refers to attempts at managing the demands of stressful situations irrespective of outcome but over time can be seen to be viewed as either adaptive or maladaptive.

Lazarus and Folkman (1984) identified two types of coping, problem-focused coping and emotion-focused coping. Problem-focused coping behaviours tend to be adaptive and are termed “approach” strategies (e.g., information seeking, planning, seeking support, taking action) that are aimed at facilitating changes to solve a situation or event that is perceived as being changeable. In contrast, emotion-focused coping aims to reduce the intensity of distressing negative emotions rather than the problematic situation. Emotion-focused coping is often used when a situation feels out of our control (e.g. terminal illness) and we need to cope with the situation (Stanton, Kirk, Cameron & Danoff-Burg, 2000). Some emotion-focused coping behaviours (e.g., rumination, avoidance, self-blame, denial) are viewed as being maladaptive and encourage emotional disengagement. Whilst other emotion-focused coping behaviours (e.g., acceptance, emotional expression, reinterpretation) are viewed as adaptive strategies and promote efforts to understand one’s emotions (Zeidner, 1995), they can also help create new meanings in relation to a situation or event that is unlikely to change (Lazarus, 1999; Park 2010; Park & Folkman, 1997). Religion and spirituality are often viewed as important examples of meaning based coping especially when coping with aversive traumatic events such as emotional deprivation, abuse or accidents (Pargament, 2011).

In practice, both emotion-focused and problem-solving strategies tend to be used interchangeably when dealing with stressful events (Lazarus, 1999). For example, a socially anxious person who gave a speech to a room of a hundred people would likely feel anxious and stressed. Under these circumstances, maladaptive emotion-focused strategies (e.g., avoiding public speaking, rumination, self-critical thinking) would increase the person’s social anxieties and fears, whereas adaptive emotion-focused coping skills (e.g., calming breathing, self-reassurance) and problem-focused coping skills (e.g., rehearsal, planning) work together to reduce the person’s fear and improve their self-confidence and self-efficacy (Carver & Scheier, 2005).

In summary, coping is not a linear process and involves a series of feedback loops involving the evaluation and re-evaluation of primary and secondary appraisals and coping strategies until equilibrium is obtained and the affective response to the stressor is reduced or neutralised. Building upon the work of previous forgiveness researchers (Strelan & Covic, 2006; Worthington, 2006; Worthington & Shearer, 2004) it will be proposed that transgressions can be regarded as stressors that are appraised for the

perceived level of threat or loss that they pose. How these perceptions are appraised reflect a person's disposition towards self-forgiveness and how they feel at the time following a transgression. If the person has a low capacity for self-forgiveness they may tend to utilise emotion-focused coping (e.g. avoidance, self-criticism, rumination) whereas more self-forgiving people would tend to generate more challenge-based responses such as self-compassion that would be more helpful in generating psychological health. Before discussing these concepts in more detail I will first review the literature on coping and forgiveness followed by a discussion of Worthington's stress and coping model of forgiveness.

2.4 Coping and forgiveness

Strelan and Covic (2006) and Worthington (2006) suggest that viewing forgiveness as a coping strategy is important, as it has the potential to provide a better explanation of the process of forgiveness as an ongoing interaction between internal and external factors rather than assuming that one has to reach a certain stage or outcome. Strelan and Covic (2006) and Worthington (2006) point out that whilst previous researchers have proposed links between forgiveness and coping (e.g., Berry, Worthington, Parrott, O'Connor & Wade, 2001; Maltby, Day & Barber, 2004; Worthington & Scherer, 2004), however, none of these researchers have outlined how Lazarus and Folkman's (1984) model can guide research. Strelan and Covic (2006) and Worthington & Scherer (2004) went on to outline six ways in which coping is related to a forgiveness process:

- 1. Forgiveness is a reaction to a stressor (transgression) that involves negative cognitive, affective and behavioural responses.*

- 2. Reactions to the transgression involve primary appraisals and secondary appraisals that often take the form of questions or statements with affective and behavioural responses. In the case of primary appraisals these could be "am I hurt by what has happened?" (harm-loss); "how hurtful was this? (threat), that may produce anger together with a range of behavioural responses such as avoidance (withdrawal), attack (retaliation), or a freeze response (minimisation of harm). If the transgression is appraised as a threat that yields the secondary (challenge) response, "I want to understand myself and my partner better", then the behaviours associated with this*

appraisal may be expressions of understanding, empathy and compassion that will motivate a better understanding of such dyadic exchanges in the future. For example, a transgression may be reframed as less threatening because of new insights about a partner's historical experiences (e.g., prior experiences of rejection) which may increase compassionate responses as such transgressions may be viewed as less personal.

3. Coping strategies describe how people forgive: With reference to the above example, forgiveness can be conceptualised as emotion-focused coping because of a wish to; reduce angry responses and problem-solving with the aim of effecting a repair, deal with the causes of such transgressions, or leave the relationship if it is felt that the relationship is irreparable. Coping responses are viewed in terms of effectiveness rather than in pejorative terms such as 'good' or 'bad'. For example, whilst an angry response in relation to a misunderstanding (e.g., being late) may be very understandable, continuing to blame others and not taking responsibility for one's contribution to the misunderstanding would not be effective.

4. Forgiveness and coping can be future-orientated: Whilst coping is associated with adaptation and survival, coping is also associated with future-based coping, such as anticipatory and proactive coping in relation to uncertain or expected stressful events. For example, we may choose to forgive a transgression (e.g., excessive spending) because of the love that we have for that person, the damage that would be caused to the relationship should we not do so, and for reasons of common humanity and humility, such as 'everyone makes mistakes.' (Strelan, McKee, Calic, Cook & Shaw, 2013).

5. Forgiveness occurs within us (intrapersonally) and in relation to others (interpersonally): Coping and forgiveness both involve the formation of appraisals and the formulation of choices in relation to social and situational factors (Hall & Fincham, 2005; Thompson & Snyder, 2003).

6. Forgiveness is a dynamic and unfolding process: Evidence from lay, clinical, and research perspectives confirm that the processes of coping and forgiveness are dynamic, rarely linear and involve appraisals and re-appraisals that can be positive and negative until the stress associated with the stressor is resolved. In this way, it is possible to feel both anger and compassion to a transgressor much as one can feel anger

towards oneself in relation to coping with a stressful situation until equilibrium is obtained.

In summary, Strelan and Covic (2006) and Worthington (2006) suggest that it is more helpful to view the process of forgiveness and self-forgiveness as an ongoing interaction between internal and external factors rather than assuming that one has to reach a certain stage before forgiveness is complete. Viewing forgiveness as coping also allows for differences of responses in relation to the same appraisals and outcomes. For example, most adaptive responses (e.g. compassion) tend to lead to positive outcomes, but often compassion can lead to increases in fear and resentment which can complicate outcomes if the associated fear and stress is not neutralised. Finally, the vast literature on coping offers a good theoretical base from which to develop methodologies to study forgiveness. Within the research on forgiveness and stress and coping, Worthington's (2006) stress and coping model of forgiveness is seminal, and will be discussed in the next section.

2.4.1 Worthington's (2006; 2013) stress and coping model of forgiveness

Drawing upon previous research (Berry et al., 2001; Worthington & Scherer, 2004), Worthington (2006; 2013) developed the Stress and Coping Model of Forgiveness (Figure 2.3) that will briefly be reviewed.

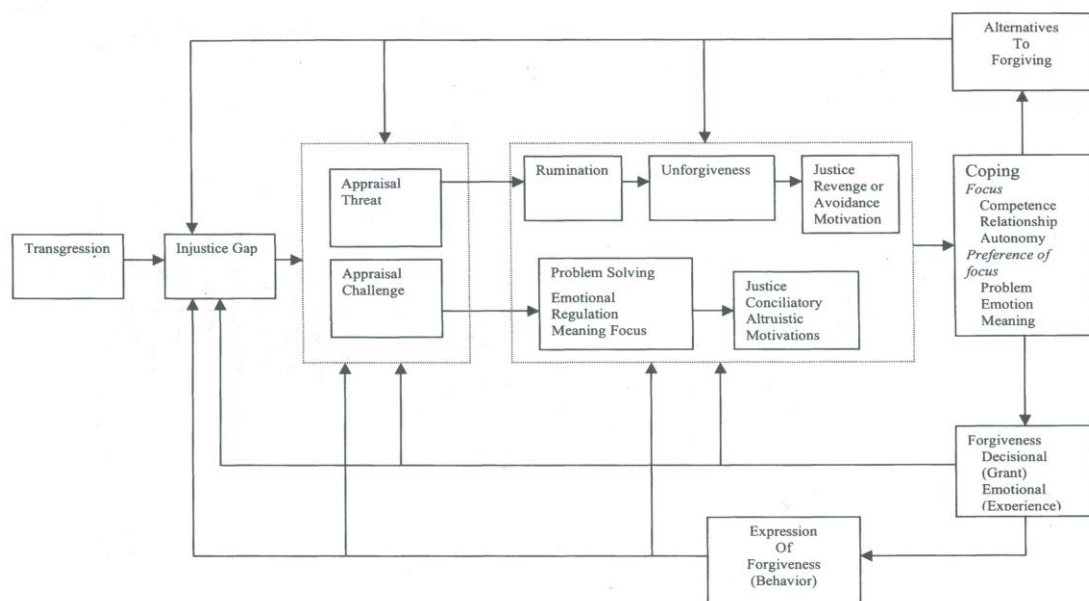


Figure 2.3: A theoretical model for coping with interpersonal transgressions (taken from Worthington, 2006, p. 31).

Worthington asserts that transgressions lead to a perceived injustice gap involving a discrepancy between the perceived outcome and the desired outcome (Exline, Worthington, Hill, & McCullough, 2003). The degree of injustice felt will depend on the size of the injustice gap (e.g. severity of the transgression) and the extent to which the transgression will be appraised as a threat or a challenge. If the transgression is appraised as a threat, then negative emotion-focused coping (e.g. rumination) and a state of unforgiveness would tend to occur together with strong affects (e.g. anger) that can motivate a desire for justice through seeking revenge or avoiding those who have transgressed. Challenge-based responses tend to involve problem-focused coping (e.g. altruism, decisional forgiveness) and adaptive emotion-focused coping (e.g. acceptance) that help understanding the motivations of the transgressor and make meaning about the transgression. The outcome of such coping is subjected to further primary appraisals that may lead to the transgression being appraised as more or less threatening. If the transgression is unresolved then the impact of the transgression can influence the development of personality traits such as neuroticism that will be later discussed.

Strelan and Covic (2006) and Worthington (2006) assert that viewing forgiveness as a coping process better reflects the process of forgiving as it provides a clearer explanation for variations in the process and experience of forgiveness and self-forgiveness. For example, some clients experience considerable fear and stress about becoming more understanding, empathic, and compassionate towards themselves. Finally, it is suggested that the vast literature on coping offers a good theoretical base from which to develop methodologies to study forgiveness.

A review by Yesseldyk, Matheson and Annisman (2010) identified seven empirical studies (Konstam, Holmes, & Levine, 2003; Maltby, Macaskill & Gillett, 2007; Rhoades, McIntosh, Wadsworth, Ahlqvist, Burwell Gudmunssen, Raviv & Rea, 2007; Seybold, Hill & Neumann, 2001; Strelan & Wojtysiak, 2009; Yesseldyk, Matheson & Annisman, 2009) that have examined the stress and coping model of forgiveness. Given the established links between compassion, forgiveness and well-being, it would be expected that forgiveness would be positively associated with adaptive emotion focused coping and problem-solving coping, but negatively associated with maladaptive emotion-focused coping (e.g. rumination). However, Ysseldyk et al., (2010) identified some inconsistencies. For example, forgiveness has been positively associated adaptive emotion-focused coping, and negatively associated with

maladaptive emotion-focused coping (e.g. rumination), especially with women (Kontsdam et al, 2003; Maltby et al., 2007). However, reduced dispositional forgiveness has also been found to be negatively associated with emotion-focused coping (Ysseldyk et al., 2007), and terrorists (Rhoades et al., 2007). More recent studies suggest that these findings may be linked to whether threat or challenge-based appraisals are studied (Yesseldyk, et al., 2010), the stage or phase at which forgiveness is appraised (Strelan & Wojtysiak, 2009) and how motivated individuals are to forgive (Rhoades et al., 2007).

2.4.2. Toussaint, Webb and Hirsch's (2017) stress and coping model of self-forgiveness and health.

Most recently, Toussaint, Webb and Hirsch (2017) have developed a stress and coping model of self forgiveness and health. Drawing upon a recent meta-analysis (Davis et al., 2015; Gilbert & Leach, 2017) they base their model upon two propositions. Firstly, they propose that self-condemnation is stressful and leads to poor health (see Fig 2.4, path A), and secondly they provide evidence linking shame and guilt with corticosteroid inflammatory markers (Dickerson, Grunewald & Kemeny, 2004), poorer psychological health (Kim, Thibodeau & Jorgenson, 2011) and reciprocal links between mind and body (Reiger, Göllner, Trautwein & Roberts, 2016).

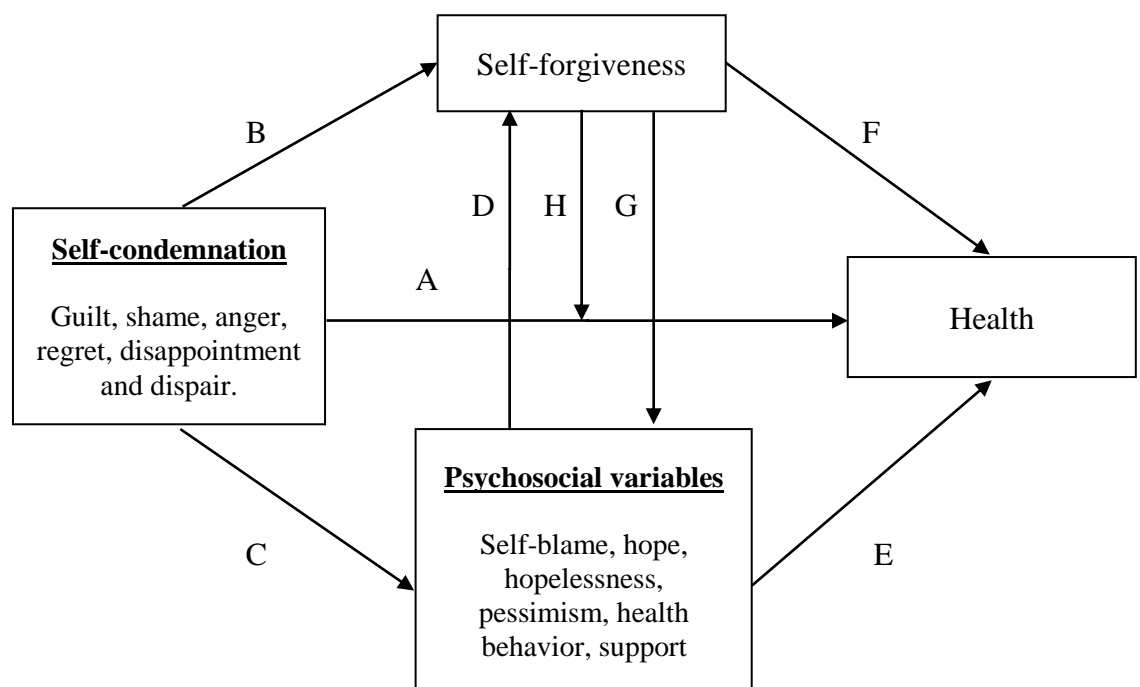


Figure 2.4. Stress and coping model of self-forgiveness and health (taken from Toussaint, Webb, & Hirsch, 2017, p. 89).

Secondly, Toussaint et al., (2017) that self-condemnation can elicit a range of coping responses (e.g. denial, rationalisation, justification, amends-making, substance abuse, behavioural disengagement etc.) as well as more clearly adaptive emotion-focused coping responses such as self-forgiveness that may reduce the stress of self-condemnation (path B). Toussaint et al. (2017), highlight that the motivation to adopt a self-forgiving response has been linked with guilt but not shame (e.g. Carpenter, Tignor, Tsang & Willett, 2016).

Toussaint et al., (2017) acknowledge potential complex mediating links between self-condemnation and health with a range of psychosocial variables (path C), such as self-blame, hopelessness, guilt, and shame, as well as the impact of these variables upon self-forgiveness (path D). They also point towards the mediating effects of the psychosocial variables on health (path E), and the mediating effects of self-forgiveness on the psychosocial variables (path G) and health (path F). They also highlight the moderating effect of self-forgiveness (path H) on the association between self-condemnation and physical health (Forsythe & Compass, 1987; Liao & Wei, 2015). Whilst Toussaint et al.'s (2017) model provides a useful basis for further research, major criticisms of this model include that key aspects of Lazarus and Folkman's (1986) model such as primary and secondary appraisals do not appear to feature in their model. Neither do the influence of prosocial responses such as self-compassion, and key socio-demographic (e.g. age, SES, gender, culture) and personality factors (e.g., neuroticism) especially in relation to genuine and pseudo-self-forgiveness.

In summary, research into forgiveness and self-forgiveness has certainly grown and developed since Strelan, Covic, and Worthington's reviews (Strelan & Covic, 2006; Worthington, 2006). Whilst there are some inconsistencies within the research, the empirical evidence in support of the stress and coping model of forgiveness is encouraging. It clear that much more research is needed, and many of the original research problems that Strelan and Covic (2006) highlighted remain. Toussaint et al., (2017) propose that given self-condemnation is central to the stress and coping model, and that self-condemnation needs to be more clearly distinguished from self-forgiveness. They suggest that studies need to consider different types of self-condemnation and how they influence stress associated with life events (stressors) as well as physical and psychological well-being. Indeed, whether self-forgiveness acts as a mediator, moderator or both? They go on to stress that self-forgiveness research has

an over-reliance of undergraduate psychology students as research subjects and cross-sectional research. Furthermore, the paucity of longitudinal and clinical studies that means that the validity of the proposed model is open to question. Whilst self-condemnation is a key factor, the researcher asserts that there is also a lack of research into adaptive constructs that have been associated with forgiveness and improved mental health outcomes (e.g. compassion, self-reassurance and positive affect), and maladaptive constructs that are associated reduced mental health outcomes (uncompassionate self-responding, self-criticism, and negative affect). Such research may clarify some to Toussaint et al's (2017) concerns about delineating the concepts of self-condemnation and self-forgiveness.

In this next section I will outline the models of self-compassion and compassionate therapies that have been developed before moving on to forge links with self-compassion, self-forgiveness, affect and health-related outcomes. This will eventually yield the researcher's stress and coping model of self-forgiveness, self-compassion, affect and psychological health that pays reference to these criticisms and which will be later subjected to empirical testing.

2.5 Models of compassion and self-compassion.

Before defining what self-compassion is, it is important to consider the concept of compassion from religious and philosophical perspectives. Historically compassion has been conceptualised as a virtue that it often associated with Buddhist thinking, but its essence can be found in other religions such as Hinduism, as well as the Muslim and the Judeo-Christian traditions (Ozawa-de Silva, Dudson-Lavelle, Raison & Tenzin Negi, 2008). Within these religions, compassion is generally regarded as a desire to alleviate suffering and distress within others (compassion for others) and within oneself (self-compassion), as well as the desire to do no harm towards others and oneself through benevolent action (Davies, 2001). Drawing upon an ethical framework, Ozawa-de Silva, et al., (2008) point out that within a range of diverse religious traditions, compassion and ethical behavior are closely intertwined and they define ethics as *“a way of conceptualising how human beings relate to one another and their environment with specific regard to the alleviation of suffering and its alleviation”* (p.5). It has been suggested that compassion can serve as a unifying ‘secular’ foundation of human values

and ethics that transcend religious thinking and can act as a guide to life (Dalai Lama, 2001) and concepts of social justice (Williams, 2008).

The next sections of this review will focus upon how compassion has been conceptualised before examining the literature on self-compassion, how self-compassion has been assessed, and how compassion and self-compassion have informed the development of compassion focused therapies.

2.5.1 Models of compassion

Recent reviews of the compassion literature (e.g. Goetz, Keltner & Simon-Thomas, 2010; Gilbert, 2014; Jazaieri, et al., 2013; Kirby, Tellegen & Steindl, 2015; Kirby, 2016; Strauss, Taylor, Gu, Kuyken, Baer, Jones & Cavanagh, 2016) highlight how compassion has been conceptualised from several perspectives.

Jazaieri et al., (2013) describe compassion as a multidimensional framework comprising four-dimensional components; (1) a cognitive component (an awareness of suffering), (2) an affective component (being emotionally moved by the suffering), (3) an intentional component (a wish to see the suffering alleviated), and (4) a motivational component (a wish to intervene and alleviate suffering). Goetz et al., (2010) explore compassion in relation to a number of pro-social affective states such as understanding, empathy and sympathy, and define compassion as *“the feeling that arises in witnessing another’s suffering and that motivates a subsequent desire to help”* (p.352). In their model, compassion constitutes an evolutionary advantage that influences caregiver’s responses to their offspring, tendencies that become genetically selected. They suggest that compassion is a trait that potential mates regard as valuable because of its capacity to promote survival. Gilbert (2005; 2011; 2014) also conceptualises compassion within an evolutionary and affiliative framework. Within the context of recent neuroscience research, he emphasises compassion as a motivational force as defines compassion as *“the feeling to suffering in self and others, with a commitment to try and alleviate and prevent it”* (Gilbert, 2014, p.19). Kristin Neff has explored compassion from within a Buddhist framework and does not distinguish between compassion and self-compassion regarding both as having the same qualities. Neff (2003b) defines self-compassion as *“being open and moved by one’s own suffering, experiencing feelings of caring and kindness toward oneself, taking an understanding, non-judgmental attitude toward*

one's inadequacies, and failures, and recognising that one's experience is part of the common human experience," (p. 224).

Over the past decade Gilbert and Neff's models of self-compassion have become the most influential, both of which have yielded models of therapy that have been subjected to empirical evaluation (Kirby et al., 2015). Whilst Gilbert's model does not exclusively focus on self-compassion, both models will now be subjected to further discussion and evaluation.

2.5.2 Models of self-compassion

Paul Gilbert's (2010) Model of self-compassion

Paul Gilbert is a Clinical Psychologist and researcher who is based at the University of Derby, UK, who developed the Compassionate Mind Training (CMT) model that subsequently evolved into Compassion Focused Therapy (CFT). Gilbert (2014) explains that his model and therapy arose out of a four key clinical observations and reviewed research findings over many years of practice. Firstly, he became aware that people who are highly shaming and self-critical experience difficulties in being kind to themselves, feeling self-warmth or being self-compassionate (Kaufman, 2009; Schore, 2003). Secondly, that the origins of shame and self-criticism are often rooted in histories of emotional neglect, and physical and sexual abuse that leave them sensitive to the external threats of rejection or criticism, whilst their internal worlds can quickly become self-attacking. Thirdly, that undertaking therapy with these clients tends to involve a focus on resolving memories of early childhood trauma (Brewin, 2003; 2006; Gilbert, 2005; Van der Hart, Nijenhuis, & Steele, 2006). Fourthly, these clients often had poor outcomes when offered CBT (Rector, Bagby, Segal, Joffe & Levitt, 2000) because they found it very difficult to generate feelings of safety and warmth both in their relationships with others and in relation to themselves (Gilbert, et al., 2009).

By way of explaining these phenomena and findings, Gilbert (2010; 2014) draws upon the recent advances in neuroscience that highlight the existence of three emotional regulation systems (Dupue & Morrone-Strupinsky, 2005; LeDoux, 1998; Liotti & Gilbert, 2011; Panksepp, 1998) (Figure 2.5 overleaf).

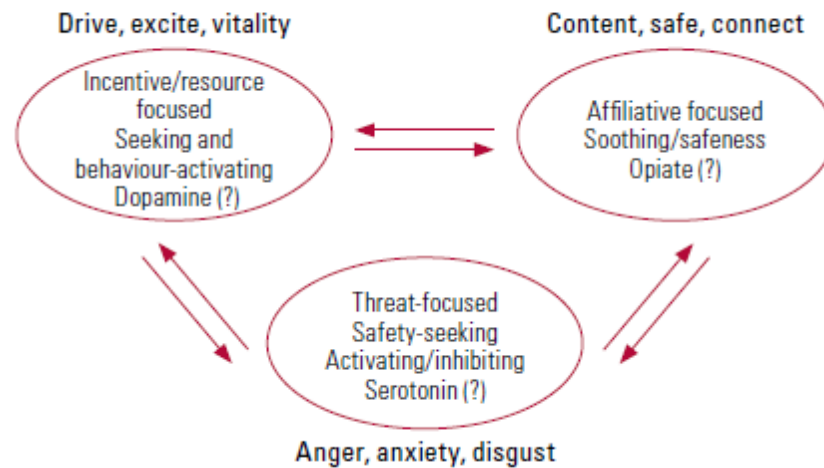


Figure 2.5. The three affect regulation systems (taken from Gilbert 2009. p. 200)

The threat and self-protection focused systems – these systems are designed to enhance survival through detecting both internal and external threats associated with danger. The threat system is associated with a range of ‘negative’ emotions (anger, fear, anxiety, shame, disgust) that produce a range of behavioural responses (attack, avoid, submission, freeze) that can be influenced by the remaining two emotional systems.

The drive, seeking and acquisition focused system – the drive system is linked to attention/motivational desires to engage with others in contest/conflict interactions to obtain evolutionary necessities to ensure survival (obtaining food, access to sexual partners, kinship, homes, land, social rank) and which give rise to positive emotions such as excitement and vitality. When individuals do not achieve their goals then there is a tendency towards dispassion, self-judgment, negative social comparisons, shame and self-criticism (Gilbert et al., 2004; Judge et al., 2012).

The contentment, soothing and affiliative focused systems – these systems are linked to the mammalian attachment system that are activated when the individual is not being threatened and when the drive system is not required. This system underpins the positive feelings of warmth, love, being calmed, soothed, and turns off the emotions associated with the threat and drive systems. It also affords the positive effects of social bonding and attachment behaviours such as touch, holding and stroking that are essential in creating safeness, connectedness and the development of secure attachment.

Bonds that foster cooperation and enhance survival of the individual and the social group (Bowlby, 1988, Crozier, Webster & Dillon, 2012; Hrdy, 2009).

Gilbert (2005: 2014) points out that the threat, drive, and affiliate systems are always interacting and create neurological pathways that have reciprocal effects on each other. For example, the child who has experienced regular experiences of compassion, love, holding and affection will have a highly developed soothing system that lead them to feel more emotionally regulated and calmer when stressed due to being able to draw upon historical experiences of being soothed (Schoore, 2003). In contrast, if the child has experienced low levels of compassion associated with emotional neglect or abuse, then the threat system will be more highly developed resulting in feelings insecurity, hypervigilance, and conditional self-worth. Feeling soothed and affiliated will be contingent upon driving themselves to achieve or please others, or themselves through external rewards such as alcohol or drugs.

In summary, within Gilbert's model, compassion is comprised of a range of evolved motives, attributes and competencies that act together to have a major impact on the regulation of negative affect through helping the individual to attune to their own needs and the needs of others through the expression of warmth and safeness.

Kristin Neff's (2003b) model of self-compassion

Kristin Neff is a research psychologist based in Austin, Texas, whose research into self-compassion is seminal within the field of psychology. Neff's approach (Neff, 2003a; 2003b), has its roots within the Buddhist tradition whose conceptualisations focus upon the empathic wish to be sensitive to the suffering of others and a desire for all beings to be free from suffering. Compassion is regarded to be a mental capacity that, when strengthened, empowers all positive states of mind that help us achieve our fullest human potential.

In the Buddhist tradition, compassion is closely connected with the "*four elements of true love*" Nhat Hanh, (1997, p.1). These are termed: *Metta* (loving-kindness – wishing happiness to others, self and environment); *Karuna* (compassion – sympathetic identification with another's suffering); *Mudita* (sympathetic joy – rejoicing in the happiness of others) and *Upekkha* (equanimity – a non possessive love of all things) that

are mutually supportive of each other, and when balanced with wisdom form the basis of meditative insight. Buddhism emphasises the sympathetic understanding of the nature and cause of suffering, and acts to ease suffering through the use of unconditional non-discriminatory benevolence towards all human beings (Makransky, 2012).

It was from this framework that Neff (2003b) undertook her PhD and went on to develop and evaluate the Self-Compassion Scale (SCS) (Neff 2003a) the factor structure of the SCS comprises three main interrelated bipolar components that Neff (2015) requests are termed ‘Compassionate Self-Responding’ (CSR) and ‘Uncompassionate Self-Responding’ (USR) behaviours. These components are exhibited at times of pain and distress each of which has two polarities that are reflective of related opposing states of mind which mutually interrelate, the synthesis of which reflect how self-compassionate we feel (Table 2.3). Each of which will now be explored in more detail.

Table 2.3. Identifying the 3 bipolar constructs of self-compassion as measured by the Self-Compassion Scale (Neff, 2003b).

Self-compassion sub-scales	Vs	Uncompassionate sub-scales
Self-kindness	Vs	Self-judgment
Common Humanity	Vs	Isolation
Mindfulness	Vs	Over-identification

Self-kindness versus self-judgment.

Self-kindness involves the extension of a range of pro-social attributes such as being gentle, empathic, understanding, kind, sensitive, warm, and forgiving to all aspects of oneself including one’s thoughts, feelings and behaviours and impulses. Self-kindness has been associated with unconditional self-worth irrespective of success,

failure, setback or feelings about personal inadequacies (Neff, Kirkpatrick & Rude, 2007; Neff, Hsieh & Dejitterat, 2005). In contrast, self-judgment involves, being hostile, disrespectful, demeaning, unempathic, cold, insensitive, unforgiving and rejecting of oneself or aspects of oneself. Self-judgment is associated with a conditional sense of self-worth where perfection is strived for and failure is ceased upon as justifications for relentless self-criticism and self-punishment that can seem a just, reasonable and even natural state of mind (Gilbert, McEwan, Matos, & Ravis, 2011).

Common humanity versus isolation.

Common humanity involves recognising that we are all suffering, imperfect and make mistakes, and in so doing we have an awareness that we are not alone in our suffering. We cannot get what we want nor can we be what we want. Common humanity involves being able to forgive ourselves for our imperfections, as being imperfect is a unifying part of the human condition suggesting that our failures need not be taken so personally (Neff 2003a). In contrast, isolation emerges when we consider our differences and failures from a self-referential point of view, where they “only apply (or happen) to me.” The lives of others may be idealised as examples of perfection (e.g. status, appearance, success and intellect) that only serve to heighten the perceived difference between individuals. These perceptions tend to lead to increased suffering and isolation through self-criticism, self-pity and shame, whereby there is a tendency to socially withdraw, hide our true self, and deny ourselves the compassionate support associated with self-forgiveness (Jacinto, 2009).

Mindfulness versus over-identification.

Self-compassion requires an ability to be mindful and aware of the present moment, non-judgmentally, whilst being able to see the self just as it is without trying to ignore, deny, change or ruminate about aspects of ourselves that we do not like (Brown & Ryan, 2003). Being mindful involves regarding emotions, thoughts and feelings as ‘epiphenomena of the mind’ and in so doing developing a sense of perspective about the workings of the mind rather than reacting to and identifying with what the mind generates. In contrast, the ability to be mindful can be moderated by the two opposing tendencies of over identification and avoidance. Over-identification involves being swept away with ruminations about the self (e.g., failure, worthlessness)

as well as one's negative thoughts and emotions, tendencies that compromise the mind's ability to be compassionately aware of their suffering in present moment (Neff, Hsieh, & Dejitterat, 2005). If the suffering is intense and chronic we can become more avoidant and self-reflection and understanding tend to be compromised (Germer, 2009).

Whilst the work of Kristin Neff and the development of the SCS has revolutionised research into compassion over the past 15 years, Macbeth and Gumley (2012) are critical of the lack of clinical and longitudinal studies of self-compassion and the tendency for researchers to only report the single factor SCS total score. They point out there is a lack of research in identifying whether some self-compassion factors of the SCS may be more active at sometimes in certain circumstances and call for further research into these issues. A proposition that is supported by authors such as van Dam, Shepard, Forsyth and Earlywine, (2011).

Neff (2016) encouraged researchers to explore the two-factor model and subscales of the SCS. It is noted that subsequent research into the use of the bifactor model by Neff and her colleagues found evidence supporting the use of the single-factor across the samples, and the use of the bifactor scores with non-clinical samples but not clinical samples (Neff, Whittaker & Karl, 2017). Further research by Neff, et al., (2018) examined the factor structure of the SCS in 20 diverse samples ($n = 11,685$), the results of which supported use of the SCS total scale score or the six subscale scores, but not the bifactor model representing compassionate and uncompassionate self-responding. Neff et al., (2018) acknowledge that there were limitations to this study, namely that the majority of the participants were female and were obtained from non-clinical (student) community settings and that further research is required.

Having reviewed Neff and Gilbert's theoretical models, I will now examine their models of compassionate therapy and the bodies of research that each have inspired. I will also briefly review the related outcome research that has been undertaken that led the researcher to choose CFT as the therapeutic modality of choice for this study.

2.5.3 Models of compassion therapy

The evidence presented thus far suggests that self-compassion is associated with improved psychological well-being and appears protective in terms of coping with the

stresses of living. But can self-compassion be taught effectively? A recent review of compassion interventions by Kirby (2016) highlights that six types of empirically validated compassion therapy have been developed over the past 10-15 years. These include: Compassion Focused Therapy (Gilbert, 2005; 2009; 2014), Mindful Self-compassion (Neff & Germer, 2012), Compassion Cultivation Training (Jazaieri et al., 2013), Cognitively Based Compassion Training (Pace, Tenzin, Adame, Cole & Suilli, 2009), Cultivating Emotional Balance (Kemeny, et al., 2012) and Compassion and Loving-kindness Meditation (Hoffman, Grossman & Hinton, 2011).

In terms of similarities, Kirby (2016) points out that all of these programmes take a secular approach and are theoretically influenced by Buddhist meditative psychology. Furthermore, they can be delivered in groups and all contain phases of psycho-education, meditative practice, and experiential practice and have the expectation that participants will undertake homework between sessions. In terms of differences, Compassion Focused Therapy (CFT) stands out theoretically, as it is the only intervention that draws upon evolutionary psychology, attachment theory and neuroscience research. Its method of delivery is also different, as it is the only intervention that is regarded as form of psychotherapy. Finally, as the evidence has developed over the past decade, Mindful Self-compassion (MSC) and CFT have emerged as arguably the two most well-known and evaluated compassionate interventions.

MSC teaches a variety of core meditations (affectionate breathing, loving-kindness to ourselves, giving and receiving compassion) and practices (e.g. soothing touch, compassionate imagery, letter writing) within a group setting that afford the participant the opportunity to develop self-compassion in their daily lives. The author is only aware of two randomly controlled trial (RCT) studies that have evaluated MSC. Neff and Germer have published one randomly controlled outcome study (Neff & Germer, 2013) that compared an MSC treatment group with a waitlist control group. Participants within the MSC group reported significant increases in self-compassion, mindfulness, compassion for others and life satisfaction with reductions in anxiety, depression stress and emotional avoidance that were maintained at 6 and 12 month follow up. Life satisfaction increased significantly at 12 months suggesting that MSC enhanced the quality of life over time. A second RCT study by Friis, Johnson, Cutfield and Consedine (2016) examined the effectiveness of an 8 week MSC training program

upon the mood and metabolic outcomes within a sample of diabetes patients. Friis et al. found that taking part in the MSC group yielded significant reductions in depressive symptoms, diabetes-specific distress and blood glucose levels (reduced HbA_{1c}), results that were maintained at 3-month follow-up.

Gilbert (2010) asserts that CFT aims to help clients develop a more compassionate mind towards themselves and others through the development of six key compassionate attributes termed; empathy, sympathy, sensitivity, care for well being, non-judgment and distress tolerance, that can be developed through learning compassionate skills (soothing rhythm breathing, compassionate reasoning / thinking, compassionate behaviour, compassionate imagery, compassionate letter writing). Together they calm the mind so that clients can respond to their self-critical narratives with nurturance, and self-compassion that enhances psychological well-being (see figure 2.6).

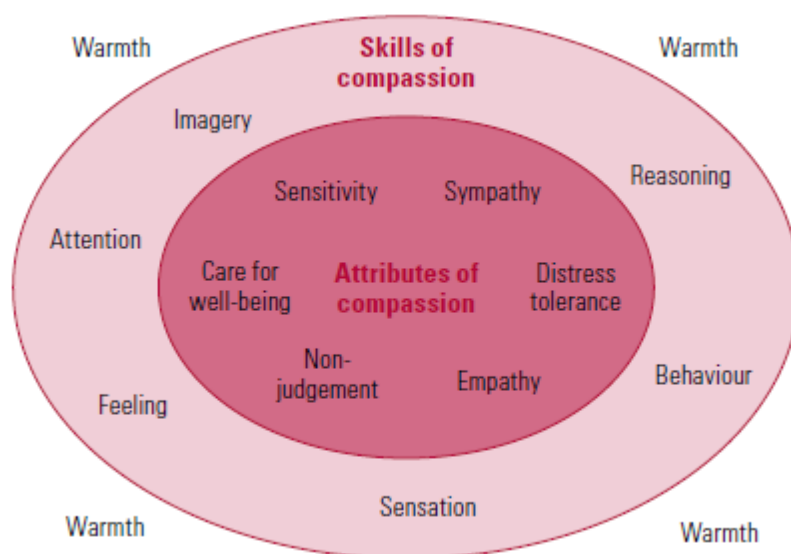


Figure 2.6. Multimodal compassionate mind training: The key aspects and attributes of compassion (inner ring) and the skill training required to develop them (outer ring), taken from Gilbert (2009). p. 203.

Within these contexts, Gilbert (2010) outlines the five modules of Compassionate Mind Training (CMT) as the core compassionate skill competencies that are used focally in within CFT. More recently Gilbert and Woodyatt (2017) have clarified the role of these competencies in relation to self-forgiveness.

1. Psychoeducation:

This module focuses on helping participants to understanding the reasons why human beings have difficulties in meeting the challenges of living. Participants explore how the human brain has evolved, and how our sense of self and behaviour emerges from interactions between evolutionary motives and current environmental challenges. Participants learn how more recently acquired perceptual capacities such as self-awareness, imagination, self-monitoring, self-criticism and rumination, have enabled human beings to become a successful species but who at the same create suffering. In this way participants learn that much of what goes on in our mind is ‘not our fault’, a stance that helps reduce shaming and blaming.

An important part of this module involves learning about the three motive systems (threat, activation/drive, affiliation/soothing/caring) and how it is possible to learn skills to reduce our capacities for threat, and increase our capacities for caring, helping and soothing, and in so doing take responsibility for personal change. Participants learn about the importance of intention and motivation in reducing their resistance to developing their compassionate self.

2. The use of body-focused interventions for grounding the mind.

In this module participants learn the connections between the body and mind and how through learning skills (mindful attention, soothing rhythm, mindful breathing, and emotional tones) it is possible to increase parasympathetic activity to slow down the body and improve distress tolerance. Gilbert and Woodyatt (2017) suggest that in order to become more self-forgiving it is important to tolerate the guilt associated with personal transgressions as well as the shame and distress associated with self-criticism and self-hate. Not to be able to do so would inhibit self-acceptance and self-forgiveness (Gilbert & Irons, 2005).

3. Developing capacities for attention, observation and mindfulness

Compassionate Mind Training does not encourage the use of mindfulness over long periods because many people find it difficult and disturbing due to difficulties in focusing the mind. Instead participants are introduced to the principles of mindfulness

and simple mindfulness practices (e.g. mindful breathing, attention-observation, and attention-gratitude) that are used to help develop participant's awareness of the mind and daily activities with the intention to develop a compassionate self. Gilbert and Woodyatt (2017) suggest that not to be able to notice or attend to an aversive state would increase the risk of dissociation that would complicate the skills of mindfulness that are so necessary for self-forgiveness and self-compassion to occur.

4. The nature of compassion and the development of compassionate attributes and skills.

Participants learn about the nature of compassion and discuss their fears and negative beliefs about developing self-compassion. Typically, people express no problem in being compassionate and forgiving to others but report considerable barriers to developing self-compassion and self-forgiveness. They learn that compassion is not a weakness but is instead a way of building courage and determination to tackle the challenges of living. Building upon the previous module, participants learn a range of transformative skills that facilitate compassion. This involves the development of compassionate imagery, compassionate thinking, compassionate behaviour, and using emotions to appropriately guide behaviour (e.g., using anger as a marker of injustice to guide assertiveness) that together helps to develop the affiliative system and promote resilience, commitment, wisdom and strength.

Participants learn about the six attributes of compassion (attention sensitivity, sympathy, distress tolerance, empathy, and non-judgment). Sensitive and sympathetic noticing allows participants to pay attention towards, tolerate and be moved by their own distress and disappointment to a point where it is possible to experience empathy for their circumstances and be moved by it. Empathy involves two dimensions: emotional contagion and attunement, and perspective-taking (Decety & Cowell, 2014). Together, it becomes possible for participants to understand and experience the impact of their transgressions on others and themselves providing links with a sense of common humanity and fallibility.

Within CFT participants learn about the influence of evolutionary forces that bind us, in particular our tendencies to react mindlessly with judgment and condemnation such as self-criticism and self-hate (Gilbert & Irons, 2005). With this wisdom and

understanding it becomes more possible to develop self-empathy in relation to the forces and motivations that drive us towards committing transgressions and become less judgmental towards others and ourselves. In this way we can become more aware of our ‘tricky minds’ and how unrealistic our self-expectations can be. Over time it is possible to develop new insights around the developmental circumstances that led to the development any related negative self-beliefs. By being less self-condemning and more open to experiencing the guilt, remorse and sadness about the transgression it becomes possible to unhook ourselves from the beliefs and assumptions that impede the process of self-forgiveness.

5. Developing the compassionate self

Participants learn that they can develop compassionate and safe-place images and sensory experiences to help themselves in particular ways and roles. For example, through the use of acting techniques and compassionate letter writing, participants learn that pairing an image of a ‘coping self’ with a soothing smell (e.g. lavender) can help with intrusive self-critical thoughts, images, and emotions such as shame and guilt about failing or not coping. In so doing participant’s learn that through developing a compassionate self it is possible to develop a sense of strength and confidence (secure base) to help cope with the real and perceived threats associated with living and gain respite from enduring feelings and conflicts.

Gilbert (2010) has encouraged clinicians’ and researchers to utilise these five modules (not necessarily in a linear way) to act as a guide to help clinicians’ and researchers to develop individual and group psychotherapeutic CFT approaches. In response, CFT clinical texts have been developed to treat a range of particular symptoms such as anger (Kolts, 2011), social anxiety (Henderson, 2011), anxiety (Tirch, 2012), post-traumatic stress disorder (Lee, 2012), as well as more general problems such as self-confidence (Welford, 2012).

2.5.4 Compassion Focused Therapy outcome research

CFT is a relatively new psychological therapy and like all new forms of psychotherapy has undergone a process of theory development (Gilbert, 2005; 2010; 2012; 2014; Gilbert & Choden, 2013) and clinical practice over the past decade. In the

first empirical review of CFT outcome research, Leaviss and Uttley (2014) identified fourteen studies, three of which were Randomised Controlled Trials (RCTs) (Kelly, Zuroff, Foa & Gilbert, 2010; Shapira & Mongrian, 2010; Braehler, Gumley, Harper, Wallace, Norrie & Gilbert, 2013). Of these, the study by Braehler et al., (2013) was the more in-depth. Braehler et al undertook a 16-week CFT group program with clients presenting with psychosis and compared them to a treatment as usual group, the results of which indicated a significant reductions in depression in the CFT group over the control group. The remaining studies were a mixture of non-RCTs and case and observational studies that generally indicated improvements of a range of markers of psychological well being (e.g., depression, anxiety, self-compassion, eating behaviours, self-criticism). Leaviss and Uttley (2014) concluded that whilst it was very early to undertake a review of CFT outcome research, they concluded that CFT “*showed promise as an intervention for mood disorders, particularly those high in self-criticism*” (p.1).

More recently, Kirby et al., (2015) undertook the first meta-analysis of 23 compassion-focused interventions that were reduced to 12 studies after utilising a focused set of criteria with seven outcome variables. Kirby reported significant effect sizes for compassion ($d = .559$), self-compassion ($d = .694$), and mindfulness ($d = .525$), depression ($d = .656$), anxiety ($d = .547$) psychological distress ($d = .374$), life satisfaction and happiness ($d = .540$). Of the compassionate therapies that were evaluated, Kirby (2016) concluded that CFT has been subjected to the most empirical evaluation and is the only compassionate therapy that has been validated for use with clinical populations. Hence its selection as the chosen therapy intervention for this research. More recently, a recent meta-analysis by Wilson, Mackintosh, Power and Chan (2018) claimed that CFT and other self-compassion therapies were no more effective than other therapies. In response Kirby and Gilbert (2019) asserted that the claims of Wilson et al., (2018) were ‘misleading’, broadly because the ‘self-compassion therapy group’ contained outcome data from therapies (e.g., mindfulness-based cognitive therapy, emotion-focused therapy and acceptance and commitment therapy) that are not specifically designed to increase self-compassion.

Empirical studies are just beginning to identify processes of change within CFT. For example, a very recent review by Sommer-Spijkerman, Trompetter, Schreurs and Bohmeijer, (2018a) highlighted that whilst a number of these studies appear supportive

of the effectiveness of CFT in increasing positive affect (Engen & Singer, 2015) and reducing negative affect (Leary, Haupt, Strausser & Chokel, 1998; Diedrich, Grant, Hofmann, Hiller & Berking, 2014; Deidrich, Hofmann, Cuijpers & Berking, 2016; Arimitsu & Hofmann, 2017), evidence supporting Gilbert's (2014) theory of change is lacking at this time.

In summary, following the seminal work of Paul Gilbert and Kristin Neff, there has been an enormous growth in psychological research into self-compassion over the last decade. Whilst Gilbert and Neff have both developed effective models of therapy, it appears that at this stage CFT has been evaluated more extensively and is most effective with mild to moderate psychological difficulties, although the processes of change appear yet to be empirically validated. As forgiveness and self-forgiveness are associated with psychological well-being and appear protective in terms of coping with the stresses of living, it would be important to review the empirical evidence linking self-compassion with these concepts. This would be especially prudent given that one part of the current study focuses on the delivery of a CFT group therapy intervention as part of this research.

In this next section I will briefly review the literature linking self-compassion with psychological well-being and resilience before examining the evidence linking self-compassion with the stress and coping literature. I will then move on to explore the links between self-compassion, self-forgiveness and psychological health.

2.6 Self-Compassion, Stress and Coping.

Macbeth and Gumley (2012) point out that the majority of the self-compassion research that has been undertaken has examined the impact of construct as an individual difference variable upon psychological health and well-being. Their meta-analysis explored associations between self-compassion and psychopathology and found a large effect size $d = -0.54$ (95%CI = -0.57 to -0.51; $Z = -.34$; $p < .0001$) and concluded that *"compassion is an important explanatory variable in understanding mental health and resilience"* (p.1).

Drawing upon the stress and coping literature (e.g., Lazarus & Folkman, 1984), Allen and Leary (2010) suggest that in comparison with less compassionate people, self-compassionate people experience tend to experience less stress because they use

more effective coping strategies such as adaptive coping (e.g. positive restructuring, problem-solving, distraction, support seeking) rather than maladaptive coping strategies such as escape-avoidance strategies (e.g. cognitively or behaviourally disengaging from the stressor). After reviewing the available literature they concluded that in terms of coping, self-compassionate people tend to rely heavily on positive cognitive restructuring and less on escape-avoidance-escape than less self-compassionate people, but that both used distraction and problem-solving. There was inconclusive evidence to suggest that self-compassionate people use more support seeking.

Recent research by Sirois, Molner and Hirsch (2015) has extended research into links between stress, self-compassion and coping with the impact of physical ill-health. Using the Brief COPE Scale (Carver, 1997) and the Coping Efficacy Scale (Gignac, Cott & Badley, 2000), Sirois et al., (2015) found further evidence to support the link between increased self-compassion and adaptive coping (positive reframing and acceptance) and decreased use of escape-avoidance strategies (self-blame, denial, and behavioural disengagement). Of these strategies behavioural disengagement and self-blame were associated with reduced coping self-efficacy, and acceptance, positive reframing and active coping were associated with increased coping self-efficacy. This suggests that self-compassionate people may be more able to adjust to illness-related stressors because they utilise more appropriate and realistic problem-solving coping strategies to reduce the stress associated with their illness. Whilst the authors did not use the self-kindness as part of their analysis, the known close links between self-kindness and self-compassion (Neff, 2003a; 2003b), reinforces the link between self-kindness, reduced self-critical thinking and confidence in managing chronic stressors (Sirois, et al., 2006), poor psychological well-being (Voth & Sirois, 2009) and may be protective against self-blame coping (Sirois et al., 2015).

In summary, Gilbert and Neff's models and theories of self-compassion have transformed and unified the research of self-compassion over the past decade. The reviewed research strongly suggests that self-compassion is associated with increased psychological health and well-being (Macbeth & Gumley, 2012), and a greater capacity to utilise more appropriate and realistic problem-solving coping strategies to reduce the stress associated with living (Sirois, Molner & Hirsch, 2015). Preliminary reviews of the last decade of research suggest that CFT in particular holds promise in their ability to increase self-compassion, life satisfaction with reductions in self-criticism and

psychological markers of distress that makes CFT the therapy of choice for this research.

Given the extensive spiritual and religious writings that draw links between compassion and forgiveness. In the next section I will draw together the threads of this thesis through summarising the previously reviewed research into the phased process of self-forgiveness. I will then draw upon the work of Neff and Gilbert and propose that the relationship between self-forgiveness and self-compassion can be viewed as a process of coping. With this accomplished, the empirical studies that have been undertaken into the links between self-forgiveness, self-compassion and psychological health will be explored.

2.7 Self-compassion, self-forgiveness, and psychological health

Self-forgiveness and self-compassion have both been hypothesised to be moral restorative responses to address unjustified harm to the self (Dalai Lama & Ekman, 2008; Goetz et al., 2010; Hall & Fincham, 2005; Worthington, 2006). A recent review of the self-forgiveness and self-compassion literature by Woodyatt, Wenzel and Ferber (2017) highlights that the process of self-forgiveness has been conceptualised as comprising two pathways in relation to self-compassion that the researcher proposes to extend in relation to the compassion-focused literature, Cornish and Wade's, (2015a) four-phase model of self-forgiveness, and Gilbert's (2009) three-affect regulation systems model

The first pathway involves taking a hedonic approach. This approach involves using self-compassion to work through the negative feelings and affects (e.g. anger, shame, guilt) that arise following a transgression. A process that leads to a reduction of self-punishment and negative affect and the increase in subjective well-being and positive affect. Woodyatt et al., (2017) stress that genuine self-forgiveness tends to be a difficult and painful experience, and as such is likely to be *un*-hedonic as this process involves taking *responsibility* for one's thoughts, feelings and actions in relation to the transgression.

Within the context of Gilbert's 3-circle model (Gilbert, 2009), the researcher suggests that following a serious transgression, transgressors tend to experience guilt, remorse and a range of other affects that places the transgressor in a challenging

position. If the threat-system is overwhelmed by negative affect, then the affiliative system can be deactivated leading to the transgressor experiencing appraisals of over-responsibility, with increased feelings of guilt and *remorse* that lead to an increase in self-condemnation (self-criticism, self-hate, self-loathing) that maintains activity within the threat system and complicates the process of self-forgiveness.

Drawing upon the previously reviewed compassion-focused outcome studies (see Kirby et al., 2015), it is asserted that self-compassion is a skill that can be learnt. The outcomes of which indicate a process of *restoration* through reductions in self-criticism, shame, anxiety and avoidance through transforming negative emotions through developing the pro-social emotions and attributes (empathy, understanding, kindness, caring, love) associated with self-compassion (Gilbert & Procter, 2006; vanOyen, et al., 2014). In relation to Gilbert's model (Gilbert, 2009) and the process of self-forgiveness (Cornish & Wade 2015a), it is asserted that the effect of becoming more self-compassionate re-activates the affiliative system thereby reducing self-condemnation and the negative affects (anxiety, fear, shame) associated with the threat system (Gilbert & Procter, 2006; Neff & Germer, 2013). Reviewed research indicates that self-compassion also promotes increased feelings of warmth. Whilst self-acceptance promotes more realistic responsibility appraisals that can transform negative responses to perceived personal failures (Breines & Chen, 2012; Leary, Tate, Adams, Batts, Allen & Hancock, 2007) effecting a sense of *renewal*. Therefore, it is proposed that the natural processes of exploration and growth exemplified by the drive-based system, can be activated making it more possible to cope with disappointments and threats associated with the ongoing challenges of living.

As a caveat the above, Woodyatt et al., (2017a) draw upon some of the previously reviewed research on pseudo self-forgiveness, and point out that self-compassion may not always be beneficial. They suggest that with some individuals, self-compassion can be used to transform the negative affects (most importantly guilt) to such an extent that the need to assume responsibility and experiencing remorse for the transgression is removed (Zachmeister & Romero, 2002). Responses that would tend to complicate the process of genuine self-forgiveness.

Woodyatt et al., (2017a) go on to explain that the second pathway involves a eudiamonic approach. This pathway involves addressing psychological needs through

focusing on well-being, personal growth and is not determined by the presence of positive affect or the absence of negative affect. Within the context of self-forgiveness, the focus of the eudiamonic pathway often leads to the violation of personal values and beliefs about themselves in relation socio-moral identities (Baumeister & Leary, 1995). With regards to effecting repairs to one's personal identity, Woodyatt et al., (2017a) highlight that the challenge with self-forgiveness is *"to acknowledge one's failures to be a good person, group member or relationship partner, and yet still move forward towards the repair of positive self-regard"* (p. 519).

Woodyatt, et al., (2017a) went on to examine the hedonic and eudiamonic pathways to self-forgiveness through undertaking two studies using a psychology student sample. The first study utilised a cross-sectional design that examined relationships between self-compassion, reaffirmation of values, self-punitiveness, defensiveness, genuine self-forgiveness, reconciliation, perceived stigma, and forgiveness following a self-reported interpersonal transgression (termed end-state self-forgiveness). In the second study, participants were randomly allocated to one of three groups. One group was asked to undertake a self-compassionate writing exercise, the second group was asked to complete a values reaffirmation exercise after committing a transgression, and the third group was a control group (Time 1). Participants' end-state self-forgiveness and amend-making behaviour were reassessed a week later (Time 2). Together the results of this study suggest that following interpersonal transgressions, self-compassion reduced self-punitiveness and increased end-state self-forgiveness, through a reduction in perceived stigma. Whereas value reaffirmation increased genuine self-forgiveness and reduced self-defensiveness through concern for group values led to an increased desire for reconciliation, and end-state self-forgiveness at 1 week follow up. In conclusion, the researchers stated that both the hedonic and eudiamonic models of self-compassion were helpful in reducing self-punitiveness, and they suggested that both may have a part to play in self-forgiveness interventions. With regard to the utility of self-compassion versus a taking a values affirming approach, Woodyatt et al., (2017a) suggest that self-compassion appears helpful in reducing self-punitiveness and self-blame. Whereas taking a values-based approach may be more helpful in reassessing and acting in accordance with personal values. It is noted that these two approaches reflect Griffin, Worthington, Lovelock, Wade and Hoyt's (2015) dual-process model of self-forgiveness, where the first part of this process involves the affirmation of values requires accepting responsibility for ones actions and living according to ones values, and the second part of

the process involves a process of restoration involving the reduction of self-punishment and an increase in self-compassion and pro-social affects.

In summary, the reviewed empirical evidence suggests that there are close links between self-compassion and self-forgiveness, and that one's capacity for self-compassion may also influence the tendency towards and capacity for self-forgiveness. Bearing mind that the focus of this current study is upon the relationship between self-forgiveness and psychological health, what is the empirical evidence to support this?

2.7.1 Empirical evidence linking self-forgiveness, self-compassion and psychological health

Perhaps surprisingly, very few published empirical studies have examined the relationship between self-compassion, self-forgiveness and psychological health symptoms (Cornish & Wade, 2015b; Neff, 2008, Roxas, Adonis & Caligner, 2014), although there have been several unpublished PhD studies (Terzino, 2010, Mistler, 2010, Matsuyuki, 2011, Griffin, 2014) that have examined these relationships. An examination of these studies reveals that all apart from Griffin (2014) and Cornish and Wade (2015b) who utilised a cross-sectional in design, with both of these treatment interventions focusing on developing self-forgiveness rather than self-compassion. In terms of measurement, all of the studies used the Self-Compassion Scale (Neff 2003a), but the researchers used different scales to assess forgiveness, complicating the findings. Three studies Neff, (2008), Roxas, et al., (2014), Mistler, (2010), used the self-forgiveness sub-scale of the Heartland Forgiveness Scale (Thompson et al., 2005) and reported positive correlations of 0.59, 0.63, and 0.72, respectively, between self-forgiveness and the total score of Self-Compassion Scale.

Neff (2008) found self-compassion to be a stronger predictor of mental health than self-forgiveness suggesting that self-compassion may be better viewed as a trait, whereas self-forgiveness may be more state specific and more likely to occur in relation to self-compassion. Roxas et al., (2014) examined the association of compassion for others and self-compassion with forgiveness for self and others among a sample of 231 Filipino counsellors. Using the Compassion Scale (Pommier, 2010) the authors also found a positive relationship ($r = .26$) between self-compassion and compassion for others, but no significant relationship between compassion for others and forgiveness of the self.

Regression analyses revealed that self-compassion predicted forgiveness of others ($\beta = .42$), and forgiveness of the self ($\beta = .63$), as did compassion for others with forgiveness of others ($\beta = .32$). However, forgiveness of others did not predict self-compassion. Neff and Pommier (2012) found that self-compassion was significantly linked to increased perspective taking, positive mood states, less distress and greater forgiveness of others in both undergraduate and adult community samples suggesting that there are more barriers to self-compassion than forgiveness of others.

Matsuyuki (2010) investigated the relationship between state forgiveness, self-compassion and psychological well being in a sample of 112 American Buddhist practitioners. Matsuyuki found a positive predictive association between state forgiveness and self-compassion ($\beta = .38$) accounting for 13.2% of the variance. She went on to undertake regression analyses and found that self-compassion predicted psychological well-being ($\beta = .72$) accounting for 52% of the variance, as did state forgiveness, which accounted for 16.1% of the variance. When the combined effects of state forgiveness and self-compassion upon psychological well-being were performed they accounted for 68.1% of the variance. When self-compassion was introduced as a mediating variable the beta for state forgiveness reduced from .41 to .16, demonstrating that self-compassion partially explained the relationship between state self-forgiveness and psychological well-being.

Cornish and Wade (2015b) undertook a pilot study that examined the effectiveness of an intervention based upon the modality of Emotion-Focused Therapy (Greenberg, 2002) that was designed to increase self-forgiveness in relation to historical interpersonal transgressions. Twenty-six participants who had previously identified that they had unresolved emotions about a past wrongdoing were randomly assigned to either a delayed or immediate treatment condition. Results indicated that after controlling for screening scores, those participants who received the treatment reported significantly lower levels of self-condemnation and psychological distress. Participants also reported significantly greater levels of self-forgiveness and self-compassion regarding their wrongdoing than did those waiting for treatment. These results were maintained at 2-month follow-up, with improvements in state self-forgiveness predicting lower levels of general psychological distress.

Griffin (2014) examined the effectiveness of a self-directed workbook (Worthington, 2013) designed to promote self-forgiveness through randomly assigning students to a four-week treatment programme or waitlist control group. Self-forgiveness was measured using the State Self-Forgiveness Scale (Wohl, De Shea, & Wahkinney, 2008) and Self-compassion was measured using the kindness/ judgment sub-scale of the Self-Compassion Scale (Neff 2003a). Both measures were administered over three time points (initial assessment, 2 weeks and 4 weeks) after entry into the study. Results indicated that self-forgiveness improved as a function of treatment, and that the effect of treatment depended upon the level of self-compassion felt. It is noted that Griffin et al., (2015) subsequently went on to describe a dual-process theory of self-forgiveness, suggesting self-forgiveness not only requires a decision to affirm and repair that the values that have been violated, it also requires replacing self-condemnation with affirming prosocial emotions including self-compassion.

Mistler (2010) investigated the relationships between forgiveness, and maladaptive perfectionism, using the Heartland Forgiveness Scale, and the Discrepancy sub-scale of the Almost Perfect Scale (Slaney, Rice, Mobley, Tripp & Ashby, 2001) that measures the perception that one's high standards have not been met and is associated with high psychological distress and self-criticism (Slaney et al., 2001). Mistler (2010) found significant negative relationships between Discrepancy and Total Forgiveness (-.60), self-forgiveness (-.60), others forgiveness (-.34) and situational forgiveness (-.53), and significant positive relationships between Self-Compassion and the HFS scale scores; Total Forgiveness (.71), forgiveness of self (.72), forgiveness of others (.40) and forgiveness of situations (.64). As a secondary hypothesis, Mistler investigated the mediating role of self-compassion on the relationship between self-forgiveness and discrepancy, and found that when self-compassion was introduced to the model the initial effect of self-forgiveness on maladaptive perfectionism reduced from $\beta = -.61$ to $\beta = -.27$ suggesting that self-compassion partially mediated the relationship between self-forgiveness and discrepancy.

Terzino (2010) developed a six-item self-forgiveness scale derived from the Heartland Forgiveness Scale, and examined self-compassion as a factor in relation the models of self-forgiveness (Hall and Fincham, 2005; 2008). Terzino found that shame, guilt and rumination were critical factors in predicting both intra-personal and inter-personal forgiveness, suggesting that self-forgiveness may be based on the emotions and

thoughts one experiences when thinking about a transgression. The mediating effects of these variables on self-forgiveness and anxiety and depression were not studied.

The author is unaware of any studies that have yet to examine the impact of the SCS sub-scales on the relationship between self-forgiveness and psychological health. However, studies have been undertaken into the effects of the SCS sub-scales upon depression. A recent review by Korner et al., (2018) and a meta-analysis by Wilson, Mackintosh, Power, & Chan, (2018) claim that empirical studies by Mills, Gilbert, Bellew, McEwan and Gale, (2007); Hupfeld and Ruffieux, (2011); van Dam et al., (2011); Krieger, Altenstein, Baettig, Doerig and Grosse-Holtforth, (2013) report stronger associations between the negative SCS sub-scales than the positive sub-scales and depression. This finding was tested in the most recent systematic review and meta-analysis by Wilson et al., (2018) who ran a random effects analysis on the pre and post scores of SCS sub-scales with self-compassion linked interventions against controls. Wilson et al found that the negative subscales of the SCS demonstrated slightly stronger relationships than the positive sub-scales. This was especially the case with over-identification ($g = 0.72$) and isolation ($g = 0.63$) that demonstrated the largest effect sizes.

In summary, research into the links between compassion and forgiveness are in their infancy, however, the tentative findings described above appear to suggest that self-compassion and self-forgiveness are associated with improved mood states and psychological well-being (Cornish & Wade, 2015b; Matsuyuki, 2010; Mistler, 2010; Neff, 2008; Roxas, et al., 2014; Terzino, 2010). Self-compassion and compassion for others appear to be linked and may reflect similar hedonic and eudaimonic processes (Roxas et al., 2014; Gilbert & Choden, 2013; Woodyatt et al., 2017), with self-compassion mediating the relationship between self-forgiveness and psychological well-being (Matsuyuki, 2010) as well as forgiveness and maladaptive perfectionism (Mistler, 2010). Furthermore, it appears that self-forgiveness and self-compassion can be learnt over time, but that the level self-forgiveness achieved appears linked to the degree of self-compassion that an individual feels about the transgression (Griffin, 2014).

Importantly, studies have yet to examine the impact of the self-uncompassion sub-scales on the relationship between self-forgiveness and psychological health, and in this next section I will examine some of the key moderators and mediators of the associations between these variables.

2.8 Relationships between self-forgiveness and self-compassion, with psychological health, personality and socio-cultural variables.

Drawing upon the work of Frazier, Tix and Barron (2004), when undertaking research into a particular area, such as self-forgiveness, self-compassion and psychological health, it is important to answer basic questions such as “are self-forgiveness and self-compassion predictive in terms of psychological health?” However, Frazier et al., assert that it is important to move beyond these basic questions and also examine possible interaction effects in relation to other key variables that may influence such associations. One way to advance such knowledge is through undertaking mediation analyses and controlling for the effects of key variables that are at the heart of undertaking psychological research (Cohen, West & Aiken, 2003). If such investigations are not undertaken then it is possible that any subsequent theories or clinical interventions may be compromised (Kraemer, Stice, Kazdin, Offord & Kupfer, 2001).

In this section, I will firstly undertake a more detailed review into the links between self-forgiveness and self-compassion in relation to a range of key psychological variables that researchers have found to be associated with psychological health. These include: positive affect, safe affect, and negative affect (Gilbert, et al., 2008; Barnard & Curry, 2011; Orth, Berking, Neff, Kirkpatrick & Rude, 2007), guilt and shame (Fisher & Exline, 2010; Barnard & Curry, 2011), and psychological distress (Barnard & Curry, 2011). I will then go on to review some other key variables that research suggests may be important to control for. These include personality variables such as agreeableness, neuroticism, narcissism, social desirability (e.g. Mullet, Neto & Riviere, 2005), as well as socio-cultural variables such as age (Neff & McGhee, 2010), gender (Yarnell, Stafford, Neff, Reilly, Knox & Mullarkey, 2015), socio-economic status (Stellar, Manzo, Kraus & Kelmer, 2011), ethnicity (Hook, Worthington, Utsey, Davis & Burnette, 2012), and religiosity and spirituality (Saslow, et al., 2013). The empirical literature linking these variables will now be explored in more detail.

2.8.1 Psychological health

Psychological health has been the subject of considerable study, with the outcome that two major branches of research have emerged that reflect their different conceptualisations of psychological health, namely hedonism and eudiamonism (Ryan

& Deci, 2001). As previously mentioned, a hedonic view of psychological health focuses upon increasing pleasant feelings and thoughts, and decreasing unpleasant feelings and thoughts. Whereas a eudaimonic view of psychological health well-being focuses upon self-growth and discovering the purpose and meaning of life in spite of any risks, mistakes or errors. Psychological health is usually conceptualised as a combination of both hedonic and eudaimonic states, involving the presence of happiness and success in one's personal and social life (Deci & Ryan, 2008; Huppert, 2009). These two different approaches to studying psychological health are reflected in the following section, with a particular emphasis upon eudaimonic concepts such as self-forgiveness and self-compassion and a range of key symptoms of psychological health, including positive, safe and negative affect, guilt, shame and psychological distress.

2.8.1.1. Positive, safe and negative affect

Reviews of research into psychological health and affect (e.g., Barrett & Russell, 1999; Crawford & Henry, 2004) highlight the seminal work of Watson and Tellegen (1985) who assert that there are two basic universal affective dimensions that they term Positive Affect (PA) and Negative Affect (NA). Watson and Tellegen subsequently went on to develop the Positive And Negative Affect Scales (PANAS: Watson, Clark & Tellegen, 1988) that have been used extensively within the research literature. Whilst there are no agreed definitions of positive and negative affect, Watson et al (1988) suggest that PA reflects emotions that are associated with a positive engagement with the environment (e.g. alert, active, proud, excited, interested, enthusiastic) and reduced levels of anxio-depressive symptoms. Whereas NA reflects a range of emotions associated with unpleasurable engagements (e.g., anger, irritable, afraid, guilty, scared, and upset) and increased anxio-depressive symptoms (Crawford & Henry, 2004). Positive and negative affect are viewed as bipolar constructs (happiness vs. unhappiness) and as being part of the bio-behavioural systems of approach (activating) and withdrawal (deactivation) that are helpful in managing obstacles and threats (Watson, Weise, Vaidya, & Tellegen, 1999).

Reviews of studies suggest that in contrast to people who experience negative mood states, those who experience more positive mood states view life situations more positively, are more sensitive to environmental rewards, are more optimistic, and form

more adaptive and flexible perspectives that helps them to cope with negative life events (Carver & Scheier, 2005; Folkman & Moskowitz, 2000; Fredrickson, 2001; Tugade, Fredrickson, & Barrett, 2004; Green, Decourville & Sadava, 2012). Of relevance is a recent review by Inwood and Ferrari (2018) that provides preliminary evidence that emotion regulation may be a mechanism through which self-compassion is associated with mental health outcomes, and offers some initial support for an emotion regulation model of self-compassion (Gilbert, 2009; 2014).

Inwood and Ferrari (2018) identified five studies (Barlow, Goldsmith, Turow & Gerhart, 2017; Diedrich, Hofmann, Hiller & Berking, 2017; Findlay-Jones, 2017; Scoglio et al., 2015; Vettese et al., 2011) linking self-compassion, emotional regulation and psychological health. These results suggest that self-compassion impacts on mental health by facilitating adaptive emotion regulation, potentially by enabling negative emotions to be processed (Diedrich et al., 2017; Findlay-Jones, 2017). In addition, the findings suggest that the impact of trauma and early childhood maltreatment is associated with the development of low levels of self-compassion and difficulties with emotion regulation (Barlow et al., 2017; Scoglio, et al., 2015; Vettese, Dyer, Li, & Wekerle, 2011). However, the findings also suggest that habitual use of self-compassion may facilitate adaptive emotion regulation (Barlow et al., 2017; Vettese et al., 2011). Specifically, self-compassion appears helpful in enabling individuals to down-regulate hyper-arousal, allowing them to compassionately experience and process negative emotions, and manage distress (Gilbert, 2014; Svendsen, et al., 2016; Diedrich et al., 2017). Therefore, Inwood and Ferrari (2018) propose that self-compassion may act as a protective factor through increasing one's ability to tolerate negative emotions may enable integration and processing of negative emotions, consequently reducing the deployment of maladaptive emotion regulation strategies such as avoidance (Berking & Whitley, 2014; Neff & Germer, 2013). This finding supports previous research and suggests that tolerance of negative emotions is a crucial competency for the maintenance and recovery of mental health and may be a protective factor for survivors of abuse and other mental health symptoms (Berking & Whitley, 2014; Gilbert & Procter, 2006).

Reviews of research linking self-compassion and self-forgiveness research appear to confirm respectively, reciprocal relationships with positive and negative affect (Barnard & Curry, 2011; Orth, et al., 2007; Walker, Meier & Znoj, 2007; Arimitsu &

Hofman, 2015; Sommers-Spijkerman; Trompetter, Schreurs & Bohlmeijer, 2018) and adaptive and maladaptive coping (Allen & Leary, 2010; Worthington & Sandage, 2015). Furthermore, Gilbert and Woodyatt (2017) suggest that self-compassion promotes self-forgiveness through helping people to adopt positive pro-social emotions (e.g., warmth, kindness, empathy) that are calming and facilitate the reduction of negative affect states through promoting forgiveness and adaptive coping (Worthington & Scherer, 2004; Worthington, O'Connor, Berry, Sharp, Murray & Yi, 2005; Neff & Pommier, 2012).

Drawing upon recent advances in neuroscience research, Gilbert (2009; 2014) has been critical of the bipolar model of positive and negative affect, and he has proposed a tripartite model of affect regulation involving; threat management, affiliative-soothing needs, and resource-achievement needs that reflects more recent developments in neuroscience research (e.g., Panksepp, 1998; Dupue & Morone-Strupinsky, 2005). Subsequent research by Gilbert, et al., (2008) led to the development of the Two Types of Positive Affect Scale (TTPAS) to tap into these three emotional systems. The TTPAS measures two types of positive affect involving three factors: feelings of safety, relaxation and excitement. Positive safety/warmth affect (e.g. safe, content, secure, warm) and positive relaxed affect (e.g., relaxed, serene, calm, tranquil, laid back) were associated with the affiliative-seeking system, and positive activating affect (e.g., adventurous, enthusiastic, excited) were associated with the resource-seeking regulation systems. Of the three factors, Gilbert et al., (2008) found that positive safe / content affect had the highest negative correlations with depression, anxiety, stress, self-criticism and insecure attachment.

Kelly, Zuroff, Leybman and Gilbert, (2012) used a measure of social safety, the 13-item Social Safety and Pleasure Scale (Gilbert, McEwan, Mitra, Richter, et al., 2009) and the PANAS to examine Gilbert's tripartite model in relation to measures of psychological vulnerability and maladjustment. They identified the positive affect scale of the PANAS to be more associated with the resource-seeking system and the negative affect scale to be associated with the threat-management system, whilst the Social Safety and Pleasure Scale (SSPS) was associated with the affiliative-seeking system. Of these scales, the SSPS was most strongly associated with indicators of vulnerability (self-criticism, self-esteem, insecure attachment) and maladjustment (depression, avoidant, paranoid, borderline personality traits). Akin and Akin (2016) used the SSPS

to investigate links between trait forgiveness, social safety, pleasure and life satisfaction and found that social safety and life satisfaction were predicted by forgiveness, and life satisfaction positively predicted social safeness. Social safeness was also found to mediate the relationship between forgiveness and life satisfaction, suggesting that social safety helps people to view their transgressors in less threatening and perhaps more compassionate ways.

In summary, this review appears to offer preliminary support for Gilbert's (2009; 2014) theory and Gilbert and Woodyatt's (2017) review, that maladaptive early childhood development may lead to an under-developed self-soothing system, a hyper-aroused threat system, and that low self-compassion and low self-forgiveness may act as a vulnerability to developing psychological problems. In contrast, high levels of self-compassion, self-forgiveness, and positive affect and feelings of safety/warmth are most associated with positive outcomes. As yet only the PANAS has been used in research into self-compassion and self-forgiveness, with reviews of research suggesting that self-compassion and self-forgiveness are both positively correlated with positive affect and negatively correlated with negative affect (Barnard & Curry, 2011; Toussaint & Friedman, 2008; Neff, Kirkpatrick & Rude, 2007; Orth, Berking, Walker, Meier & Znoj, 2008). It has been suggested that self-compassion promotes self-forgiveness through helping people to adopt pro-social emotions (e.g., warmth, kindness, empathy) that are calming and facilitate the reduction of negative affect states through helping them to forgive themselves for in their transgressions (Worthington, et al., 2005; Neff & Pommier, 2012). Given the importance of the Gilbert's tripartite model to the study of self-compassion, it is proposed to extend Gilbert's research into the areas of self-forgiveness, self-compassion and affect by being the first study to use both the PANAS, and the TTPAS 4-item Positive-safety/warmth affect sub-scale. It is noted that the Positive-safety/warmth affect sub-scale is briefer than the SSPS and is more compatible with the PANAS as like the PANAS it uses affect-linked words

2.8.1.2. Guilt and Shame

Recent reviews of research (e.g. Tangney, Stuewig & Hafez, 2011; Cohen, Wolf Panter, & Insko, 2011; Leach, 2017) suggest that shame and guilt are generally considered to play a key role in the motivation of moral thought and behaviour, and the socialisation of accepted socio-cultural standards. In this way, guilt and shame are

considered critical for deterring unethical and anti-social behaviour that has an evolutionary function in helping to maintain harmony within societies (Eisenberg, 2000; Haidt, 2003; Gilbert, 2002; 2003).

There is general agreement that both shame and guilt are generally experienced when a transgression is committed which leads to the realisation that one has not lived according to a social or moral rule (Cohen, et al., 2011). However, Tangney et al., (2011) assert that there is some disagreement between researchers about the focus of these emotions that they term; the *self-behaviour* focus and the *public-private* focus. The self-behaviour focus suggests that guilt tends to be associated with self-judgments about the behaviour associated with the transgression (e.g. I have done a bad thing), whereas shame tends to relate to generalised judgments about the self (e.g. I'm a bad person). The public-private focus suggests that transgressions that remain in the private realm are likely to evoke feelings of guilt, whereas if they transfer to the public realm they are more likely to create feelings of shame. In their review, Tangney et al., (2011) found that the evidence favours the self-behaviour focus, however, there is some evidence that public exposure of the transgression does increase shame's intensity through humiliation (Silfver-Kuhlampi, Figueiredo, Sotheix & Fontaine, 2015).

In terms of their effects, shame is generally associated with more suffering. This is because the self rather than the behaviour is the subject of negative judgments with the tendency to hide, cover up and feels small, powerless, inferior, humiliated and worthless in relation to others. In contrast, guilt is associated with rumination, remorse and regret about a transgression and motivates a desire to repair the damage that has been done. Both emotions appear associated with experiences of neglect and trauma and tendencies towards critical thinking, depressive symptoms (Kim, Thibodeau & Jorgensen, 2011; Bennett, Wolan-Sullivan & Lewis, 2010; Matos, Pinto-Gouveia & Duarte, 2013), stress-linked physiological responses, markers of inflammatory response (Kemeny, Gruenwald & Dickerson, 2004; Dickerson, Kemeny, Aziz, Kim & Fahey, 2004b) and personality traits such as narcissism (Aktar & Thompson, 1982; Rose, 2002), the latter of which will be discussed later in this chapter.

A range of different combined measures of guilt and shame have been developed, such as the Adapted Shame and Guilt Scales (Hoblitzelle, 1987), the Test of Self-Conscious Affect (Tangney, Dearing, Wagner & Gramzow, 2000) and the State Shame

and Guilt Scale (Marschall, Sanftner, & Tangney, 1994). Of these, only the State Shame and Guilt Scale (SSGS) were brief and reliable enough for the purposes of this study. The SSGS has the advantage of coming from a good theoretical background and has been used in a number of key studies on self-forgiveness (Terzino, 2010, Hall & Fincham, 2008).

Reviews of research indicate that shame and guilt are both negatively associated with self-forgiveness (Fisher & Exline, 2010; Gilbert & Woodyatt, 2017; Hall & Fincham, 2008; Leach, 2017; Terzino, 2010; Zachmeister & Romero, 2002), however, there is some evidence that under certain circumstances these emotions can promote positive change in resolving and coping with interpersonal and intrapersonal conflicts. Studies by Behrendt and Ben-Ari, (2012) as well as Lickel, Matta, Schmader, Kushlev, and Savalei, (2014) found that people who report higher levels of guilt report a greater sensitivity towards others and a desire to change because of their tendency to feel remorse. Whereas higher levels of shame and regret appear associated with reported a greater concern for themselves and a desire for personal change. Whilst the effect of self-compassion and self-forgiveness was not studied, Fisher and Exline, (2006) found that guilt proneness was strongly associated with adaptive outcomes such as repentance, and self-forgiveness. Reviews of research (Barnard & Curry, 2011; Enright, Gassin, & Wu, 1992; Fischer & Exline, 2006; 2010; Gilbert & Woodyatt, 2017; Trompetter, de Kleine & Bohlmeijer, 2016) suggest that self-compassion and self-forgiveness would tend to have a buffering effect on guilt, shame and psychological distress, the latter of which will now be subject to further discussion.

2.8.1.3. Psychological distress

Psychological distress is a widely used concept and indicator of mental well-being in public health, surveys, and epidemiological studies and in clinical trials and intervention studies. A recent review by Drapeau, Marchand and Beaulieu-Prévost (2012) define psychological distress “*as a state of emotional suffering characterized by symptoms of depression (e.g., lost interest; sadness; hopelessness) and anxiety (e.g., restlessness; feeling tense)*” p. 105 (cf. Mirowsky & Ross, 2002). Drapeau et al., (2012) go on to point out that stress is another key feature of psychological distress research, and pays reference to the diathesis-stress model where exposure to a stressful event threatens an individual’s physical or mental health, through their inability to cope

effectively with this stressor resulting in a range of emotions (Horwitz 2007, Ridner 2004).

Whilst anxiety, depression and stress are regarded as conceptually distinct, studies have found high levels of inter-correlation (Clark & Watson, 1991a). Subsequent reviews by Clark & Watson (1991b) proposed a tripartite structure of anxiety and depression, involving a negative affective component (distress and negative affect), physiological arousal (unique to anxiety), and the absence of positive affect (specific to depression). A separate research programme by Lovibond and Lovibond (Lovibond & Lovibond, 1993) to develop a measure of anxiety and depression yielded a third factor consisting of stress-related items (e.g. irritability, agitation, difficulty in relaxing) the total score of which reflects the concept of psychological distress. Lovibond and Lovibond went on to develop the Depression, Anxiety and Stress Scales (DASS) (Lovibond & Lovibond, 1995a) the 21-item version of which will be used in this study. It is noted that both the original 42 item and subsequent 21-item scales are highly correlated with the PANAS and Beck's measures of anxiety and depression (Brown, Chorpita, Korotitsch, & Barlow, 1997; Lovibond & Lovibond, 1995b).

Self-compassion and self-forgiveness appear to be consistently negatively associated with anxiety, depression (Neff, 2003a; Neff et al., 2005; Diedrich, et al., 2014; Krieger et al., 2013; Maltby, Macaskill, & Day, 2001; Sternthal, et al., 2010; Thompson et al., 2005; Wohl, et al., 2008; Terzino, 2010), and stress (Lawler, Younger, Piferi, Jobe, Edmundson & Jones, 2005; Neely, Schallert, Mohammed, Roberts & Chen, 2009; Sirois, 2014). In the case of self-compassion, these relationships held even after controlling for the effects of self-criticism and self-esteem (Barnard & Curry, 2011). Studies that have examined the relationship between self-compassion and depression suggest that this relationship can be partially mediated by a fear of failure (Neff et al 2005); rumination, brooding and worry (Raes, 2010); irrational beliefs (Podina, Jucan & David, 2015); and life satisfaction (Ying, 2009). The relationship between self-forgiveness and depression has been less studied, but there appears to be a consistent relationship between ruminative and angry intropunitive feelings (Barber et al., 2005; McCullough & Witvliet, 2002; Terzino, 2010), with increased self-forgiveness being protective of depression in later life (Ermer & Proulx, 2015).

Three studies have examined the effects of the self-compassion sub-scales upon

depression (Mills et al., 2007; Ying, 2009; Podina, et al., 2015). Depression was found to be negatively associated with self-kindness (av -0.44), common humanity (av -0.23) and mindfulness (av -0.32) and positively associated with self-judgment (av. 0.50), isolation (av. 0.52), and over-identification (av. 0.54). Of the three positive self-compassion sub-scales, Podina et al., (2015) found that only self-kindness significantly moderated the relationship irrational beliefs and depression. It is noted that this study will be the first to examine the links between self-forgiveness and psychological distress and the effects of the self-compassion sub-scales.

As has previously been discussed, reviews of research (Worthington & Scherer, 2004; Allen & Leary, 2010; Toussaint et al., 2017) have argued that forgiveness, self-forgiveness and self-compassion may buffer the deleterious effects of stress on physical health. Specifically, it has been suggested that people who use forgiveness and compassion cope better and experience less stress in their daily lives than people who unforgiving and less compassionate (Lawler, et al., 2003; Sirois, et al., 2015). Subsequent empirical research (Lawler et al., 2005; Toussaint, Shields, Dorn & Slavich, 2016; Sirois, et al., 2015) has found that negative affect and stress are robust mediators of the relationship between forgiveness, self-compassion and markers of physical health. With self-forgiveness and self-compassion being positively related to improved physical health in both young adult and older populations (Wilson, Milosevic, Carroll, Hart & Hibbard, 2008; Neff & McGhee, 2010; Allen, Goldwasser & Leary, 2012). Recent reviews by Toussaint, Worthington and Williams, (2015) and Toussaint, et al., (2017) suggests that forgiveness and self-forgiveness appear to have an indirect effect on health through decreasing physiological markers of stress such as cortisol levels, inflammatory markers blood pressure, muscle tension (Dickerson, et al., 2004; Dickerson et al., 2004b). Forgiveness and self-forgiveness have also been to be linked with increasing social support and life satisfaction, through reducing the internal barriers associated with personal neglect (e.g. fear, shame, guilt) and so increasing access to health care (Green, et al., 2012; Webb, Robinson & Brower, 2009).

Gilbert (2004) proposes an evolutionary biopsychosocial formulation of depression, threat and stress, and highlights the role of the Hypothalamic-Pituitary-Adrenal (HPA) system has upon the development of stress-linked health problems (e.g. Chron's Disease, cardiovascular disease, immunological system) through elevating cortisol levels and influencing the parasympathetic nervous systems (PNS) and

sympathetic nervous systems (SNS). A detailed review of these links is beyond the scope of this review, but a recent review of the neuroscience, stress and health literature by Muscatell and Eisenberger (2012) clarifies the neural systems involved in processing perceived environmental and internal threats and perceptions of social safety (e.g. social comparisons, rejection, isolation) and the risks for chronic physical health conditions. Furthermore, Gilbert (2014), highlights the capacity of CFT to influence the activity of the heart rate variability (HRV) that has been shown to be an important physiological marker for overall health, and the body–mind connection. This is supported by a recent review by Kirby, Doty, Petrocchi and Gilbert, (2017).

Having examined the relationships between self-forgiveness and self-compassion, positive and negative affects and psychological health, I will now focus upon the personality variables such as neuroticism, agreeableness, narcissism and social desirability that self-forgiveness and self-compassion researchers suggest are important to identify when undertaking research into self-forgiveness and self-compassion (Barnard & Curry, 2011; Woodyatt et al., 2017b; Toussaint et al., 2017).

2.8.2. Personality

A recent review of theories of personality (Schutz & Schutz, 2012) defines personality as “*the unique relatively enduring internal and external aspects of a person’s character that influence behaviour in difference situations*” (p.8). Over the past 30 years there has been an emerging consensus amongst personality researchers that the Five-Factor Model (FFM) of personality (Costa & McCrae, 1992) is the best representation of personality structure currently available (John, Naumann & De Soto, 2008). These so called ‘Big Five’ factors represent dimensions of personality and include: Agreeableness (vs. antagonism), Conscientiousness (vs. lack of direction), Extroversion (vs. introversion), Neuroticism (vs. emotional stability), and Openness (vs. closed to experience) that comprise of a series of personality facets that are described in table 2.4 overleaf. These facets have been found to be commonly inherited, stable and are found cross-culturally (McCrae & Costa, 2007). Of these five factors, neuroticism and agreeableness appear most associated with self-forgiveness and self-compassion and will be explored in more detail.

Table 2.4. The Big Five Factors and facets descriptions (recreated from John & Srivastava, 1999).

Big Five Factor	Facet (and adjective description)
Agreeableness vs. antagonism	Trust (forgiving); Straight-forwardness (not demanding); Altruism (warm); Compliance (not stubborn); Modesty (not show off); Tender-mindedness (sympathetic).
Conscientiousness vs. lack of direction.	Competence (efficient); Order (organised); Dutifulness (not careless); Achievement striving (thorough); Self-discipline (not lazy); Deliberation (not impulsive).
Extroversion vs. Introversion	Gregariousness (sociable); Assertiveness (forceful); Activity (energetic); Excitement-seeking (adventurous); Positive emotions (enthusiastic); Warmth (outgoing).
Neuroticism vs. emotional stability	Anxiety (tense); Angry hostility (irritable); Depression (not contented); Self-consciousness (shy); Impulsiveness (moody); Vulnerability (not self-confident).
Openness vs. closed to experience.	Ideas (curious); Fantasy (imaginative); Aesthetics (artistic); Actions (wide interests); Feelings (excitable); Values (unconventional).

2.8.2.1 Neuroticism and agreeableness

A number of studies have examined the relationship between forgiveness, self-forgiveness and self-compassion and the five-factor trait models of personality (Costa & McCrae, 1992), with comprehensive reviews (e.g. Brose, Rye, Lutz-Zois, & Ross, 2005; Maltby, Day, Gill, Colley & Wood, 2008; Mullet, Neto & Riviere, 2005), finding self-forgiveness to be most consistently negatively associated with Neuroticism (-.28 to -.54) and positively associated with Agreeableness (.27 to .41). Reviews of self-compassion (Neff, Rude, & Kirkpatrick, 2007) indicate associations with agreeableness (.35), extroversion (.32), and conscientiousness (.42), with self-compassion appearing most closely correlated with neuroticism (-.65). The researcher is aware of only one study that has examined the relationship between social safety and the FFM (Uysal, 2015), who found that agreeableness and extraversion positively predicted social safety, whereas, neuroticism negatively predicted social safety.

By way of explaining these findings, it is useful to conceptualise personality traits as filters that shape one's perceptions of the transgressor, such as their ability to care, and their worthiness, value, and safety. For example, an explanation for the negative

associations between neuroticism, safety, self-forgiveness and self-compassion could be that neuroticism makes transgressions feel more severe and painful. Furthermore, the ‘just’ anger that is felt towards their transgressor or themselves about the injustice that has been purportrated, may led to a preference for punishment rather than compassion, as compassion may be linked with condoning the transgressors behaviour (McCullough & Hoyt, 2002). Such a position may compromise an individuals’ ability to feel calm and reassure themselves because of increased painful affects (e.g. guilt, shame, anxiety, stress, depression), that are likely to complicate their ability to feel safe and cope with their situation. In contrast, agreeableness may make it easier for victims to experience empathy and compassion for themselves and their transgressors, thereby making transgressors seem more care-worthy, safer and therefore more forgivable. In addition, highly agreeable people might anticipate that a relationship with a transgressor possesses future value.

2.8.2.2. Narcissism

Narcissism is characterised by feelings of self-admiration, superiority, vanity, self-importance, entitlement and a tendency towards interpersonal exploitation (American Psychiatric Association, 2013). Narcissism is thought to be dimensional personality trait ranging from a clinical disorder that has been linked with psychopathy and machiavelism (known as the dark triad), though to sub-clinical traits in non-clinical populations (Jonason & Webster, 2010; Campbell & Miller, (2011). Researchers have identified two types of narcissism called overt and covert narcissism (Aktar & Thompson, 1982). Within the five-factor model, overt narcissists have been found to score high on extraversion (gregariousness, forceful, excitement-seeking), openness to experience (fantasy), low on agreeableness (low levels of modesty, altruism, tender-mindedness, and straightforwardness) and neuroticism (insensitive to evaluations). In contrast, covert narcissists are less well defended and present with higher levels of agreeableness, because of their wish to avoid humiliation and rejection, and neuroticism that reflect their underlying insecurity and vulnerability (Ames, Rose, Cameron & Anderson, 2006; Corbitt, 2002).

Most recently, the Single Item Narcissism Scale (SINS) (Konrad, Meier & Bushman, 2014) has been developed for situations involving time constraints. The authors of the SINS undertook a range of validity studies and found that the SINS to be

correlated with two of the Big-Five personality sub-scales: extraversion (.20) and agreeableness (-.29), as well as the positive affect (.24) and negative affect (.34) scales of the PANAS. The authors also found moderate associations of .40 and .44 respectively between the SINS and measures of overt narcissism (the Narcissistic Personality Inventory, NPI-40: Raskin & Terry, 1988) and covert narcissism (the Hypersensitive Narcissism Scale, HNS: Hendin & Cheek, 1997). Suggesting that the SINS is a valid measure of covert and overt narcissism when time pressures do not allow for the use of longer scales.

Whilst the SINS has not been used with measures of self-compassion and self-forgiveness, previous studies have found self-compassion to be consistently unrelated to measures of overt narcissism (Neff, 2003a; Neff, Rude & Kirkpatrick, 2007; Terzino, 2010), but the relationship between self-compassion and covert narcissism has yet to be studied. Forgiveness researchers (e.g. Hall & Fincham, 2005; Tangney, Boone & Dearing, 2005) have been interested in narcissism because of associations with the phenomena of pseudo forgiveness that was highlighted earlier in this chapter. Briefly, pseudo self-forgiveness involves transgressors failing to accept responsibility for their wrongdoings resulting in condoning, denying or blaming others, traits that are associated with narcissism. However, studies that have examined the association between forgiveness and overt narcissism have yielded mixed results. For example, Exline, et al., (2004) found a moderate negative association between forgiveness and overt narcissism, whilst Eaton, Struthers and Santelli (2006) reported a weak relationship, and Brown (2004) found no relationship. A Korean study by Ra, Cha, Hyun, and Bae, (2013) examined the effect of attribution style on overt-covert narcissism and forgiveness and found that covert narcissism alone to be associated with forgiveness, and that this relationship was mediated by attributions of responsibility that perhaps reflect their greater concerns about interpersonal rejection and humiliation (Gabbard, 1989; Holdren, 2004).

In summary, these results appear to suggest that it may be wise to include a brief measure of narcissism such as the SINS in this research study. Given the links between self-forgiveness, shame and guilt, it is possible that participants may not feel able to be as open as they would like and may present themselves in socially desirable ways.

2.8.2.3. Social desirability

Crowne and Marlowe (1964) define social desirability as “*the need for social approval and acceptance and the belief that it can be attained by means of culturally acceptable and appropriate behaviours*” (p. 109). Social desirability can therefore be conceptualised as an individual difference in the tendency to present oneself favourably to others even if the presented self does not reflect the actual self (Lalwani, Shrum, & Chiu, 2009). Fredericksen (2001), cited in Huang, Liao and Chang, (2001) showed that social desirability is related to the need for self-protection and is an attempt to avoid shame and criticism, through social conformity with the aim of gaining social approval.

As noted by Podsakoff, MacKenzie, Lee, and Podsakoff (2003), social desirability presents a methodological concern, as it may bias self-report data and can inflate or suppress the true relationship between two variables. The links between compassion, forgiveness and social desirability are of theoretical and methodological interest in the case of this study, as it is suggested that the participants who will be selected for the CFT group may have a high desire for social desirability. This is because the selection criteria (inc. high levels of shame and self-criticism) may make them more motivated to conform with the aims of the group and report that they are more compassionate and forgiving (socially desirable responses) rather than present with socially undesirable responses (Allen & Gilbert, 2011; Catarino, McEwan, Gilbert & Baiao, 2014; Razo & Pratarelli, 2016).

Whilst there appears to be no correlation between the Self-Compassion Scale and social desirability (Neff, 2003a; Neff & Beretvas, 2013; Neff, Kirkpatrick, et al., 2007), a meta-analysis by Fehr, Gelfand, and Nag (2010) of correlates of interpersonal forgiveness (i.e., forgiveness of a single transgressor by a single victim) with social desirability across 14 studies, found a correlation of $r = .10$. Furthermore, Thompson et al., (2005) also found significant correlations between the Heartland Forgiveness Scale (HFS) total scale score (.38) and the Marlowe-Crowne Social Desirability Scale (MCSDS) (Crowne & Marlowe, 1960). Thompson et al., (2005) concluded that the ability of the HFS to predict individual differences in psychological well-being was not compromised by its relationship with social desirability. However, their findings, together with those of Fehr, et al., (2010) are by no means unequivocal, suggesting that it would be wise to include a measure of social desirability like the MCSDS in this

research study, especially as it has been suggested that participant's likely high levels of shame and self-criticism as may report that they are more self-forgiving than perhaps they really are (King & Brunner, 2000).

Whilst the MCSDS has been found to be a reliable and valid measure, the measure has been criticised because of its length, and this concern led to the subsequent development of a number of short forms of the original Marlowe-Crowne Scale (Fischer & Fick, 1993). Straham and Gerbasi (1972) developed a 10-item measure, the MCSDS-10 that was based on the original 33-item scale. A review by Fischer and Fick (1993) endorsed the MCSDS-10 as the measure having the highest level of internal consistency (0.88) and as a result this social desirability measure will be used in this study.

In summary the reviewed research suggests that personality has been shown to be linked with self-compassion, forgiveness and psychological health, and that neuroticism, agreeableness, narcissism and social desirability may confound the results of this study making these variables important to measure. But what are the links between self-forgiveness, self-compassion and socio-cultural variables?

2.8.3. Socio-cultural variables

Reviews of research (e.g., World Health Organisation, 2012) suggest that a range of socio-cultural variables such as; age, gender, socio-economic status, culture and ethnicity, together with religiosity and spirituality can influence psychological health. These relationships create methodological concerns that require further consideration and will now be reviewed in relation to the literature on forgiveness, self-forgiveness and self-compassion.

2.8.3.1 Age

A recent review of research by Steptoe, Deaton and Stone, (2015) suggests that there are inconsistent findings linking aging and psychological well-being, but that there are more consistent bi-directional effects between psychological and physical health. For example, an on-going international survey involving 160 countries found that in rich English-speaking countries, participants reported a U-shaped relationship between life satisfaction and age with the lowest levels occurring around 45-54 years of age.

This finding was not been replicated in the UK and Australia. Furthermore, in Eastern European, former Soviet countries and Latin American countries, life satisfaction was found to decline with age, whilst in sub-Saharan Africa well-being did not change with age. Steptoe et al., (2013) highlight that the reasons behind these findings are complex and have been linked with economic and social theories, but no unifying theory has emerged to explain these findings. More understandable are the consistent findings linking age with physical illness (e.g. diabetes, cardio-vascular disease, mental health) and situational stress (e.g. poverty), the effects of which impair feelings of happiness and the ability to live a meaningful life. Furthermore, Steptoe et al., (2013) found that living a life that has purpose and meaning may also have a protective role in health maintenance with longer survival rates.

Woodyatt, Worthington, Wenzel and Griffin (2017) point out that the links between Self-forgiveness and aging have not been systematically studied, however, self-forgiveness and self-compassion appear closely linked to well-being and life satisfaction (Matsuyuki, 2011). A recent review by Allemand and Steiner (2012) suggests that as people age they become more forgiving, wise, reflective and relaxed, and are more equipped to handle the conflicts and dialectics of living. They suggest that dispositional forgiveness varies as a function of age, with young children and adolescents, on average, being least willing to forgive, and older adults being most willing (Allemand, 2008; Bono & McCullough, 2004; Girard & Mullet, 1997; Mullet, Houdbine, Laumonier, & Girard, 1998; Toussaint, Williams, Musick, & Everson 2001; Lawler-Row & Piferi, 2006). Explanations for these results tend to focus on the roles of contextual factors (e.g. life events, circumstances, and challenges) and dispositional factors such as older people having more forgiving and compassionate value systems. For example, there is some evidence to suggest that older adults perceive transgressions less personally (Steiner, Allemand & McCullough, 2013) and that age is positively associated with religiousness, and religiousness with forgivingness (Bono & McCullough, 2004; Huber, Allemand, & Huber, 2011; Mullet, Barros, Frongia, Usai, Neto, & Riviere-Shafighi, 2003).

There is also evidence that self-compassion is a powerful moderator of the relationship between stressful life events and well-being in young adults (Neff, 2003b; Neff & McGhee, 2010), middle aged adults (Sirois, Molner & Hirsch (2015), and in the elderly (Allen, Goldwasser & Leary, 2011). For example, Allen et al., (2012) found that

self-compassion appears to affect how older adults feel about themselves through moderating their reactions to inevitable losses (e.g. health, bereavements, failures) and suggest that self-compassion is associated with well-being in later life. In summary, the reviewed research literature suggests that age is an important variable to examine when undertaking research into self-forgiveness, self-compassion and psychological health but that further research is needed.

2.8.3.2 Gender

Reviews of gender and psychological research (e.g., Stewart and McDermot, 2004) highlight that “*gender tends to be understood as defining a system of power relations embedded in other power relations that tend to focus upon sex differences, within-sex variability, and gender roles*” (p. 519). Woodyatt, et al., (2017) point out that there have been no systematic investigations into the links between self-forgiveness and gender other than both men and women engage in self-forgiveness (Macaskill, Maltby & Day, 2002), and that one study found that self-forgiveness may be more protective in terms of depression with women rather than men (Ermer & Proulx, 2010). Whilst more research has been undertaken into gender effects upon forgiveness, the findings are not equivocal. For example, a meta-analysis by Fehr, et al., (2010) involving 175 studies found no gender effect, whilst a review by Worthington and Lerner, (2006) and the results of another meta-analytic study by Miller, Worthington and McDaniel, (2008); suggested that men have a slightly lesser tendency to forgive than do women. Worthington and Lerner (2006) found that compared to women, men appeared to be less willing to forgive a specific hurt or to see forgiveness as an acceptable way to respond to being hurt. Miller et al’s., (2008) meta-analysis found a modest effect (mean d was .28) supporting this finding. Whilst no methodological variables (sample type, hypotheses, type of forgiveness measure, actual vs. hypothetical transgressions, culture) moderated the relationship between gender and forgiveness, there were larger gender differences with men scoring higher on vengeance than on any other forgiveness related measure. They recommended that further research be carried out on a range of variables such as differences in perception, situational, disposition, and religiosity.

Some theorists propose a theory of gender socialisation to explain these findings, whereby men are encouraged to suppress most emotions, except for aggressive ones,

and women are expected to respond to offences with understanding, compassion, and empathy (Gault & Sabini, 2000; Kopper & Epperson, 1996). They suggest that this type of socialisation might predispose men (especially those who are more traditional) to respond to hurtful situations with anger, vengeance, aggression, and bitterness (i.e. unforgiveness), whereas women may generally find it easier to experience the prosocial responses of understanding and compassion that are inherent in forgiveness and self-forgiveness (Ermer & Proulx, 2010).

A recent review of self-compassion research by Barnard and Curry (2011) and a meta-analysis by Yarnell, Stafford, Neff, Reilly, Knox and Mullarkey (2015), however, do not appear to support this assertion, where women were found to be modestly less self-compassionate and more self-critical than males (Neff, 2003a; Neff & McGehee, 2010; Neff & Vonk, 2009; Leadbeater, Kuperminc, Blatt & Hertzog, 1999). These findings are in keeping with the findings of Neff (2003b), who originally proposed that women would tend to be more prone to self-judgment and over-identification than males because of a greater tendency to be self-critical and ruminative but they would report higher levels of on common humanity than men. Barnard and Curry (2011) point out that it is unfortunate that studies have only reported the total score of the self-compassion scale and that further research is needed to examine other self-compassion factors measures by the SCS; a recommendation that this study hopes to examine.

In summary, whilst very little research has been undertaken into the links between gender and self-forgiveness, there is the research literature suggesting that there are gender-differences between forgiveness and self-compassion, but that more research is needed to better understand these differences.

2.8.3.3. Socio-economic status

The role of socio-economic factors (e.g. income, occupation, and education) in influencing psychological health and disease throughout the lifespan is well accepted (Kaplan, Shema, & Liete, 2008). Whilst these linkages are complex, it is broadly suggested that people from lower socio-economic backgrounds endure harsher environments (e.g., increased poverty and less social status) that are more threatening and have been found to influence their psychological health (e.g., increased anxio-depressive symptoms and emotional dysregulation), physical health (e.g., cortisol levels, diet,

smoking and drinking habits) and increased health inequalities (e.g., healthcare access and life expectancy) (Lareau, 2003; Gallo & Matthews, 2003).

A recent review of research into links between compassion and socio-economic status (Stellar, et al., 2012) reflects these concerns, with Stellar et al defining socio-economic status as “*reduced material resources (e.g., lower income, educational attainment) and sub-ordinate social rank vis-à-vis others*” (p. 1). Stellar et al., (2012) cite previous research evidence indicating that that lower-class individuals tend to experience elevated negative emotions as compared with their upper-class counterparts (e.g., Piff, Krause, Cote, Cheng & Keltner, 2010). Furthermore, lower-income individuals have been found to consistently give a higher proportion of their annual income to charity, when compared to higher-income individuals (Greve, 2009; Johnston, 2005). By way of explanation, Stellar et al., (2011) suggest that lower-class individuals may exhibit two distinct responses to threat. In certain situations, lower-class individuals respond with greater hostile reactions to threat (Chen & Matthews, 2001; Gallo & Matthews, 2003; Kraus, Horberg, Goetz & Keltner, 2011; Piff et al., 2010). In other situations, when another person is suffering or in need, more vigilant lower-class individuals may instead more directly attune to the way in which this event adversely affects the sufferer. As a result, lower-class individuals would perceive the sufferer as feeling more distressed, and subsequently respond with greater compassion than their upper-class counterparts.

In contrast to the research on compassion, there is very little research into links between forgiveness and socio-economic status, and the researcher is unaware of any research into self-forgiveness and socio-economic status. Some theoreticians such as McCullough (2008) suggest that the broader social context including ones socio-economic environment determines when forgiveness (or revenge) is appropriate and hence adaptive or beneficial for survival. For example, Anderson (1999) found that individuals living in Philadelphia’s less affluent (often black) neighbourhoods are socialised to view any signs of forgiveness or conciliatory acts as a sign of weakness because it can encourage others to prey on them. However, McCullough (2008) goes on to suggest that the negative effects of poor social environments outweigh the benefits of being seen to be tough and unforgiving in low socio-economic communities. Subsequent empirical research by Toussaint and Williams (2003) and McFarland, Smith, Toussaint, and Thomas, (2012) appears to support this argument.

Toussaint and Williams (2003) found that forgiveness of others was associated with lower levels of diastolic blood pressure and basal cortisol, but only among low socioeconomic status (SES) African-Americans, and not high SES African-Americans or high or low SES 'White' Americans. Although far from conclusive, this study provides some empirical support for the argument that forgiveness of others may be especially protective for low SES African Americans. McFarland, et al., (2012) went on to examine the longitudinal relationship between interpersonal forgiveness, socio-economic status, and measures of health (self-reported health, alcohol use, chronic health), for older African-Americans and 'White' Americans. These results suggested that forgiveness of others was protective of health for African Americans but not White Americans. Moreover, among African Americans, it was found that: (a) forgiveness was positively associated with self-reported health over time, (b) forgiveness was negatively associated with alcohol use and number of chronic conditions, and (c) forgiveness interacted with neighbourhood deterioration with the beneficial effects of forgiveness for self-reported health not extending to those living in run-down neighbourhoods.

In summary, research into socio-economic status, forgiveness and especially self-forgiveness is in its infancy, but these studies suggest that researchers should give more consideration to race and social socio-economic status in attempting to more fully understand the relationship between forgiveness and health. It is noted that the author is unaware of any research between socio-economic status and self-forgiveness, and within this study socio-economic status will be identified using the six socio-economic groupings as laid out in the New Zealand Socio-Economic Index 13 (Fahy, Lee, & Milne, 2017).

2.8.3.4 Ethnicity and culture

As with socio-economic status, ethnicity is a key social factor that is used in psychological research and has been used to study a wide range of issues such as social identity, social comparisons, psychological health including forgiveness and self-compassion. A review by Zagefka (2009) highlights that there is considerable disagreement about how to define ethnicity. Within New Zealand the statistical standard for identifying ethnic background is drawn from the New Zealand Statistical Standard for Ethnicity (NZSE) Classification (Statistics New Zealand, 2013). They define ethnicity as *“the ethnic group or groups that people identify with or feel they belong to. Ethnicity is*

self-perceived and people can belong to more than one ethnic group.” (p.2). Within this study ethnicity will be identified according to the Level 1 ethnicity classification (NZ European, Māori, Pacific Islander, Asian, Middle Eastern / African / South American, Other) as laid out by Statistics NZ (Statistics NZ, 2013).

Recent review of studies by Tripathi and Mullet (2010) and Hook, Worthington, and Utsey, (2009) provides some cross-cultural evidence for the way that forgiveness is conceptualised. For example, common predictors of forgiveness such as receiving an apology, intention to forgive, and the need for consequences subject to offence, have also been found across cultures (Girard & Mullett, 1997; McCullough & Witivlet, 2002). Importantly, Worthington’s (2006) the stress-and-coping conceptualisation of forgiveness has been shown to have validity in cultures throughout the world (Hook, et al., 2009).

Whilst these findings provide evidence to suggest that the development of moral reasoning about forgiveness is broadly cross-cultural (Enright & Enright, 2000), more recent evidence suggests that culture may affect the forgivingness of people (Sandage & Wiens, 2001; Sandage & Williamson, 2005). For example, studies suggest that in non-collectivist cultures (e.g. Europe, USA), people conceive of the self as being independent, individualistic and emphasise personal achievement, well-being, and responsibility. In more collectivistic societies and cultures (e.g. Chinese, Congolese, Māori), people conceive the self as interdependent with individuals’ emphasising collective goals, well-being, and relationships (Bagnulo, Munoz, Sastre & Mullet, 2009; Kadiangandu, Gousche, Kinsonneau & Mullet, 2007; Tripathi & Mullet, 2010). Individuals with more collectivistic views have been found to report higher trait forgivingness, which predicted the tendency to respond to specific offences with decisional forgiveness for the betterment of the group rather than emotional forgiveness (e.g. understanding, compassion). Therefore, individuals with a more collectivistic self-construal (e.g. Māori) appear to place more value on group, interpersonal harmony, reconciliation, and decisions to forgive rather than personal well-being and emotional peace (Hook et al., 2012). Woodyatt et al., (2017) point out that no research has been undertaken that examines cross-cultural beliefs in relation to self-forgiveness and self-compassion.

A recent review by Goetz, et al., (2010) suggests that compassion is a universally

experienced emotion across cultures and is associated with a wish to reduce suffering within others and that compassion is recognisable in displays of behaviour involving touch and facial expressions. However, there do appear to be cultural differences with experiences of compassion. For example, compassion for others has been found to be associated with increased capacities for perspective-taking in collectivist countries such as China and Japan where compassion is regarded as a pro-social behavior and where people tend to help each other. In contrast, in more individualistic countries (e.g. USA, UK), increased levels of compassion for others tend to be focused upon people from other cultures who do not share their socio-cultural norms (Wong & Hong, 2005).

In summary, whilst the author is unaware of any research into the influence of self-forgiveness, ethnicity and culture, however, the reviewed forgiveness research suggests that in contrast to non-collectivist cultures, collectivist cultures tend to place more value on pro-social behaviours such as interpersonal harmony, reconciliation, compassion and be motivated to forgive for the betterment of the group rather than personal well-being (Goetz, et al., 2010; Hook, et al., 2012). Further research is needed to examine these links and findings in relation to self-forgiveness.

2.8.3.5 Religiosity and spirituality

Worthington and Sandage (2015) define religion as *“a system of beliefs or practices endorsed by a community of like-minded people.”* They go on to define spirituality as *“a set of patterns in how people relate with the sacred”* (p.32). By sacred they include God, or a divine being, humans, nature, rituals, or a sense of transcendence. Reviews (e.g., Koenig (2008; 2012) distinguish three types of religious / spiritual activity: Organisational Religious Activity (ORA: - e.g., going to church), Non-Organisational Religious Activity (NORA – e.g., private prayer) and Intrinsic Religiosity (IR). Koenig and Büssing, (2010) define IR as *“persons with this orientation find their master motive in religion. Other needs strong as they may be, are regarded as of less ultimate significance, and they are, so far as possible, brought into harmony with the religious beliefs and prescriptions. Having a creed, the individual endeavours to internalise it and follow it fully. It is in this sense that he lives his religion.”* (p. 80).

Koenig (1997) had previously developed a brief measure 5-item of religiosity

called the Duke University Religion Index (DUREL) based upon these dimensions that has subsequently been used in over 100 studies around the world. A subsequent review of studies (Koenig & Büssing, 2010) has found that the DUREL is a very reliable measure, and after controlling for age, race and gender, regression analyses found that IR was most associated with recovery from depression (Koenig, Hays, George, Larson & Landerman, 1997). Given the focus of this research is upon the links between self-forgiveness and psychological health, it was decided only to utilise the 3-item IR scale in this research.

Recent reviews of research (e.g., Exline, Wilt, Stanner, Harriott & Saritoprak, 2017; Saslow et al., 2013; Worthington & Sandage, 2015) point out that the quality of one's relationship to one's god or sacred object appears to affect the way that people relate to their world including their capacities for forgiveness and compassion. A recent review and meta-analysis by Worthington, et al., (2012) has confirmed previous self-reports that forgiveness is related to higher levels of religiousness and spirituality. With religiousness and spirituality being positively related to trait forgivingness (i.e., across relationships and situations; $r = .29$), state forgiveness (i.e. a specific offense; $r = .15$), and self-forgiveness ($r = .12$). By way of explanation, religiosity and spirituality have been viewed as social-moral mechanisms that have self-regulatory value through exerting pressure to forgive (McCullough & Worthington, 1999; McCullough & Willoughby, 2009; Tsang, McCullough, & Hoyt, 2005). There are some reports that allow us to make tentative links between the impact of religiosity, gender and gender role. For example, Toussaint, Williams, Musick and Everson-Rose, (2008) found that women tend to be more forgiving, religious and spiritual than men, whereas Christian men's ability to be forgiving appears to be compromised if they adhere to traditional male stereotypes (Walker & Doverspike, 2001).

Several lines of evidence suggest that more religious and spiritual individuals are more prosocial and tend to feel more compassion (e.g., Bonner, Koven & Patrick, 2003; Smith, 2009; Saslow, et al., 2013). Religious and spiritual individuals should therefore behave more altruistically even in anonymous situations with strangers and without the opportunity for reciprocity or reputational advantages in the eyes of other people (Sober & Wilson, 1998; Wilson, 2003). Research has identified that more religious participants report feeling more "compassionate love" towards close others and strangers (Sprecher & Fehr, 2005), behave more altruistically and empathically (Saroglu, Pichon, Tromette,

Verschuren & Dernelle, 2005) and have a more altruistic loving style such as agape (Hendrick & Hendrick, 1987). However, more recent research contradicts this evidence suggesting that the prosociality of less religious individuals is driven more by compassion than is the case for more religious individuals (Saslow, et al., 2012;). Saslow, et al., (2013) went on study differences between religious and spiritual groups and found that spirituality was related to greater altruism and compassion even when controlling for religiosity, whereas religiosity was unrelated to altruism. By way of explanation, they found that more spiritual individuals were also more compassionate and that this helped explain their tendency to be more altruistic towards strangers.

In summary, whilst further research is needed, it would be reasonable to hypothesise positive associations between self-compassion, forgiveness, self-forgiveness religiosity and spirituality, as yet the author is unaware of any empirical study that has examined links between all of these variables.

2.9 Summary of the literature

In summary, Chapters 1 and 2 reviewed the literature on self-forgiveness, self-compassion, affect and stress and coping. Drawing upon the work of Cornish and Wade (2015b), it was proposed that self-forgiveness can be conceptualised as a four-phase process involving a process of responding to and coping with transgressions and the associated incompatible emotions (guilt, shame, anger). It was also proposed that self-compassion facilitates self-forgiveness through transforming the negative affects associated with a transgression, thus restoring the damage caused to ones socio-moral identity (Exline et al 2003; Graham, et al., 2017; Worthington & Wade, 1999; Woodyatt et al., 2017b).

Firstly, it was proposed that self-forgiveness involves the need to identify and take *responsibility* for an injustice or transgression against the self and or other. Secondly, feelings of *remorse* and moral outrage are then felt without diminishing or excusing any issue of responsibility associated with any transgression. Thirdly self-forgiveness was conceptualised as a process of *restoration* through coping with transgressions and the associated emotions (guilt, shame, anger) by transforming these emotions through developing the pro-social emotions and attributes (empathy, understanding, kindness, caring, love) associated with self-compassion (Cornish & Wade, 2015b; Gilbert &

Woodyatt, 2017; Van Oyen, et al., 2014). Fourthly, it was proposed that self-compassion plays an important role in motivating self-forgiveness through *renewal* by calming the threat-based emotional regulation system and increasing the affiliative system through: (a) extending calmness, safety, kindness, warmth, empathy and understanding to the self, rather than the threat associated with harsh judgment and self-criticism; (b) seeing one's experiences and perceived failings as part of a larger human experience rather than seeing them as separate and isolating; and (c) holding one's painful thoughts and feelings in mindful awareness rather than over-identifying with them. In this way the natural processes of exploration and growth exemplified by the drive-based system can be activated enabling one to cope with disappointments associated with the ongoing challenges of living. Finally, it was proposed that over time, self-efficacy and the skills of emotional regulation would develop balancing the emotional regulation systems and yielding improvements in psychological health and well-being.

The reviewed literature provided good evidence that self-forgiveness and self-compassion are associated with a range of improved psychological health variables such as reduced guilt, shame, anxiety, stress and depression (Leach, 2017) and that there is some evidence that self-compassion and positive and safe affect appear to have a positive buffering effect upon a range of psychological health variables associated with stress-related challenges. Equally, variables associated with being self-uncompassionate such as negative self-judgments, feelings of social difference and isolation, over-identified thinking together with negative affect appears to complicate coping with stress-related challenges.

The influence of a range of demographic and personality variables was also explored that highlighted that self-compassion, self-forgiveness and psychological health can potentially be influenced by a range of potential demographic variables (age, gender, ethnicity, class, and religiosity/spirituality) and personality variables (neuroticism, agreeableness, narcissism and social desirability). This review has also highlighted some of the criticisms and gaps within the literature that will now be re-examined and set the scene for introducing the researcher's proposed stress and coping model of self-forgiveness, self-compassion, affect and psychological health.

2.10 Criticisms and gaps in the literature

Research into forgiveness and self-forgiveness has certainly grown and developed since Strelan and Covic's (2006) and Worthington's reviews (Worthington, 2006), but many of the original research problems that they highlighted remain. Most notably, these include methodological concerns over the over-reliance of undergraduate psychology students as research subjects, and the paucity of longitudinal and clinical studies and qualitative research (Woodyatt, et al., 2017b). There is also a lack of research into constructs associated with self-forgiveness and improved mental health outcomes (e.g. compassionate self-responding, self-reassurance and positive and safe affect) and reduced mental health outcomes (uncompassionate self-responding, self-criticism and negative affect).

Furthermore, Strelan and Covic's and Worthington's original proposals to utilise Lazarus and Folkman's (1984) stress and coping model as an alternative theoretical model for unifying and guiding future forgiveness and self-forgiveness research appears to have been influential in understanding forgiveness and self-forgiveness. However, given the role that self-compassion is asserted to play within the process of self-forgiveness (Cornish & Wade, 2015b; Gilbert & Choden, 2013; Gilbert & Woodyatt, 2017; Griffin, 2014; Matsuyuki, 2010; Roxas et al., 2014; Terzino, 2010), it is perhaps surprising that the stress and coping model of self-forgiveness proposed by Toussaint's et al., (2017) does not include self-compassion within its design. In response, this research proposes a new stress and coping model of self-forgiveness, self-compassion, affect and psychological health as a theoretical paradigm to account for the relationship between self-forgiveness and self-compassion as coping responses. This model will now be described in more detail in relation to the reviewed literature.

2.11 The researcher's proposed stress and coping model of self-forgiveness, self-compassion, affect and psychological health.

Drawing on the work of Lazarus (1999), Worthington (2006, 2013) asserts that people advance through a four-step process (stressor, appraisal, stress response, coping attempt) in order to manage the psychological, social, and spiritual consequences of wrongdoing.

Stressor

The first step in the model is when one identifies that a transgression (e.g. a hurt or an offence) has been committed by the self that is felt to be serious enough to violate a personal or shared moral standard, value or expectation, and thus functions as a *stressor*. Leary, Haupt, Strausser, and Chokel, (1998) identified the following examples of interpersonal transgressions that include hurts and offences such as criticism, humiliation, betrayal, rejection. The effects of these transgressions increase especially when they are perpetrated interpersonally by close friends, romantic partners, family members, or intrapersonally when these hurts and offences are perpetrated against the self by the self in the form of transgressed values and which yield self-criticism and self-punishment. In this regard, Woodyatt et al., (2017) assert that intrapersonal transgressions represent a ‘rupture’ in one’s personal socio-moral identity – of being a “good person” -that is derived from our need for self-consistency, self-acceptance, relatedness and communion with others (Shnabel & Nadler, 2008, 2015). Therefore from a social and evolutionary point of view, intrapersonal transgressions are significant stressors as they represent a threat to our sense of social belonging and potential loss of social agency, and it is from within these attachment relationships that appraisals frequently occur (Bowlby, 1969; Gilbert, 2005; Giliath, Shaver & Mikulincer, 2005).

Appraisal

The second step in the model refers to when one utilises *primary appraisals* such as self-evaluations around the meaning and nature of the transgression, and *secondary appraisals* around which coping strategies are available to deal with the stressor. From within the context of interpersonal forgiveness research, Strelan and Covic (2005) assert that primary appraisals reflect the extent to which the transgression poses a current *threat* or *loss*. Within the context of self-forgiveness it is asserted within the model that primary appraisals of threat and loss also form as a result of the transgression. As has previously been stated, transgressions usually represent a threat and potential loss of one’s social-moral identity because they involve the perceived violation of group expectations, values and norms that elevates the risk of being marginalised by one’s social group. This would involve the loss of social agency such as loss of status, and punishment. Sometimes transgressors may feel that their transgression is linked to a lack of self-control and perceived inability to manage their lives, appraisals that may be linked with long-held

negative personal beliefs and schemata such as “I’m bad, worthless, a failure” that may include feelings of psychological distress (anxiety, depression and stress) as well as remorse, guilt and shame. It is noted that there may also be appraisals around sadness and *loss*, and the extent to which one has been the subject of an injustice by others or ourselves, and whether we are deserving of self-compassion or self-forgiveness (Cornish & Wade, 2015b; Hall & Fincham, 2005; 2008; Holmgren, 2012). Some of these appraisals and beliefs may reflect a person’s trait disposition towards self-forgiveness and self-compassion, and as the reviewed research indicates are likely to be influenced by a range of socio-demographic variables (age, gender, ethnicity / culture and religiosity and spirituality) and personality variables (agreeableness, neuroticism, narcissism, and social desirability). These appraisals also tend to be influenced according to the perceived severity and responsibility of the current transgression in relation to similar perceived historical transgressions (e.g., trauma). Within Gilbert’s (2009) three-circle model these appraisals would lead to the activation of the threat-based emotional regulation system and negative affects (e.g., fear, anxiety, disgust, anger).

Secondary challenge-based appraisals determine the extent to which the individual can draw upon their capacity for trait and state self-forgiveness. Typically, challenge-based primary appraisals (e.g. controllability) have been found to be related to better psychological adjustment, whilst threat and loss primary appraisals are related to poorer psychological adjustment (Ferguson, Mathews, & Cox, 1999). Reviews of forgiveness research (e.g. Maltby et al., 2007), suggest that it is the quality of one’s primary appraisals, their perceived level of injustice and personal responsibility, together with the severity of the transgression, that will determine the extent to which they will appraise the stressor as a threat, loss, or a challenge. Whilst the evidence directly linking the stress and coping appraisals with self-forgiveness and self-compassion is currently lacking, there is evidence indicating that self-forgiving people would tend to generate more challenge-based appraisals such as self-compassion whereas being self-unforgiving would complicate the development of compassion (Cornish & Wade, 2015b; Matsuyuki, 2010).

Stress response

The third step in the model refers to how the transgression is appraised. This involves evaluations of oneself, or others thoughts or behaviors, as falling short of our

internal standards, values that comprise our socio-moral identities (Shnabel & Nadler, 2015). If there is a discrepancy then an ‘injustice gap’ and sense of dissonance will be evoked, leading to feelings of anger, guilt and poorer psychological health until the discrepancy is bridged and the dissonance neutralised (Worthington, 2006). If the discrepancy to one’s socio-moral identity is so threatening, cannot be bridged, and exceeds the individual’s capacity for self-forgiveness, then justice and a sense of social and moral agency can be regained through the stress response of *self-condemnation and self-blame*. Reviewed research suggests that self-condemnation and self-blame can take the form of self-critical appraisals around personal inadequacy (e.g., I’m a failure) or self-hatred and shame, involving seeing oneself as characterologically flawed (e.g., “I’m a bad person”) that reflect an individual’s capacity for trait and state self-forgiveness and a wish to purge one’s self of guilt (Bastian et al, 2011). Low levels of state self-forgiveness tend to lead to retributive coping through self-punishment in order to preserving a sense of social agency, personal control and affiliation but at the cost of moral-social identity repair (Fischer & Exline, 2007; 2010; Holmgren, 2012). When these self-critical appraisals endure, they tend to become paralysing and have the opposite effect as the research suggests that they tend to undermine a sense of agency (de Vel-Pelumbo et al., 2017). Research suggests that this is because these appraisals are bound with guilt, and shame based traumatic memories that can lead to feeling overly responsible, ‘at fault’, inadequate, or defective, resulting in poorer psychological health such as increased humiliation, shame and guilt (Matos & Pinto-Gouveia, 2010; 2013).

Reviews of self-forgiveness and self-compassion research (e.g., Barnard & Curry, 2010; Fehr, et al., 2010; Toussaint & Friedman, 2008, Toussaint et al., 2017), propose that positive and safe / content affect helps transgressors form more adaptive and flexible self-appraisals. It is proposed that changes in these appraisals help calm self-condemning appraisals (over-responsibility, self-criticism/hate, severity of their transgression) that are helpful in viewing transgressions as less threatening to their socio-moral identity (Okimoto & Wenzel, 2014). In this way it is suggested that transgressors who are more able to develop pro-social emotions (e.g. empathy, kindness, and understanding) and become more self-forgiving would be more able to activate their affiliative-based emotional regulation system (Gilbert, 2009).

Coping attempt

The fourth and final step in the model refers to the response that arises as a product of the three previous steps, and appears most closely linked to the renewal phase of self-forgiveness. Within this step of the model there are two options.

In the first option, self-condemnation could be viewed as *adaptive* if it motivates restorative prosocial outcomes such as understanding, self-empathy, kindness, and understanding. These constructs are associated with self-compassion, positive and safe affect that would yield a reduced stress-based threat and loss responses yielding reduced psychological distress, guilt and shame. Within Gilbert (2010) and Neff's (2003b) models, this would occur through facilitating calmness, safety, kindness, warmth and understanding to the self rather than the threat associated with self-condemnation. There would also be an increased tendency towards viewing one's experiences and perceived failings as part of a larger human experience or common humanity, rather than feelings of difference and isolation. This would also lead to an increased ability to hold painful thoughts and feelings in mindful awareness rather than through over-identifying with them. Within Gilbert's three-circle model, self-compassion would calm the threat-based emotional regulation system, and increase activity the affiliative-based system, that would increase activity within the drive system and make it more possible to cope with the inevitable disappointments associated with the ongoing challenges of living. Over time it would be expected that the skills of emotional regulation and self-efficacy would develop leading to balancing the three emotional regulation systems and yielding improvements in psychological health and well-being.

In the second option, self-condemnation can be *maladaptive* if the retributive responses that become habitual and excessive. For example, high levels of activity within the threat-based system, and low levels of activity within the affiliative and drive systems would tend to complicate coping. Importantly, self-condemnation has been found to reduce one's capacity for self-compassion and self-forgiveness through an increase in retributive responses such as being unempathic, using negative self-appraisals, self-criticism, dispassion, negative affect and poorer psychological health (Davis et al., 2015; Hall & Fincham, 2008; Neff & Pommier, 2012; Fischer & Exline, 2010).

An alternative maladaptive response involves the use of pseudo self-forgiveness

that has been associated with narcissism (Exline et al., 2003). As has been reviewed, narcissists tend to deny responsibility for their transgressions through externalising personal responsibility through disavowal or blame. It is suggested that whilst such responses may be helpful in the short term through reducing activity and distress within their threat-based system, ultimately the need for high levels of activity within their drive-based system associated with their need for self-gratification, cannot be sustained through external reward. This could lead to increased self-criticism that if not defended against may complicate the process of self-forgiveness increasing activity within their threat-based system and decreasing activity in their affiliative system (Woodyatt & Wenzel, 2013). Finally, the possible confounding effects of other personality variables (agreeableness, neuroticism, social desirability) and individual demographic variables (age, gender, class, ethnicity, and religiosity/spirituality) previously highlighted in the reviewed literature are included within the proposed model (Barnard & Curry, 2011; Exline, Baumeister, Bushman, Campbell & Kinkel, 2004; Fehr, et al., 2010; Fischer & Exline, 2010; Hall & Fincham, 2005; 2008).

In summary, in drawing upon the work of Worthington (2006), Gilbert (2005; 2014) and Neff (2003a; 2011), it is proposed that how one copes with the stress associated with our transgressions appears associated with our capacities for self-forgiveness and which influence psychological well-being. It is also proposed that the relationship between self-forgiveness and self-compassion is mediated by the levels of compassionate self-responding and positive and safe affects, and uncompassionate self-responding and negative affects that are felt at the time. It is also proposed that these mediating relationships will be influenced by a range of personality variables (neuroticism, agreeableness, narcissism, and social desirability) and socio-economic variables (age, gender, ethnicity, and religiosity / spirituality). These relationships are described diagrammatically in Figure 2.7 overleaf. It is noted that given the complexity of the model, only these key relationships will be subjected to evaluation in the forthcoming three studies.

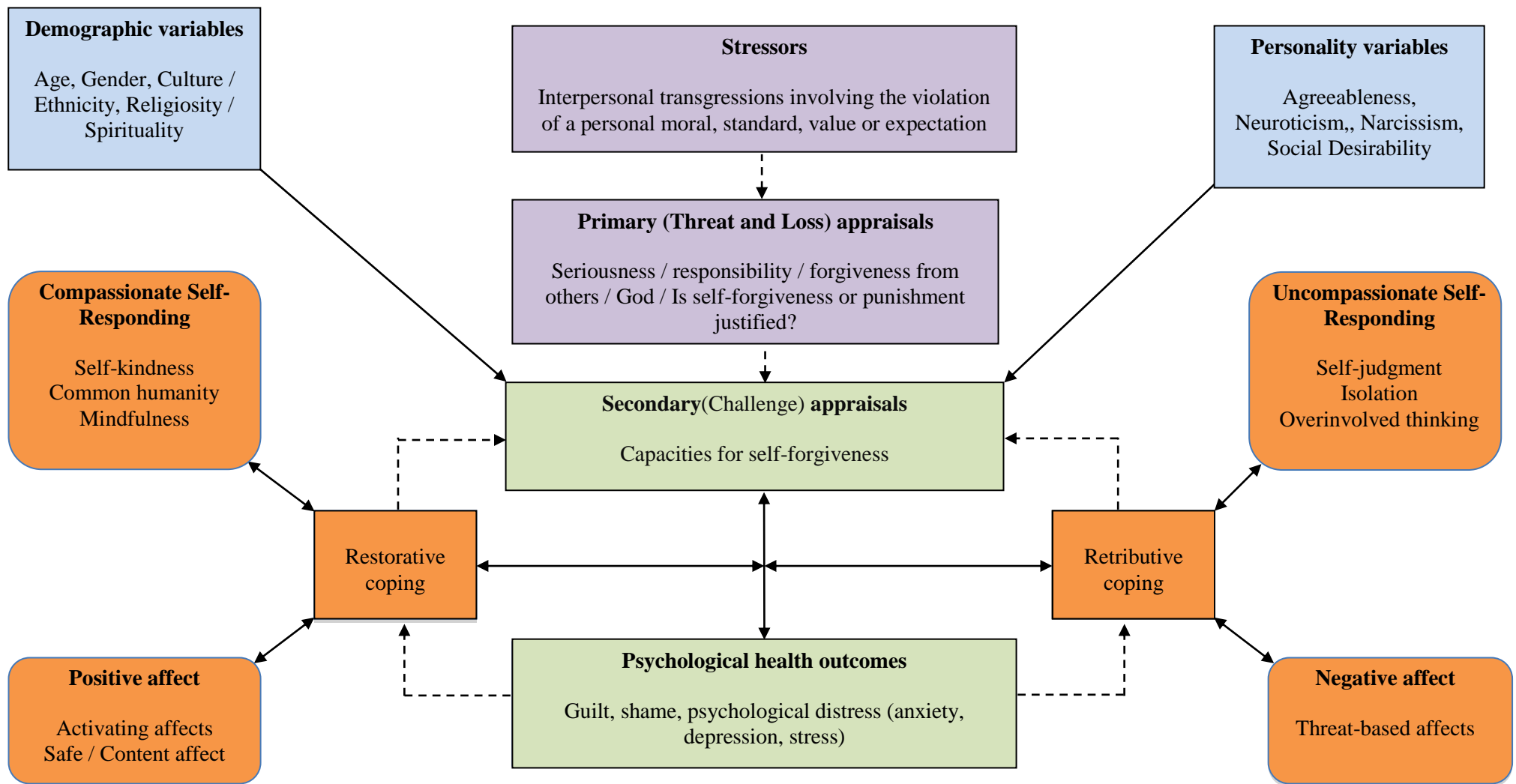


Figure 2.7. Illustrating the researcher's proposed stress and coping model of self-forgiveness, self-compassion, affect and psychological health.

Note: The black solid lines indicate the relationships that will be subjected to testing. The orange round boxes represent the mediating variables, green square boxes are independent variables (secondary appraisals) and dependent variables (self-condemning response), and the square blue boxes are the control variables.

CHAPTER 3

3.0 The studies

This chapter will provide an overview of the focus of this present thesis and present the three studies that will be used to explore the researcher's stress and coping model of self-forgiveness, self-compassion, affect and psychological health. The aims of each study will be outlined followed by a critique of the chosen philosophical epistemology for each study. This will be followed by the rationale for adopting the chosen mixed methods approach before describing the design of this study in more depth. Because of the comprehensiveness of the proposed model, the present thesis focused on certain key aspects of the model that are identified in Figure 2.7.

3.1 Study 1

The first aim of Study 1 was to test key aspects of the researcher's model through examining the proposed relationship between trait self-forgiveness and a range of psychological health variables (psychological distress, guilt and shame). It was then proposed to examine the mediating effects of Neff's (2003a; 2003b) bifactor model that she terms Compassionate Self-Responding (CSR) and Uncompassionate Self-Responding (USR), in addition to the effects of negative, positive and safe/content affects upon these relationships.

Given the recent controversy around the bifactor model (Neff et al., 2017; Neff et al., 2018), highlighted in the literature review, the second aim of Study 1 was to examine the mediating effects of Neff's (2003) single-factor model of self-compassion represented by the Self-Compassion Scale (SCS) total scale score, in addition to the effects of negative, positive and safe/content affects upon these relationships.

The third aim of Study 1 was to examine the influence of the demographic variables (age, gender, culture/ethnicity, class, and religiosity/spirituality) and personality variables (neuroticism, agreeableness, narcissism and social desirability), that the reviewed research suggests may have effects upon the relationships between trait self-forgiveness, self-compassion and the psychological health variables under study.

3.2 Study 2

The first aim of Study 2 was to examine the proposed model over time through testing predicted associations longitudinally. This involves the use of a repeated-measures design where participant's capacities for self-forgiveness, compassionate self-responding /uncompassionate self-responding, positive and negative affects and their psychological health outcomes (stress, anxiety, guilt, shame and depression) were assessed for change as a result of participating in a 12-week CFT group.

The second aim of Study 2 was to examine the mediating effects of compassionate self-responding, uncompassionate self-responding and positive affect (activating affect and safe/warm affect) and negative (threat) affect upon the relationship between trait self-forgiveness and the psychological health variables at three time points (Weeks 1, 6 and 12) during the course of the CFT group intervention. Study 2 thus tested the hypothesised associations from Study 1 using a design that permitted stronger inferences between the variables to be made.

3.3 Study 3

Drawing upon the recommendations of Woodyatt et al., (2017b), the aim of Study 3 was to collect qualitative data to help contextualise the interpretations derived from the quantitative data and to provide more detailed understanding of participant's experience of the CFT group and the expected process of change. Participants were asked to take part in a 40min focus group (Krueger & Casey, 2014) at Week 12 of the CFT group where several questions relevant to the aims of Studies 1 and 2 were discussed (see Appendix D, p. 413).

3.4 The study methodology

As a both a Clinical Psychologist, a Counselling Psychologist and a reflective scientist practitioner, I have always had an interest in developing generalisable ideas and how these relate to individual experience and clinical practice. Historically, this has led me to focus upon value of the epistemological lenses of Positivism, Post positivism, Critical Realism and Pragmatism to guide my research and clinical practice. By way of

background I shall now briefly outline each of these approaches before I move towards describing the value of taking a mixed methods approach that was used in this study.

The development of Positivism is most closely linked with August Comte (Bourdeau & Chazel, 2002), and more recently Post-positivism (Popper, 1959/2002) and Critical Realism (Bhaskar, 1975; 1979; 1989). Positivism is based upon the premise that the only authentic knowledge is scientific knowledge, and that such knowledge can only come from the affirmation of theories through strict scientific method. This involves utilising techniques for investigating phenomena based on gathering observable, empirical and measurable evidence, that are then subject to specific principles of reasoning. It is asserted that Positivism assumes that there are associations and causalities between phenomena that exist in the natural world that can be discovered through such scientific enquiry (Hacking, 1981). Such premises are at the heart of the quantitative methodological approach. Guba and Lincoln (1989) point out that historically positivism has been criticised on two essential grounds. Firstly, that positivism fails to accurately represent human social action as human activity and consciousness as a process of social construction. Furthermore, as a paradigm it fails to recognise that the philosophy and ideas upon which it is based are themselves products of social construction. Secondly, it is asserted that positivism neglects the social context. Specifically, that as a paradigm it is conservative, resists refutation and reflection in a way that is in opposition to the scientific approach that it aspires to, thus undermining the validity and reliability of the approach (Kuhn, 1962).

Critical realism emerged out of these criticisms as part of the post-positivist crisis within social sciences during the 1970's and 80's (Bhaskar, 1975; 1979; 1989). Like positivism, critical realism proposes that reality that is independent of our thinking. However, where critical realism differs is that it proposes that any reality or theory is fallible, revisable, and therefore reality can never be known. Critical realists assert that science and scientists are inherently biased because of personal and cultural biases. Mearns (2011) points out that critical realists tend to emphasise the need for multiple methods, measures, observations and triangulation in order to understand the object of study and to reduce bias as much as possible. Therefore, objectivity is viewed as unachievable and a social phenomenon. Within the realm of science, this is the process of submission and peer review, where knowledgeable peers within the scientific

community criticise each other's work in the knowledge that objectivity cannot be achieved but only aspired to.

Mearns (2011) argues that critical realism values both quantitative and qualitative methodologies, and that critical realism has clear links with pragmatism. For example, the Stanford Philosophical Encyclopedia (2019) defines pragmatism as “*a philosophical tradition that – very broadly – understands knowing the world as inseparable from agency within it. This general idea has attracted a remarkably rich and at times contrary range of interpretations, including: that all philosophical concepts should be tested via scientific experimentation, that a claim is true if and only if it is useful.*”

Pragmatism emerged out of the USA during the late 19th Century and is most associated with the work of William James (1842-1910), Charles Pierce (1839-1914), and John Dewey (1859-1952). With the growth of positivism, the influence of pragmatism declined during the course of the 20th Century but re-emerged towards the end of the century out of the dialectical stances that reflect post-positivistic and social constructionist paradigms (e.g., Greene, 2007; Fielzer, 2009). Bacon (2012) asserts that pragmatism is not regarded as single philosophy, more it is viewed as a way of ‘doing philosophy’ that views the selection of methodology to be more associated with research objectives rather than as a result of an epistemological position. In this regard Morgan (2007; 2014) advocates that pragmatism underpins most mixed methods research (Burke, Johnson, & Onwuegbuzie, 2004; Teddlie & Tashakkori, 2009; Creswell & Piano-Clark, 2011). Mixed methods research has been defined by Creswell, Klassen, Piano-Clark and Clegg Smith (2011) as “*a research approach or methodology focusing on research questions that call for real-life contextual understandings, multi-level perspectives, and cultural influences; employing quantitative research assessing the magnitude and frequency of constructs and rigorous qualitative research exploring the meaning and understanding of constructs; utilising multiple methods (e.g., intervention trials, focus groups, in-depth interviews); intentionally integrating or combining these methods to draw on the strengths of each; and framing the investigation within philosophical and theoretical positions*” (p. 4).

Taking a mixed methods approach affords researchers the ability to combine the values and strengths of both qualitative and quantitative methods whilst diminishing their

weaknesses to better understand of the phenomena under study (Morgan, 2007; 2014; Fetters & Freshwater, 2015). In the case of this thesis, the research aims and questions outlined in Study 1 and Study 2 were most appropriately answered using quantitative positivist epistemology and methodology, whilst the aims of Study 3 were best addressed using qualitative methodology. The overarching pragmatic philosophy underpinning this thesis allowed for a systematic and practical application of appropriate epistemologies and methods to address each specific study aim.

Using the guidelines provided by Creswell and Piano-Clark (2011), an Explanatory Sequential mixed methods design was selected for the purposes of is research because it fulfilled the following criteria:

- 1) The important variables are known and appropriate measures are available;
- 2) There was an opportunity and a plan for ongoing data collection; and,
- 3) The researcher wanted to develop new questions, ideas and insights that could not be answered through quantitative analyses alone.

The study design involves two phases (see figure 3.1) the details of which will be outlined.

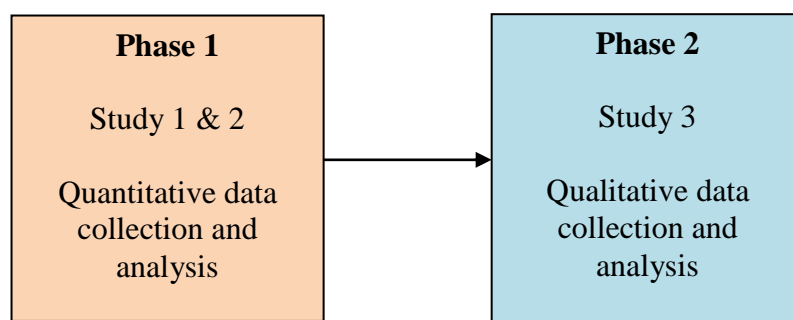


Figure 3.1. Explanatory sequential design diagram of the research studies.

Phase 1 afforded the opportunity to examine predicted relationships between self-forgiveness, self-compassion, affect, psychological health and a number of personality and socio-demographic variables, identified by previous forgiveness and compassion researchers that informed the development of the model under study. Within this phase it was also possible to explore how these associations changed over time as a result of

undertaking an intervention designed to increase participant's capacities for self-compassion. In order to test the validity of the model, the researcher utilised quantitative methodology. Phase 2, utilised the qualitative methodology of the focus group that afforded the opportunity to better understand participant's experience of change whilst participating in the self-compassion group.

It was anticipated that this mixed methods research design would allow the exploration of the relationships between self-forgiveness, self-compassion, affect and psychological health highlighted in previously reviewed research (Worthington, 2006, 2013; McConnell, 2015; Hall & Fincham, 2005; 2008; Macbeth & Gumley, 2012).

CHAPTER 4

4.0 Study 1

Recent views of self-forgiveness research by Woodyatt et al., (2017; 2017b) and the findings of the researcher's literature review highlight that there is general agreement that following an offence, the process of genuine self-forgiveness entails a hedonic component involving the release of negative feelings and emotions that are directed towards the self (e.g. self-condemnation, guilt, shame), as well as involving the development of positive feelings and emotions towards oneself (self-compassion, empathy, love). There is also general agreement that genuine self-forgiveness involves a eudaimonic component involving the repair and restoration of one's socio-moral identity caused by the offence. Whilst both pathways were shown to have value, Woodyatt et al., (2017b) assert that it is perhaps the way that they are combined which may influence the process of self-forgiveness and more research is needed to better understand these relationships.

As was identified in the literature review, researchers have advanced the stress and coping literature as one way to better understand the processes of self-forgiveness (Strelan & Covic, 2006; Worthington, 2006; Toussaint et al., 2017), and self-compassion (Allen & Leary, 2010; Sirois et al., 2014). But given the role that self-compassion is asserted to play within the process of self-forgiveness (Cornish & Wade, 2015b; Gilbert & Choden, 2013; Gilbert & Woodyatt, 2017; Griffin, 2014; Matsuyuki, 2010; Roxas et al., 2014; Terzino, 2010), it is perhaps surprising that Toussaint's et al's (2017) stress and coping model of self-forgiveness does not include self-compassion within their design. It was these issues and gaps in the literature that guided this current research and which led to the researcher to propose the current stress and coping model of self-forgiveness, self-compassion, affect and psychological health that was subjected to testing within Study 1.

4.1 Study 1 aims

The first aim of Study 1 was to test key aspects of the model through examining the proposed relationship between trait self-forgiveness and a range of psychological health variables (psychological distress, guilt and shame) and then examine the

mediating effects of Neff's (2003a; Neff et al., 2018) bifactor model that she terms Compassionate Self-Responding (CSR) and Uncompassionate Self-Responding (USR), in addition to the effects of negative, positive and safe / content affects upon these relationships.

Given the recent controversy around the use of the bifactor model (Neff et al., 2017; Neff et al., 2018), the second aim of Study 1 was to examine the mediating effects of Neff's (2003a) single-factor model of self-compassion represented by the Self-Compassion Scale total scale score, in addition to the effects of negative, positive and safe/content affects upon these relationships.

The third aim of Study 1 was to examine the influence of demographic variables (age, gender, culture/ethnicity, class, and religiosity/spirituality) and personality variables (neuroticism, agreeableness, narcissism and social desirability), that the reviewed research suggests may have effects upon the relationships between trait self-forgiveness, self-compassion and the psychological health variables under study.

Given these aims, a parallel multiple mediator model was used to test these relationships (see Figure 4.1). Hayes (2018) points out that in a parallel multiple mediator model, an independent variable *X* is proposed to directly influence a dependent variable *Y*, as well as indirectly through two or more mediators with the assumption that none of the mediators causally influence each other. This is not to say that the mediators are not correlated, but that they may be more highly correlated with the dependent variable *Y*. It is noted that in the case of the self-compassion single-factor model, the number of mediators will be reduced from five to four because of the variables USR and CSR being substituted by the self-compassion total variable score.

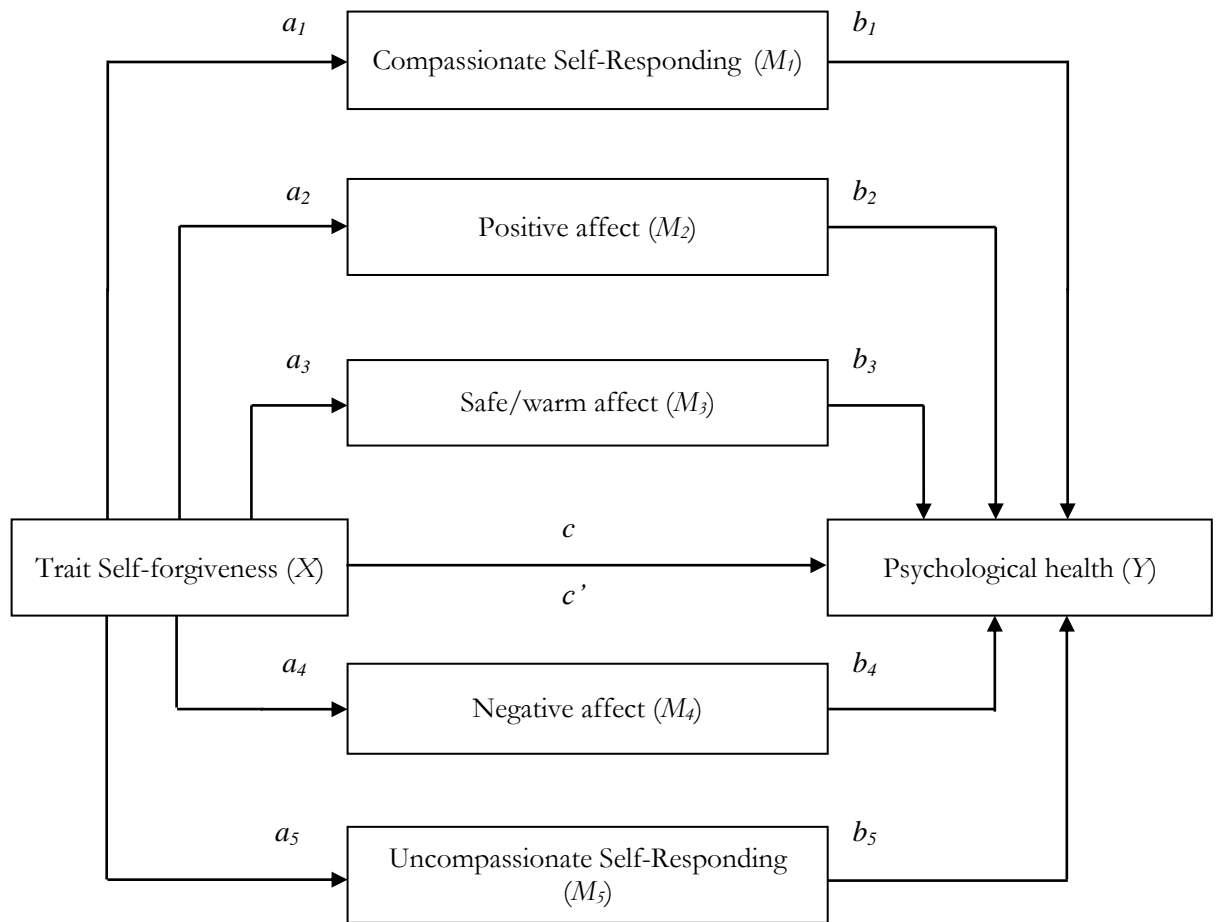


Figure 4.1. A conceptual diagram of the proposed parallel multiple mediation model (adapted from Hayes, 2018).

Note: c = the total effect of the independent variable (X) on the dependent variable (Y).
 c' = the specific direct effect of the independent variable (X) on the dependent variable (Y) through the mediator variables (M_1 - M_5).

The literature review in Chapter two indicated that certain demographic and personality variables are likely to influence the associations between trait self-forgiveness, self-compassion, affect and the psychological health variables. Drawing upon the work of Frazier et al., (2004) it was suggested that it would be necessary to control for the effects of those socio-demographic and personality variables that are correlated with the independent, dependent and mediating variables being tested (Barron & Kenny, 1986). Not to do so at this stage would raise questions about the validity of any findings. These relationships are expressed conceptually in figure 4.2 overleaf, which describes a parallel multiple mediation model with multiple statistical controls

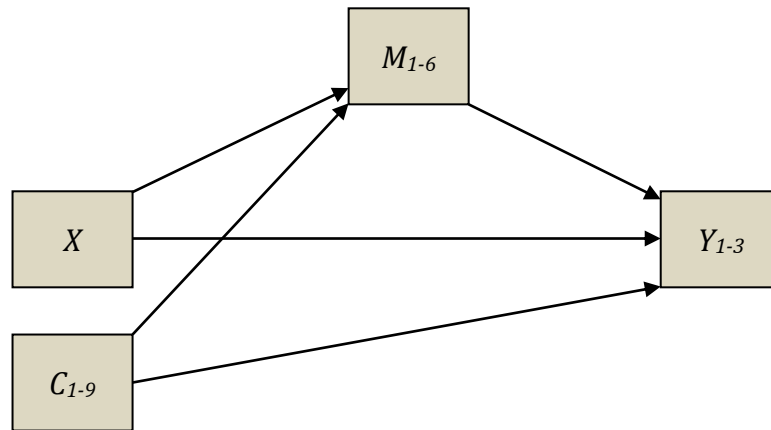


Figure 4.2. A conceptual diagram of a parallel multiple mediation model with multiple statistical controls (adapted from Hayes, 2018).

Index

Y_1 = Psychological distress

Y_2 = Shame

Y_3 = Guilt

X = Trait self-forgiveness

C_1 = Age

C_2 = Gender

C_3 = SES

C_4 = Culture

C_5 = Religiosity / spirituality

C_6 = Agreeableness

C_7 = Neuroticism

C_8 = Narcissism

C_9 = Social desirability

M_1 = Self-compassion total

M_2 = Positive affect

M_3 = Safe / warm affect

M_4 = Self-uncompassion total

M_5 = Negative affect

M_6 = Self-compassion Scale total score

This conceptual model will be tested through the use of six specific hypotheses.

4.2 Hypotheses

1. Trait self-forgiveness is expected to predict psychological distress, and this association will be mediated by compassionate self-responding, uncompassionate self-responding, negative affect, positive affect and safe / content affect after controlling for those demographic and personality variables that were found to correlated with trait self-forgiveness and psychological distress.

- 1b. Trait self-forgiveness is expected to predict psychological distress, and this association will be mediated by the SCS total scale score, negative affect, positive affect and safe / content affect after controlling for those demographic and personality variables that were found to correlated with trait self-forgiveness and psychological distress.
- 2. Trait self-forgiveness is expected to predict shame, and this association will be mediated by compassionate self-responding, uncompassionate self-responding, negative affect, positive affect and safe / content affect after controlling for those demographic and personality variables that were found to correlated with trait self-forgiveness and psychological distress.
- 2b. Trait self-forgiveness is expected to predict shame, and this association will be mediated by the SCS total scale score, negative affect, positive affect and safe / content affect after controlling for those demographic and personality variables that were found to correlated with trait self-forgiveness and psychological distress.
- 3a. Trait self-forgiveness is expected to predict guilt, and this association will be mediated by compassionate self-responding, uncompassionate self-responding, negative affect, positive affect and safe / content affect after controlling for those demographic and personality variables that were found to correlated with trait self-forgiveness and psychological distress.
- 3b. Trait self-forgiveness is expected to predict guilt, and this association will be mediated by the SCS total scale score, negative affect, positive affect and safe / content affect after controlling for those demographic and personality variables that were found to correlated with trait self-forgiveness and psychological distress.

4.3 Method

4.3.1 Design

This study will utilise a cross-sectional correlational design to test key aspects of

the proposed stress and coping model of self-forgiveness, self-compassion, affect and psychological health.

4.3.2 Participants

Participants ($n = 141$) were recruited from both non-clinical and clinical settings to establish the generalisability of the model and to yield a larger sample to upon which to test the researcher's hypotheses.

The clinical sample ($n = 78$) comprised of participants who were attending three rural Community Mental Health Team (CMHT) within a District Health Board (DHB) in the Auckland City area of New Zealand. Participants needed to be between the ages of 18-65 and be experiencing mild to moderate levels of anxio-depressive symptoms and present with low risk to self and others.

The non-clinical sample ($n = 63$) comprised of undergraduate and postgraduate psychology and nursing students who were attending a New Zealand University (Auckland University of Technology – AUT). Eligible participants needed to be between 18 and 65 years of age.

4.3.3 Procedure

Clinical sample

Potential participants were approached through two established DHB pathways; the Primary Care Pathway (clients who have been newly referred by their GP's) and the Recovery Pathway (clients who have been working with team members for a period of time). Historically, clients from both of these pathways had been referred to a pre-existing CFT group that the researcher had been running for two years prior to commencing this research. As a result, ethical consent from the Health Disability Ethics Committee (HDEC) was not required (see Appendix B, p. 306-307). Approval to conduct the research was also gained from the DHB through its Research and Knowledge Centre (see confirmation letter – Appendix B, p. 388) and ethical consent to undertake the study was obtained through application to the Auckland University of Technology Ethics Committee (AUTEC) (see Appendix B. p. 389).

Two subsequent applications were made to AUTECH to account for issues in relation to measurement and sample size. The first application involved a request to include a measure of State Self-forgiveness to measure changes in self-forgiving beliefs and behaviours as a result of running the first CFT group (Appendix B, p. 389). A second application (Appendix B, p. 390) was made because of organisational changes to DHB referrals process that led to a reduction in numbers of suitable clinical referrals for the study. As a result, permission was gained to recruit a non-clinical (student) sample from AUT.

With regard to the clinical sample, following discussions within the DHB treating team, potential participants who met the study entry and exclusion criteria (Table 4.1 below) were invited to take part in the study by their Keyworker (Recovery Pathway) or Primary Care Liaison clinician (PCL Pathway).

Table 4.1. Outlining the entry and exclusion criteria of the studies.

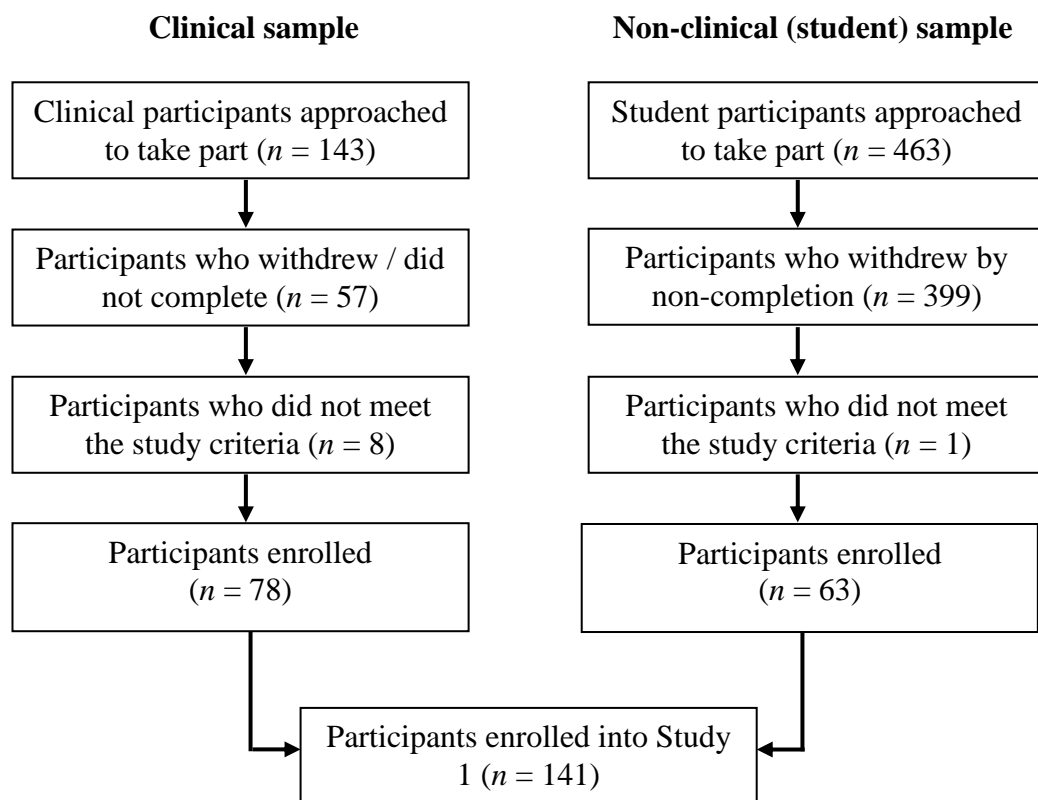
Entry Criteria	Participants (18-65) who have been diagnosed with mild to moderate levels of anxiety or clinical depression and who present with a capacity for shame and self-criticism will be asked if they wish to participate in the study.
Exclusion criteria	Participants who have an existing or past diagnosis of schizophrenia, have current drug or alcohol abuse problems, have a high risk of harm to self/others; people with intellectual / developmental disabilities; or limited English language ability and whose physical or mental health, and mental or family/work commitments may compromise their ability to attend the CFT group.

These inclusion criteria were chosen as the available evidence suggests that CFT has found to be most useful with mild to moderate psychological health problems (Kirby et al., 2015). The exclusion criteria were chosen because of the potential confounding effects serious mental health and cognitive problems upon the variables under study. This is not to say that these clients would not benefit from participating in the study, and in fact some clients with these issues did take part in the CFT group but were excluded from the study.

Clients who were interested in participating were supported to read through the Patient Information Sheet (see Appendix C, p. 392-395) and gain consent to participate. Cultural support was provided if requested and the participants' keyworkers or PCL clinician was very sensitive to the possibility of coercion. They made it very clear that the client's decision to participate would have no influence on their access to other DHB services. Additional time and cultural support was offered to ensure that participants had time to consider their decision. Once participants indicated that they wished to take part in the study, they were asked to give consent for Study 1 (see Appendix C, p.396) and complete the questionnaire booklet (see Appendix D, pp. 403-412). Once participants had completed the measures, the questionnaire booklets were passed on to the Primary Researcher for processing where all data were de-identified.

The CONSORT clinical trial guidelines (Moher, et al., 2010) recommend the use of a flow chart to explain how participants enter studies. The CONSORT flow chart for this study (table 4.2 overleaf) points out that of the 143 clinical participants who initially agreed to take part, 57 subsequently withdrew their consent either verbally or through not completing their questionnaires, yielding a 60.1% response rate. Of these participants, 8 were subsequently excluded from the study because they met the exclusion criteria, leaving 78 clinical participants who were enrolled and accepted into the study.

Table 4.2. The CONSORT flowchart for Study 1



Non-clinical sample

The Primary Researcher approached lecturers who were teaching undergraduate and postgraduate courses at AUT for permission to recruit students taking their courses. Information about the PhD study was provided to the lecturer to facilitate decision-making. Once suitable lecturers and venues were found, the Primary Researcher attended the venue and was introduced by the lecturer. The Primary Researcher explained the inclusion criteria (participants need to be 18 + years old and attending AUT undergraduate and postgraduate courses) and were supported to read through the Patient Information Sheets (see Appendix C, pp. 397-400) and give their written consent to participate using a standard AUT consent form (see Appendix C p. 401). It was agreed by AUTECH that questions linked to the study exclusion criteria would be included into the questionnaire booklet and those participants who fulfilled the exclusion criteria would be excluded from the study but not from the prize draw.

Potential participants were able to discuss any questions and/or concerns with the Primary Researcher and assess the costs and benefits of participation including the

details of the prize draw that participants would be entitled to enter once they had returned their questionnaire booklet. Participants were instructed to complete the questionnaires in private and seal their completed questionnaires into the envelope provided. They were then instructed to drop off the envelope into a locked drop box at a known secure location on campus of which only the Principal Researcher had access, thus ensuring participants confidentiality.

The CONSORT flow chart (table 4.3 above) points out that of the 463 sets of questionnaires were given out to student participants, 64 participants agreed to take part and returned their questionnaires, yielding a 13.6% response rate. One participant was excluded from the study because they indicated that had a developmental disorder, leaving 63 non-clinical participants who were accepted into the study.

4.3.4 Measures

Participants were asked to complete the following non-copyrighted questionnaires in the form of a questionnaire booklet (see Appendix D, pp. 403-412).

Independent variables

Trait Self-Forgiveness: - The Heartland Self-Forgiveness Scale, HFS-S (Thompson, et al., 2005).

The HFS-S is the six-item self-forgiveness subscale from the 18-item Heartland Forgiveness Scale (HFS), (Thompson et al., 2005) that is designed to assess dispositional (trait) self-forgiveness.

When answering the questionnaire (example item: “Although I feel bad at first when I mess up, over time I can give myself some slack”), participants are asked to consider their responses about how they typically respond to negative events using a 7-point Likert rating scale (1 = “Almost always false of me” to 7 = “Almost always true of me”). Three of the six questions are reverse coded (example item: “I hold grudges against myself for the negative things that I have done”). Responses are summed and total scores range from 6 to 42, with higher scores indicating greater trait self-forgiveness. Thompson et al., (2005) indicated that the HFS-S has good

psychometric properties (e.g., convergent validity and test-retest reliability) and adequate internal consistency reliability over the course of three studies ($\alpha = .72 -.76$). In the present study, the HFS-S subscale was found to have a high level of internal consistency (.88).

Self-Forgiving Beliefs, Feelings and Actions – An adapted version of The State Self-Forgiveness Scale, SSFS (Wohl et al., 2008).

The SSFS is a 17-item questionnaire that yields two sub-scales which measure an affective and behavioural component (self-forgiving feelings and actions: SSFA) and a cognitive component (self-forgiving beliefs: SFB) This allows researchers to examine the extent to which participants feel and act constructively toward themselves and have self-value even in the wake of a specific wrongdoing. Whilst the SSFS has been validated using clinical samples, the questionnaire asks participants to focus upon a specific transgression that creates methodological problems when undertaking group-based longitudinal studies with participants, as reflecting upon traumatic transgressions may cause levels of distress that may result in response errors (e.g. minimisation, denial). In addition, participants may focus upon different transgressions that may vary in severity over the duration of the CFT group and which could affect the reliability and validity of their responses. In order to overcome these methodological issues, the decision was taken to alter the wording of the SSFS questions so that participants consider what they did wrong in relation to the most significant mistakes that they have made during their lives.

Participants use a 4-point Likert rating scale (1 = “not at all” to 4 = “completely”) to indicate how closely their feelings and actions (SSFA = 8 items) as well as their self-beliefs (SSFB = 9 items) match self-forgiving prompts. An example prompt from the SSFA subscale is, “As I consider what I did that was wrong, I feel accepting of myself,” and an example prompt from the SSFB subscale is, “As I consider what I did that was wrong, I believe I am a bad person.” Nine of the seventeen questions are reverse coded. Responses are summed with the SSFA and SSFB sub-scale scores from 8 to 32, and from 8 to 36 respectively, with higher scores indicating higher levels of state self-forgiveness on both sub-scales.

Wohl et al., (2008) reported high levels of internal consistency (SSFA = .74; SFB

= .89) that has been confirmed with several recent studies (e.g., Cornish, 2014; Griffin, 2014). Cornish (2014) found reliabilities of .86 for the SSFA and .91 for the SFB scale, whereas a longitudinal study by Griffin (2014) yielded reliability coefficients for SSFA and SFB ranged between .86 to .91 and .78 to .93, respectively. In the present study, the SSFA and SFB sub-scales yielded high reliability coefficients of .93 and .92 respectively.

Dependent variables

Psychological Distress: – The Depression, Anxiety, and Stress Scales, DASS-21: (Lovibond & Lovibond, 1995).

Psychological distress was assessed using the 21-item Depression, Anxiety, and Stress Scales, DASS-21 (Lovibond & Lovibond, 1995). Items in this measure are answered on a 4-point Likert scale (0 = “Did not apply to me at all”, 1 = “applied to me to some degree or some of the time”, 2 = “applied to me to a considerable degree or a good part of the time”, 3 = “applied to me very much, or most of the time”) based on how participants felt within the last week.

The DASS-21 yields three subscales for depression, anxiety, and stress, as well as an overall total score, the latter of which was used in this study. Higher scores indicate higher levels of depression, anxiety, stress and overall psychological distress. Example items for each respective subscale are; depression (“I felt I wasn’t worth much as a person”); anxiety (“I felt I was close to panic”), stress (“I was intolerant of anything that kept me from getting on with what I was doing”). Responses are summed and yield subscales scores ranging from 7 to 21 with the DASS total score ranging between 21 and 63.

The DASS-21 has been found to have strong concurrent validity with other measures of depression, anxiety, and stress (Osman, et al., 2012). Previous research (e.g., Anthony, Bieling, Cox, Enns & Swinson, 1998) with a similar sample has found the reliability estimate for the DASS-21 sub-scales and total score to be in the ‘excellent’ range (Depression = .94, Anxiety = .87; Stress = .91; DASS Total Score = .91). For the current study, the reliability estimates were high; Depression (.92), Anxiety (.86), Stress (.87), and the DASS Total Score was .94.

Shame and Guilt: - The State Shame and Guilt Scale, SSGS (Marschall, Sanftner, & Tangney, 1994).

Shame and guilt were measured with the 15-item State Shame and Guilt Scale (Marschall, et al., 1994). Items on this measure are answered using a 5-point Likert scale (1 = “strongly disagree” to 5 = “strongly agree”) based upon how participants feel about themselves and any mistakes they had made in their lives.

The SSGS yields three subscales, shame, guilt and pride of which only shame and guilt were used in this study because of the well-established links between self-compassion and self-forgiveness. The shame subscale consists of 5 items that measure current feelings of shame (e.g., “I want to sink into the floor and disappear”, the guilt subscale consists of 5 items that measure current feelings of guilt (e.g., “I feel remorse, regret”). Total scores range from 5 to 25 for each sub-scale with higher scores reflecting higher levels of shame and guilt.

The SSGS has been found to have strong concurrent validity with other measures of guilt and shame and depression (Tangney & Dearing, 2002). Tangney and Dearing report high levels of internal consistency, test-retest reliability, and predictive and convergent validity with alphas ranging from .82 to .89 for each sub-scale. The reliability estimates obtained in this study for Guilt and Shame were .85 and .87, respectively.

Potential confounding variables.

Socio-economic variables

The socio-economic variables under study include; age, gender, socio-economic status, culture/ethnicity and religiosity / spirituality.

Socioeconomic status (SES) was identified by participant’s current or last occupation according to the *New Zealand Socioeconomic Index of Occupational Status Criteria 13, NZSEI-13* (Fahy, et al., 2017). Fahy et al., outline a process that involves researchers coding a participant’s previous or present occupation yielding a score that can be applied to a range of cut-off points to identify six socio-economic groups (higher

scores = higher SES). Fahy et al., (2017) point out that by using this process, students would tend to be rated lower in SES but are likely to have higher SES occupations when qualified. Fahy et al., (2017) provide information to more accurately prorate a student's SES on the basis of their current educational level.

Culture/ethnicity will be identified according to the Level 1 classification (NZ European, Maori, Pacific Islander, Asian, Middle Eastern / African / South American, Other) devised by the NZ Statistical Standard for Ethnicity Classification (Statistics New Zealand, 2013). It is noted that not all people who have Maori ancestry identify as Maori and will tend to identify more with the non-collectivist NZ/ European culture (Harrington & Liu, 2002). Therefore, participants will be asked whether they have Maori ancestry, and secondly whether they identify as Maori (Houkamau & Sibley, 2010). As the reviewed research literature (e.g., Hook et al., 2012; Goetz et al., 2010) suggests that participants who come from collectivist and non-collectivist cultures (Hofstede, 2001), have different beliefs around the concepts of forgiveness and compassion, participants were divided into two groups reflecting collectivist (Maori, Pacific Islander, Middle Eastern, African, South American) and non-collectivist cultures (NZ European, European, North American).

Religiosity/Spirituality – The Intrinsic Religiosity (IR) sub-scale of the Duke University Religion Index, DUREL (Koenig, 1997).

The DUREL is a 5-item measure of religious involvement that comprises three dimensions of religious and spiritual activity: Organisational Religious Activity (e.g., going to a religious/ spiritual venue: ORA – 1 item), Non-Organisational Religious Activity (e.g., private prayer: NORA – 1 item) and Intrinsic Religiosity (e.g., living according to one's religious / spiritual beliefs: IR – 3 items).

A review of over 100 studies (Koenig & Büssing, 2010) has found the IR sub-scale to be most associated with recovery from depression and as a result only the IR sub-scale was utilised in this research. The wording of the IR sub-scale requests participants to respond to the following three questions (“In my life, I experience the presence of the divine (i.e. God)”; “My religious beliefs are what really lie behind my whole approach to life”; “I try to carry my religion over into all other dealings in life”). Participants are asked to respond using a 5-item likert-type scale (1 = definitely not true;

2 = tends to be true; 3 = unsure; 4 = tends to be true; 5 = definitely true). Scores ranged between 1 and 15; with higher scores reflect high levels of personal religious commitment or motivation.

Koenig and Büssing (2010) found the IR sub-scale to have an adequate level of internal reliability (.75), excellent test-retest reliability (.91) and strong convergent validity (.85) with another well-validated measure of intrinsic religiosity (Hoge, 1972). For the current study, the reliability estimate for the IR sub-scale was very high (.93).

Personality variables

Neuroticism and Agreeableness - The Neuroticism and Agreeableness scales of the Big Five Inventory, BFI (John, 1990).

The Big Five Inventory (BFI) is a 44-item inventory that is designed to assess the five-factor model of personality (John & Srivastava, 1999; McCrae & Costa, 2007). Participants are asked to respond to whether characteristics apply to them using a 5-item Likert-type scale (1 = “strongly disagree”, 2 = “Mildly disagree”, 3 = “Agree / disagree equally”, 4 = “Mildly agree”, 5 = “Strongly agree”). The BFI yields five sub-scales that are reflective of the five factors of the Five-Factor Model (FFM: agreeableness, conscientiousness, extroversion, neuroticism and openness). As reviews of research (e.g., Maltby et al., 2008; Neff, Rude & Kirkpatrick, 2007) have found neuroticism and agreeableness to be most closely associated with self-compassion and self-forgiveness, only the 17 items reflecting these sub-scales will be utilised within this research. Agreeableness scores ranged between 8 and 40, and neuroticism scores ranged between 9 and 45, with higher scores reflect higher levels of these personality factors.

Reviews of research (e.g., John & Srivastava, 1999) report that the BFI has good levels of reliability across the scales: extraversion (.88), agreeableness (.79) and conscientiousness (.82), neuroticism (.84) and openness (.81). With good levels of convergent validity (mean = 0.79) with other well-established FFM measures of personality such as the NEO-Five Factor Inventory (Costa & McCrae, 1992). For the current study, the reliability estimates for the agreeableness and neuroticism sub-scales were .76 and .83 respectively.

Narcissism - The Single Item Narcissism Scale, SINS (Konrath, Meier, & Bushman, 2014).

The Single Item Narcissism Scale (SINS) was developed as a very brief measure of narcissism where time constraints prohibit the use of longer measures of overt narcissism (e.g., the Narcissistic Personality Inventory, Raskin & Terry, 1988) and covert narcissism (the Hypersensitive Narcissism Scale, HNS: Hendin & Cheek, 1997). Participants are asked to respond to the statement “to what extent do you agree with this statement: I am a narcissist.” There is an additional explanatory note underneath the statement clarifying the term narcissist, “NOTE: The word narcissist means egotistical, self-focused and vain.” Participants are requested to rate the extent to which they agree with the statement using a 7-point likert scale (1 = “Not very true of me” to 7 = “very true of me”).

Konrath, Meier, and Bushman, (2014) report good test-retest reliability (.77 over two and more weeks) and reasonable convergent validity with the NPI-40 and HNS, yielding positive correlations of .40 and .44 respectively. Konrath et al., (2014) conclude that the SINS exhibits reasonable convergent validity with both types of narcissism when time pressure do not allow for the use of longer scales. It is noted that with single-item scales it is not possible to undertake a reliability estimate.

Social Desirability - The Marlow Crowne Social Desirability Scale – Short Form 10, MCSDC-SF 10 (Straham and Gerbasi, 1972).

The 10-item Marlow Crowne Social Desirability Scale (MCSDS-SF-10) is derived from the longer original 33-item scale (Crowne & Marlow, 1960) the latter of which is regarded as the most reliable and valid measure of social desirability (Beretvas, Meyers & Leite, 2002).

Participants are asked to respond “true” or “false” to a list of 10 statements that have been designed to measure the extent to which participants like to portray themselves in a socially positive manner. Five of these items are phrased positively (e.g., “I never hesitate to go out of my way to help someone in trouble”) and require a “true” response, and five are phrased negatively (e.g. “I sometimes feel resentful when I don’t get my own way”) that require a “false” response if participants wish to portray

themselves in a socially desirable way. True items are scored one point with a possible range from 0 to 10, with higher scores reflecting greater tendencies toward social desirability.

Reviews (e.g. Fischer & Fick, 1993; Moss, 2008) highlight that a number of short forms of the original scale have been developed of which the MCSDS-SF-10 appears to offer the best combination of goodness of fit and reliability. For example, Fischer and Fick, (1993) found the MCSDS-SF-10 to yield a reliability coefficient of .79, which is comparable to the figure of .88 reported by Crowne and Marlow (1960). For the current study, the reliability estimate for the MCSDS-SF-10 was .62 which although lower was adequate for this study.

Potential mediating variables

Self-Compassion: - Self-Compassion Scale, SCS (Neff, 2003a).

The SCS (Neff 2003b) is a 26-item scale that measures the extent to which participants tend to be self-compassionate towards themselves during difficult periods. Neff (2003a, 2003b) identifies self-compassion as comprising three bipolar (positive and negative) constructs, that Neff (2018) later termed, Compassionate Self-Responding (CSR) and Uncompassionate Self-Responding (USR). Respectively, these include, Self-kindness vs. Self-judgment; Common Humanity vs. Isolation, and Mindfulness vs. Over-identified thinking. Thus the SCS yields six sub-scales, two summed scales (CSR and USR) the latter of which is reversed scored and when summed together with CSR yields a total score.

Examples of the positive items are: Self-kindness (5 Items - e.g., “When I’m going through a very hard time, I give myself the caring and tenderness I need”), Common Humanity (4 Items - “When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people”), and Mindfulness (4 Items - “When I fail at something important to me I try to keep things in perspective”). Whilst the three negatively scored sub-scales are: Self-judgment (5 Items - “When I fail at something important to me I become consumed by feelings of inadequacy”), Isolation (4 Items - “When I fail at something that’s important to me, I tend to feel alone in my failure”), and Over-identification (4 Items - “When I’m feeling down I tend to obsess

and fixate on everything that's wrong"). Participants respond to the questionnaire items indicating how often they behave in the stated manner using a 5-point Likert-type scale (1 = Almost Never to 5 = Almost Always). Total scores range from 26 to 130 with higher scores reflect higher levels of each sub-scale component.

The SCS consistently demonstrates high validity, and correlates positively with well-being measures and negatively with indices of psychopathology (Neff, 2003b; Neff, et al., 2018). In Neff's original publication (Neff, 2003a), the total SCS scores evidenced good internal reliability (.92), as did the six subscales (.75 - .81). Test-retest reliability over a three-week interval was also good for the total score (.93) and six subscale scores (.80 to .88). The internal reliability of SCS scores has been found to be high across a wide variety of cultures and populations (e.g., Neff & Pommier, 2013; Allen, et al., 2012; Werner, et al., 2012). Since the scale was published, numerous studies have provided evidence of construct validity, with higher SCS scores predicting a wide range of constructs associated with psychological health such as reduced anxiety, depression, shame, and guilt (see Neff, et al., 2017; Neff, et al., 2018, for reviews). In reviewing over a decade of research using the SCS, Neff (2015; 2016) pointed out that researchers have tended to utilise the composite total score, and encouraged future researchers to utilise the six sub-scales and the USR and CSR composite scores in subsequent research. These propositions guided the design of this study from its conception.

Subsequently, Neff, et al., (2017) undertook a psychometric study into the use of this bifactor (USR, CSR) model using clinical and non-clinical samples. Neff et al., found evidence supporting the use of the single-factor model across the samples, and the use of the bifactor scores with non-clinical samples but not clinical samples. More recently, Neff, et al., (2018) examined the factor structure of the SCS in 20 diverse samples ($n = 11,685$), the results of which supported use of the SCS total scale score or six subscale scores, but not two separate scores representing CSR and USR. However, Neff et al., 2018 acknowledge that there were limitations to this study, namely that the majority of the participants were female and were obtained from non-clinical (student) community settings. As this study was taking place within an evolving period of research on the SCS, and as the dimensionality of the SCS appears to be still in question, the decision was taken to examine the researcher's model using both the

bifactor (CSR, USR) scores and the single-factor SCS total score and to add to this growing body of research.

In this study, the overall internal reliability coefficient for the single-factor SCS total scale score was very high (.94). For the bifactor model, the CSR sub-scale Cronbach's alpha was .91, and the USR sub-scale was .92. The Cronbach alpha for the for the six sub-scales the alphas were: Self-kindness (.86), Common Humanity (.78), Mindfulness (.75), Self-judgment (.86), Isolation (.79) and Over-identification (.83).

Positive and Negative Affect – The Positive and Negative Affect Schedule, PANAS (Watson, et al., 1988).

The PANAS is a 20-item questionnaire that was designed to assess dispositions towards experiencing positive affect (PA) and negative affect (NA) and which has been used by CFT researchers to assess positive activating affect and negative (threat) affect (Gilbert et al., 2009). Ten of these items measure PA (e.g., interested, excited, strong, enthusiastic, proud, alert, inspired, determined, attentive and active), and a further 10 items measure NA (e.g., distressed, upset, guilty, scared, hostile, irritable, ashamed, nervous, jittery, and afraid). Participants respond to each item using a 5-point Likert-type scale: 1 = “very slightly or not at all”, 2 = “a little”, 3 = “moderately”, 4 = “quite a bit”, and 5 = “extremely.” Participants can respond to items in relation to a range of time-frames (e., past week, month), but in this study the time frame adopted was in ‘general.’ The score range is 10–50 with high scores being reflective of high levels of PA and NA.

A previous review of research by Crawford and Henry, (2004) utilising the PANAS has found the PA and NA sub-scales to be conceptually distinct and largely independent dimensions. Studies (e.g. Crocker, 1997; Laurent, et al., 1999; Crawford & Henry, 2004); have found the PANAS to be highly internally reliable, with reliability estimates for the PA and NA sub-scales to be in the excellent range (PA = .89 - .85; NA = .84 - .87). For the current study, the reliability estimates for PA and NA were also very high with reliability estimates of .92 and .90 respectively.

The Safe/Content Affect – The Safe-Content Affect sub-scale of the Two Types of Positive Affect Scale, TTPAS (Gilbert, et al., 2008).

The TTPAS is an 18-item questionnaire that measures the degree to which people experience types of positive affect and like the PANAS has also been used by researchers to examine Gilbert's (2009) tripartite model of affect regulation (e.g., Kelly et al., 2012; Gilbert et al., 2009). Participants are required to rate the extent to which it is characteristic that they experience 18 affect-linked words using a 5-point Likert-type scale: 0 = "not characteristic of me", to 4 = "very characteristic of me." The TTPAS produces three sub-scales: Active positive affect (8 items), Relaxed positive affect (6 items) and Safe-Content affect (6 items) the latter of which will be utilised in this research. Scores range between 0 and 24 with higher scores reflecting higher levels of safe and content affect.

Of the three factors, Gilbert, et al., (2008) found that safe/content affect had the highest negative correlations with the DASS sub-scales (depression = - 0.38; anxiety = - 0.29, and stress = - 0.33), self-criticism (self-hate = - 0.34; self-inadequate = -0.38), self-reassurance (0.56) and insecure (anxious) attachment (- 0.39). The scale authors reported good internal reliabilities: Active positive affect and Relaxed positive affect were both .83, and Safe-Content positive affect was .73. For the current study, the reliability estimate for Safe-Content positive affect sub-scale was very high (.91).

4.3.5 Analysis

Correlational analyses

Correlational analyses were performed on all the independent, dependent, and possible mediating and control variables to test the relationships between all the study variables. The researcher analysed all data using SPSS-25 (IBM, 2017) where the alpha cut-off value was set at .05.

Mediation analysis

Mediation analyses were then performed to examine and test the primary researchers model using the method described by Hayes (2018a) and the PROCESS

(3.0) macro (Hayes, 2018b). The rationale for this approach will now be outlined in the remainder of this section.

In their seminal paper, Baron and Kenny (1986) outline a procedure that to establish whether and how an independent variable (X) affects a dependent variable (Y) through the influence of one or more intervening or mediating variables (M). In order to test a mediation model, Baron and Kenny (1986) and Frazier, Barron, and Tix (2004) outline four causal steps shown in figure 4.3.

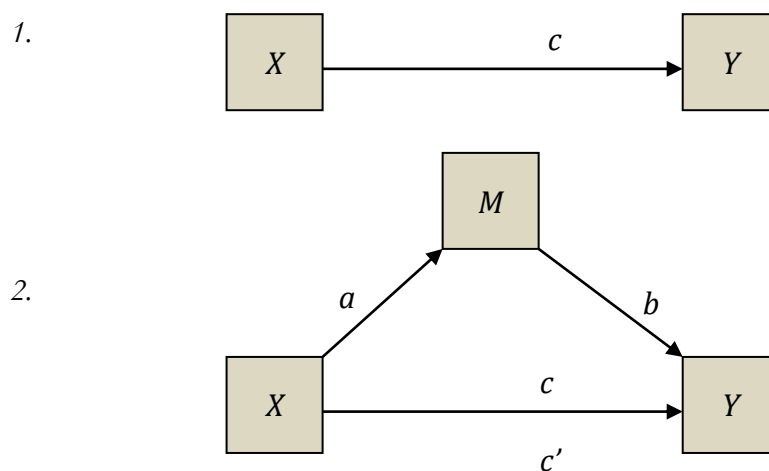


Figure 4.3. Path diagrams for (1) the total effect (c) of the independent variable (X) on the dependent variable (Y) and (2) the specific direct effect (c') of the independent variable on the dependent variable through the mediator variable (M). Adapted from Hayes (2018).

Step 1 involves establishing a significant predictive relationship (c') or *total effect* between an independent variable (X) and a dependent variable (Y) before accounting for any effect of the mediators.

Step 2 involves establishing a significant predictive relationship (a) between the independent variable (Y) and the mediating variable (M).

Step 3 involves establishing a significant predictive relationship (b) between the mediating variable (M) and the dependent variable (Y) after controlling for the effect of the independent variable (X).

Step 4 involves including the mediation variable (M) in the analysis and observing the *direct effect* upon changes in the relationship (c') between the independent variable (X) and the dependent variable (Y). The *specific indirect effect* is the amount of variance that is accounted for by a single mediator such as compassionate self-responding (a_1b_1), and the *total indirect effect* ($a_1b_1 + a_2b_2 + a_3b_3 + a_4b_4 + a_5b_5$), refers to the amount of variance accounted for in this study by the mediators; compassionate self-responding, positive affect, safe-content affect, negative affect and uncompassionate self-responding, respectively.

Baron and Kenny (1986) outline three types of mediation effect. *Full mediation* is said to have occurred if the total effect (c) is significant and the direct effect (c') is no longer significant. *Partial mediation* occurs when the total effect (c) is significant and the direct effect (c') is reduced but remains significant. An *indirect-only effect* is said to have occurred when a significant indirect effect occurs but neither the total effect (c) or direct effect (c') are significant.

Hayes (2018a) summarises the various subsequent criticisms that have been made of Baron and Kenny's seminal approach, and he is critical of the terms, 'full mediation' and 'partial mediation' and suggests that these terms should be abandoned. Space does not allow a full explanation of Hayes' criticisms and objections, but Hayes (2018a, p. 113-122), points out that saying that a variable completely mediates the effect of X and Y does not account for the possibility that other mediators may be confounding this relationship. Similarly stating that partial mediation has occurred implies that another unknown variable may be mediating this relationship or that the sample size was not big enough to detect the direct effect.

Hayes suggested that one way of examining the effects of potential confounding variables is to control for their *epiphenomenal effects*, and that not to do so presents a serious validity threat to any causal claims made. In mediational analysis, epiphenomenological associations can be ruled out by including a covariate (C) as a predictor that Hayes represents conceptually in Figure 4.4 overleaf.

Hayes has pointed out that controlling for C does not preclude the effects of some other variable, provided that other known confounding or covarying variables are measured. Hayes stresses that it is not possible to account for the effects of every

potential confounding variable, but this is not a problem provided the amount of variance contributed by the selected measures and variables is made explicit within the research. This was the approach that was taken in this study.

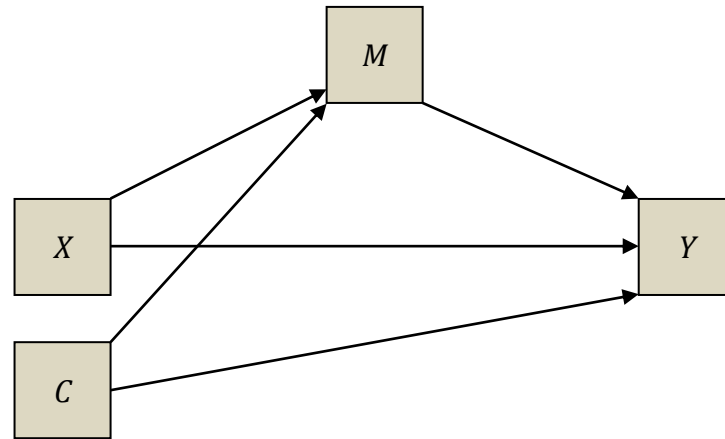


Figure 4.4. A conceptual diagram of a simple mediation model with statistical controls (taken from Hayes, 2018a, p. 123).

Following Baron and Kenny's (1986) seminal work, Hayes and colleagues developed a range of statistical procedures to take into account the developments in mediation research, the most recent of which is the PROCESS macro 3.0 (Hayes, 2013, 2018b) that is used with the SPSS software package. Unlike previous macros, PROCESS allows researchers to simultaneously estimate direct and indirect effects in a wide range of different single and multiple mediator models (parallel and serial) in one step (Hayes, 2012). This study utilised the PROCESS parallel mediation model (Model 4), involving three mediation analyses whereby trait self-forgiveness (X) and each of the three dependent variables, psychological distress (Y_1), shame (Y_2) and guilt (Y_3), were independently regressed simultaneously against the each of the five mediating variables.

Drawing upon reviews of mediation research by Rucker, Preacher, Tormala and Petty, (2011) and Preacher and Kelley (2011), Hayes (2018a) stresses the importance of effect sizes in meditational research, as effect sizes allow researchers establish the magnitude of effect of one variable upon another. PROCESS yields two key measures of effect size, the *Partially Standardized Effect* (ab) and the *Completely Standardised Effect* (ab_{cs}) that apply to the direct, indirect, and total effects of a meditational model. The partially standardized indirect effect (ab) is an expression of the effect relative to

the standard deviation of Y, whereas the completely standardized effect (ab_{cs}) is the expression of ab using the standard deviations of both X and Y. Hayes stresses the value of reporting both effects, but suggests that completely standardised indirect effects (ab_{cs}) are perhaps the most useful as they allow researchers to better describe their results. For example, it is possible to say that one standard deviation of X (e.g., trait self-forgiveness) produced an increase of Y (e.g., psychological distress).

Barron and Kenny (1986) recommended using Sobel's z -test (Sobel, 1982) to establish the level of significance of an indirect effect. PROCESS uses bootstrap resampling procedure to generate non-parametric confidence intervals (CIs), especially with small samples, as it is the least vulnerable to Type-1 errors (Preacher and Hayes, 2008). Hayes (2013) recommended using bootstrapping for two reasons. Firstly, bootstrapping does not impose the assumption of normality upon the data set, and secondly, bootstrapping has a higher power than Sobel's z -test (Hayes, 2009). In accordance with Hayes (2013, 2018a), 10,000 bootstrap re-samples were used to estimate bias corrected CIs, and a HC3 correction for heteroscedasticity was performed with all analyses (Hayes & Cai, 2007).

Drawing upon the work of Ma and Zeng (2014), and Fritz and Mackinnon, (2007), Hayes (2018a) highlighted the importance of sample size and statistical power and points out that there is no agreed way establishing the sample size needed to detect an effect. Therefore, given that the primary focus of this thesis was to; a) explore the effects of hypothesized variables have upon the proposed model, b) that it was uncertain which variables were predictive, and c), the small sample size used in this study, the research results were interpreted conservatively in relation to the obtained effect sizes.

4.4 Results

The study data will be presented in four stages;

- Data screening and preliminary analyses;
- Descriptive statistics and characteristics of the sample
- Correlations
- Mediation results.

4.4.1 Data screening and preliminary analyses.

The data set was initially subjected to preliminary examination for data entry errors, missing values and the statistical assumptions associated with regression and mediation assumptions (Field, 2018; Hayes, 2018a).

The data set comprised of 141 sets of participant questionnaires for analysis. The sample was examined for missing data and eight cases of missing data from the Single-Item Narcissism Scale were found. This data was subjected to imputation through calculating the median score for this variable. Frequency distributions, including means, standard deviations, ranges, skewness, kurtosis, (Table 4.3 overpage) were undertaken to check for normality of distribution.

Table 4.3. Illustrating the means, standard deviations, ranges, skewness and kurtosis figures of Age, Class, Religiosity/Spirituality (DUREL-IR), HFS, SSFS, SCS, PANAS, TTPAS, SSGS, SINS, SDS, BFI, and the DASS-21 for the combined (clinical/non-clinical) groups ($n = 141$).

Scale	<i>M (SD)</i>	<i>Range</i>	<i>Skewness (SE)</i>		<i>Kurtosis (SE)</i>	
Age (years)	33.7 (12.9)	18-63	.58	(.20) [†]	-1.09	(.40) [†]
Socio-Economic Status	2.72 (1.50)	1-6	1.06	(.20) [†]	-.16	(.40)
DUREL-IR	7.68 (3.95)	3-15	.28	(.20)	-1.33	(.40) [†]
HFS-S	24.17 (8.41)	6-42	.14	(.20)	-.75	(.41)
SSFS-SFFA ¹	19.23 (6.65)	8-32	.08	(.22)	-1.24	(.43) [†]
SSFS-SFB ¹	26.44 (7.34)	9-36	-.55	(.22) [†]	-.71	(.43)
SCS-Self-Compassion _{Total}	35.03 (10.80)	13-63	.18	(.20)	-.63	(.41)
SCS-Self-Kindness	12.38 (4.72)	5-24	.27	(.20)	-.87	(.41) [†]
SCS-Common Humanity	11.31 (3.97)	4-20	.25	(.20)	-.77	(.41)
SCS-Mindfulness	11.39 (3.47)	4-20	.09	(.20)	-.07	(.41)
SCS-Self-Uncompassion _{Total}	46.07 (11.49)	13-65	-.55	(.20) [†]	-.36	(.41)
SCS-Self-Judgment.	17.87 (4.97)	5-25	-.52	(.20) [†]	-.56	(.41)
SCS-Isolation.	13.91 (3.98)	4-20	-.43	(.20) [†]	-.68	(.41)
SCS-Overidentification	14.25 (3.92)	4-20	-.48	(.20) [†]	-.50	(.41)
SCS-Total	67.05 (20.28)	30-123	.43	(.20)	-.41	(.41)
PANAS-Positive Affect	28.08 (8.85)	10-46	.05	(.20)	-.98	(.41) [†]
PANAS-Negative Affect	27.77 (9.57)	10-48	.17	(.20)	-.98	(.41) [†]
TTPAS-Safe-Content Affect	11.67 (4.56)	4-20	.12	(.20)	-.97	(.41) [†]
SSGS-Shame	13.94 (6.02)	5-25	.07	(.20)	-1.13	(.41) [†]
SSGS-Guilt	15.75 (5.55)	5-25	.22	(.20)	-.72	(.41)
SINS	2.14 (1.34)	1-7	1.45	(.21) [†]	1.66	(.42) [†]
SDS	5.52 (2.04)	0-10	.08	(.20)	-.06	(.41)
BFI-Agreeableness	34.70 (5.80)	19-45	-.64	(.20) [†]	.08	(.41)
BFI-Neuroticism	27.73 (6.74)	8-40	-.25	(.20)	-.37	(.41)
DASS21 _{total}	27.13 (15.13)	1-59	.28	(.20)	-.88	(.41) [†]

Note. M, Mean; SD, Standard Deviation; HFS-S, Heartland Forgiveness Scale-Self-forgiveness sub-scale, SSFS-SFFA, State Self-forgiveness Scale – Self-forgiving Feelings and Actions; SSFS-SFB, State Self-forgiveness Scale – Self-forgiving Beliefs; SCS, Self-Compassion Sub-Scale, PANAS-PA, Positive And Negative Affect Scale; TTPAS, Two-Types of Positive Affect Scale; SSGS, State Shame and Guilt Scale; SINS, Single Item Narcissism Scale; SDS, Social Desirability Scale; BFI, Big Five Inventory; DUREL-IR, Duke University - Intrinsic Religion Index; DASS21_{total}, Depression, Anxiety, Stress Scale (21-item).

NB: [†] = skewness and kurtosis statistic was twice the standard error.

¹ $n = 124$

To identify whether variables are normally distributed, Trochim and Donnelly (2006), Field (2000; 2009) and Gravetter and Wallnau (2014) suggest that researchers can assume normality if the skewness and kurtosis is within twice the standard error of the skewness and kurtosis statistic values. Using this guideline the majority of variables distributions were normally distributed. The variables, age, state self-forgiveness beliefs (SSFA), self-uncompassion total (SCS-uncompassion_{total}), the three uncompassionate sub-scales (self-judgment, isolation and over-identification), the BFI-Agreeableness sub-scale, and the DASS-21 anxiety sub-scale just exceeded the cut off for non-normality. However, after examining the Q-Q plots (see Appendix A. figures A1 – A13, pp. 362-368), the quartiles were found to fall very close to the diagonal line, and given the size of the sample it was felt that these variable distributions did not violate the assumption of normality. Only the variables socio-economic status (SES) and the SINS narcissism scale greatly exceeded cut off for skewness both yielding a very positive skew, and as a result the SES and SINS variable data was subjected to a log transformation ($\log(X_1)$) (see Table 4.3, p. 124).

The data were examined for outliers, and tests of linearity, homoscedasticity and normality of estimation error were undertaken between the variables. In regression analyses the relationship between X and Y should be linear to minimise error. This was done through plotting the residuals against the predicted values using scatterplots from four regressions: X predicting Y, X predicting M, M predicting Y, and X and M predicting Y (Hayes & Preacher, 2010) the results of which appeared random (see Appendix A, figures A14 – A17, pp. 369-370). In homoscedasticity the estimation error should be reasonably equal across all predicted Y values, if this varies then heteroscedasticity is said to have occurred which influences the standard error of the regression coefficients. Homoscedasticity was checked through examining the linearity plots to assess if the spread of the data was consistent in a vertical range across the Y-axis. Results of showed a relatively consistent vertical range. Normality of estimation was examined through creating Q-Q plots from the regression residuals (see Appendix A, figures A18 - A21, pp. 371-372), the results of which fitted well along the diagonal line with relatively minor deviations. In line with the recommendations of Hayes (2018a), a HC3 correction for heteroscedasticity was performed with all analyses (Hayes & Cai, 2007). At the end of this process the data were found to be suitable for tests of regression and mediation.

4.4.2 Descriptive statistics and characteristics of the sample.

The final sample that formed the study analysis included 141 participants, 78 of who were obtained from a clinical setting, and 63 from a non-clinical (student) setting (see CONSORT flowchart Table 4.2, p. 108). The mean age of the combined group was 33.5 years ($SD = 12.92$), 73% of who were female, 27% of who were male. In order to determine if the sample was representative of the Auckland area, the sample was compared to the NZ census data (Statistics NZ, 2013).

With regard to relational status, the sample was found to be over-represented in terms of being single (36.3% vs. 44.0% - sample), and under-represented with being married (48.8% vs. 20.6% - sample), and divorced (24.6% vs. 12.8% - sample).

In relation to ethnicity people of NZ/European descent were over-represented within the sample (52.3% of the Auckland population vs. 66.6% of the sample), as were people who identified as of Other descent (1.1% vs. 9.2% - sample). In contrast, Maori (10.7% vs. 8.5% - sample), Pacific Peoples (14.61% vs. 2.8% - sample), and people who identified as Asian (23.1% vs. 10.6% - sample) were under-represented in the sample. People of Middle Eastern / Latin American / African descent were equally represented (1.9% vs. 2.1% - sample).

In relation to occupation, comparisons with the data suggests that the combined sample was over-represented in terms of Professionals (27.0% vs. 41.0% - sample), Sales Workers (9.1% vs. 15.8% - sample), Community and Personal Service Workers (7.9% vs. 10.1% - sample) and Labourers (6.6% vs. 9.2% - sample), and under-represented in terms of Managers (19.7% vs. 4.3% - sample), Technicians and Trades Workers (11.4% vs. 10.1% - sample), Clerical and Administrative Workers (13.3% vs. 10.1% - sample), and Machinery Operators and Drivers (5.0% vs. 1.4% - sample).

In terms of religious affiliation, 63.6% of participants in the combined sample either identified as having no religion or being atheistic or agnostic, 31.4% identified as Christians, with the remaining 5.0% identifying other denominations such as Buddhist, Jewish, Muslim, Sikh, Hindu Muslim. In relation to religious affiliation, comparisons with the Auckland 2013 Census data (Statistics NZ, 2013) suggests that the combined sample was over-represented in terms of participants who did not identify with a

religion or who were atheistic or agnostic (37.8% vs. 63.6% - sample), but was under-represented in terms of Christian affiliation (47.6% vs. 31.4% - sample), and Hindu (4.75 vs. 1.4% - sample).

Gender differences

Due to the very unequal number of males and females in the study and the possibility of violating the homogeneity assumption (Field, 2018), a series of non-parametric tests were undertaken with the combined sample to identify gender and cultural differences across the variables. Overall, there were few significant differences on any of the variables, but females tended to report higher levels of trait self-forgiveness ($U = 1504.00, p = .03$), state self-forgiving beliefs ($U = 1001.50, p = 0.026$) and self-kindness ($U = 1491.50, p = .03$), and lower levels of self-judgment ($U = 1525.50, p = .02$), and isolation ($U = 1525.50, p = .04$) than males. The full findings can be found in Appendix A (Table A1, p. 342)

Cultural differences

In terms of cultural differences, participants from non-collectivistic cultures were older ($U = 712.50, p = <.001$), and reported higher levels of negative affect ($U = 887.500, p = <.001$), psychological distress ($U = 1046.00, p = .02$) and lower levels of safe / warm affect ($U = 856.50, p = <.001$) than participants from collectivistic cultures (see Appendix A, Table A2. P. 343).

Clinical / Non-clinical differences

As a check for reliability and validity of the measures, it was expected that participants from the clinical sample would report significant differences across the measures in comparison the participants from the non-clinical sample. As in the case of gender, and culture, the differences in size of the clinical and non-clinical samples meant that non-parametric Mann-Whitney analyses was performed. The results of these analyses indicated that participants in the clinical sample reported significantly lower levels of self-forgiveness, self-compassion, positive and safe / warm affect, and higher levels of self-uncompassion, negative affect, neuroticism, shame, guilt and psychological distress (see Table 4.4 overpage). Participants in the clinical sample also

reported lower levels of agreeableness, and higher levels of narcissism and social desirability but these differences were not significant at the .05 level.

Table 4.4. The results of a Mann Whitney test upon the independent, dependent, mediating and control variables across clinical and non-clinical groupings.

			Clinical <i>n</i> = 78	Non-clinical <i>n</i> = 63
Variable	<i>U</i>	<i>p</i>	Mean (SD)	Mean (SD)
HFS - Trait Self-forgiveness	538.50	<.001	21.68 (7.52)	25.09 (8.56)
SSFS - Self-Forgiving Feelings Actions ¹	493.00	<.001	14.89 (5.18)	23.49 (5.07)
SSFS - Self-Forgiving Beliefs ¹	464.00	<.001	21.39 (6.68)	31.14 (3.99)
SCS - Self-compassion _{Total}	581.50	<.001	28.77 (8.06)	42.79 (8.50)
SCS - Self-kindness	644.00	<.001	9.65 (3.31)	15.76 (3.96)
SCS - Common humanity	898.50	<.001	9.37 (3.16)	13.73 (3.54)
SCS - Mindfulness	984.00	<.001	9.78 (2.89)	13.38 (3.10)
SCS - Self-uncompassion _{Total}	675.50	<.001	52.51 (7.51)	38.10 (10.55)
SCS - Self-judgment	662.00	<.001	20.64 (3.50)	14.44 (4.35)
SCS - Isolation	852.00	<.001	15.96 (2.76)	11.37 (3.80)
SCS - Overinvolved thinking	1181.00	<.001	15.87 (3.05)	12.24 (3.98)
SCS – Total score	443.50	<.001	62.13 (16.62)	68.86 (21.26)
PANAS - Negative affect	790.50	<.001	32.69 (8.62)	21.68 (6.82)
PANAS - Positive affect	751.50	<.001	23.42 (7.59)	33.84 (6.68)
TTPAS - Safe/content affect	421.50	<.001	8.78 (3.26)	15.24 (3.22)
BFI - Agreeableness	2059.50	.01	33.77 (6.33)	35.86 (4.84)
BFI - Neuroticism	922.50	<.001	30.94 (5.52)	23.65 (5.94)
SINS - Narcissism	2269.50	.41	2.14 (1.50)	2.09 (1.08)
SDS - Social desirability	2047.50	.08	5.77 (2.00)	5.22 (2.08)
SSGS - Shame	488.50	<.001	17.65 (4.43)	9.30 (4.21)
SSGS - Guilt	813.00	<.001	18.63 (3.94)	12.14 (5.07)
DASS 21 _{total}	587.00	<.001	35.73 (12.28)	16.18 (10.72)

Note. SD, Standard Deviation; HFS-S, Heartland Forgiveness Scale-Self-forgiveness sub-scale, SSFS-SFFA, State Self-forgiveness Scale – Self-forgiving Feelings and Actions; SSFS-SFB, State Self-forgiveness Scale – Self-forgiving Beliefs; SCS, Self-Compassion Sub-Scale, PANAS-PA, Positive And Negative Affect Scale; TTPAS, Two-Types of Positive Affect Scale; SSGS, State Shame and Guilt Scale; SINS, Single Item Narcissism Scale; SDS, Social Desirability Scale; BFI, Big Five Inventory; DASS21_{total}, Depression, Anxiety, Stress Scale (21-item).

¹ *n* = 124

4.4.3 Correlational results.

Given the importance of identifying associations between the control variables and the independent and dependent variables, the correlations between the socio-demographic variables and the personality variables were examined followed by a broader analysis between trait self-forgiveness and the mediating and dependent variables.

Socio-demographic variables

Correlational analyses (Pearson, Point Biserial, and Spearman) were performed between the socio-demographic variables and the independent, dependent, possible mediating variables and the psychological health variables (see table 4.5 overpage).

Age and SES were weakly correlated (ave. +/- .25) with the majority of the variables tested, and in comparison to age the associations with SES were fewer. Age and SES were both negatively correlated with the self-forgiveness variables, the self-compassion variables and positive and safe / warm affect, and positively associated with the self-uncompassion sub-scale scores, negative affect, neuroticism, shame, and psychological distress. Unlike age, SES was negatively associated with agreeableness and was not significantly associated with guilt. Gender (being female) was positively associated with self-kindness and safe / warm affect, and was negatively associated with self-judgment and isolation.

Coming from a collectivistic culture was negatively associated with state self-forgiving beliefs, safe / warm affect and positive affect, and positively associated with negative affect, shame and psychological distress. Religiosity (Intrinsic Religiosity) was only positively associated with agreeableness and social desirability. Importantly, these results suggest that age and SES were the socio-economic variables that were most likely to have the most confounding effect on the analysis.

Table 4.5. Pearson correlations between the Socio-Demographic Variables and the Independent Variables, Mediating variables, Control variables, and Dependent Variables (n = 141).

	Age ¹	Gender ^{a2}	SES ^{b3}	Culture ^{c2}	Religiosity ¹
HFS - Self-forgiveness	-.28**	.18	-.28**	-.15	-.01
SSFS - Self-Forgiving Feelings Actions [†]	-.24**	.15	-.28**	-.16	.12
SSFS - Self-Forgiving Beliefs [†]	-.27**	.17	-.47***	-.18*	.03
SCS - Self-compassion _{Total}	-.24**	.13	-.17*	-.07	.11
SCS - Self-kindness	-.25**	.19*	-.19*	-.10	.07
SCS - Common humanity	-.17*	.13	-.09	-.02	.16
SCS - Mindfulness	-.22**	.01	-.17*	-.06	.08
SCS - Self-uncompassion _{Total}	.23**	-.14	.20*	-.13	-.04
SCS - Self-judgment	.26**	-.20*	-.17*	.16	-.01
SCS - Isolation	.24**	-.17*	.15	.06	-.05
SCS - Overinvolved thinking	.12	.02	.20*	.13	-.06
SCS – Total score	-.26**	-.19*	-.21*	-.11	.08
PANAS - Negative affect	.27**	-.06	.21*	.28**	.06
PANAS - Positive affect	-.24**	.11	-.28**	-.10	.04
TTPAS - Safe/content affect	-.37***	.24**	-.31**	-.29**	.01
BFI - Agreeableness	.01	.03	-.18*	-.14	.19*
BFI - Neuroticism	.25**	-.02	.19*	.13	-.05
SINS - Narcissism	-.14	.01	-.05	-.09	-.14
SDS - Social desirability	.13	.09	.01	-.11	.18*
SSGS - Shame	.30***	-.16	.20*	.17*	.01
SSGS - Guilt	.28**	-.07	.13	-.89	-.06
DASS - Depression	.38***	-.24**	.27**	.18*	.07
DASS - Anxiety	.21*	-.01	.27**	.17*	.15
DASS - Stress	.22**	-.08	.11	.19*	.09
DASS 21 _{total}	.33***	-.13	.27**	.21*	.11

Note. SD, Standard Deviation; HFS-S, Heartland Forgiveness Scale-Self-forgiveness sub-scale, SSFS-SFFA, State Self-forgiveness Scale – Self-forgiving Feelings and Actions; SSFS-SFB, State Self-forgiveness Scale – Self-forgiving Beliefs; SCS, Self-Compassion Sub-Scale, PANAS-PA, Positive And Negative Affect Scale; TTPAS, Two-Types of Positive Affect Scale; SSGS, State Shame and Guilt Scale; SINS, Single Item Narcissism Scale; SDS, Social Desirability Scale; BFI, Big Five Inventory; DASS21_{total}, Depression, Anxiety, Stress Scale (21-item).

^a Gender = male (1) and female (2); ^b SES = 1-8 - managerial (1) - (8) labourer (6); ^c Culture = collectivist culture (1) and non-collectivist culture (2); ^d N = 124; ¹ Pearson correlations; ² Point Biserial correlations;

³ Spearman correlations; [†] n = 124

* $p. < .05$, ** $p. < .01$, *** $p. < .001$

Personality variables

In order to establish which personality variables were associated with the independent, dependent and mediating variables, Pearson correlations were performed (table 4.6 overpage).

The results of this analysis found that agreeableness and neuroticism were associated with the all of independent, mediating and dependent variables, whereas narcissism and social desirability were unrelated. Neuroticism yielded the strongest associations (ave. +/- .61) in comparison to agreeableness (ave. +/- .28), with increasing neuroticism being moderately associated with decreasing levels of self-forgiveness, self-compassion, and positive and safe / content affect, and increasing self-uncompassion, negative affect, shame, guilt, and psychological distress. Agreeableness was associated with increasing self-forgiveness, self-compassion, positive and safe / warm affect, and negatively associated with self-uncompassion, negative affect, shame, guilt and psychological distress. This suggested that neuroticism and agreeableness were likely to be the most influential confounding variables.

A full correlation matrix of the independent, dependent and mediating variables can be found in table 4.7 (p. 133-134) the results of which will only be summarized here. Briefly trait self-forgiveness was found to be correlated with uncompassionate self-responding ($r = -.68, p < .001$), compassionate self-responding ($r = .70, p < .001$) and the SCS – Total scale score ($r = .76, p < .001$). Trait self-forgiveness was also correlated state self-forgiveness (ave $r = .75, p < .001$), guilt ($r = -.60, p < .001$), shame ($r = -.71, p < .001$), psychological distress (DASS-42: total $r = -.62, p < .001$), negative affect ($r = -.58, p < .001$), positive affect ($r = .58, p < .001$), safe / content affect ($r = .68, p < .001$).

Table 4.6. Pearson correlations for the Moderating personality variables with the Independent Variables, Mediating variables, and Dependent Variables ($n = 141$).

	Agreeableness	Neuroticism	Narcissism	Social Desirability
HFS – Self-forgiveness	.21*	-.56***	-.05	-.08
SSFS – Self-Forgiving Feelings and Actions ^a	.25**	-.62***	-.11	-.02
SSFS – Self-Forgiving Beliefs ^a	.31**	-.61***	-.16	-.001
SCS - Self-compassion _{Total}	.25**	-.64***	-.07	.02
SCS - Self-kindness	.26**	-.60***	-.05	.01
SCS – Common Humanity	.18*	-.51***	-.05	-.01
SCS - Mindfulness	.22**	-.60***	-.07	.04
SCS – Self-uncompassion _{Total}	-.30**	.71***	.04	-.04
SCS – Self-judgment	-.27**	.61***	-.01	.01
SCS – Isolation	-.26**	.63***	.04	-.03
SCS – Overinvolved thinking	-.28**	.65***	.08	-.07
SCS – Total score	-.30***	-.74***	-.06	.03
PANAS - Negative affect	-.36***	.63***	.06	-.20*
PANAS - Positive affect	.33***	-.58***	.03	-.01
TTPAS - Safe/content affect	.45***	-.70***	-.07	.06
SSGS – Shame	-.30***	.60***	.07	-.01
SSGS – Guilt	-.24**	.54***	.16	-.11
DASS – Depression	-.24**	.59***	.01	-.07
DASS – Anxiety	-.23**	.53***	-.04	.14
DASS – Stress	-.33***	.58***	.08	.09
DASS 21 _{total}	-.31***	.65***	.02	.11

^a $n = 124$.

* $p. = < .05$, ** $p. = < .01$, *** $p. = < .001$

So in summary, the results of the correlational analysis indicated that the socio-demographic variables age and SES, and the personality variables agreeableness and especially neuroticism were important variables to control for when undertaking the meditational analyses the results of which will now follow.

Table 4.7. Pearson bivariate correlations between all the independent, dependent, mediating and control variables ($n = 141$)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1. HFS-SF																		
2. SFFS-FA [†]	.77***																	
3. SFFS-FB [†]	.73***	.78***																
4. SCS-CSR	.70***	.75***	.67***															
5. SCS-SK	.70***	.72***	.70***	.91***														
6. SCS-CH	.59***	.65***	.52***	.89***	.70***													
7. SCS-M	.57**	.59***	.51***	.87***	.69***	.68***												
8. SCS-USR	-.68***	-.72***	-.67***	-.67***	-.67***	-.56***	-.52***											
9. SCS-SJ	-.70***	-.70***	-.68***	-.72***	-.72***	-.52***	-.47***	.91***										
10. SCS-I	-.58***	-.64***	-.55***	-.57***	-.57***	-.52***	-.41***	.89***	.72***									
11. SCS-O	-.53***	-.57***	-.54***	-.54***	-.48***	-.46***	-.51***	.86***	.67***	.67***								
12. SCS-TOTAL	.76***	.81***	.73***	-.91***	.86***	.79***	.76***	-.92***	-.86***	-.81***	-.77***							
13. SSGS-G	-.60***	-.69***	-.64***	-.50***	-.48***	-.44***	-.40***	.61***	.57***	.56***	.51***	-.61***						
14. SSGS-S	-.71***	-.80***	-.77***	-.68***	-.68***	-.58***	-.55***	.67***	.67***	.65***	.57***	-.76***	.77***					
15. PANAS-NA	-.58***	-.55***	-.66***	-.53***	-.53***	-.39***	-.48***	.59***	.55***	.51***	.50***	-.62***	.65***	.72***				
16. PANAS-PA	.58**	.61***	.58***	.64***	.64***	.51***	.52***	-.57***	-.51***	-.58***	-.44***	.66***	-.41***	-.62***	-.52***			
17. TTPAS-SC	.68**	.68***	.75***	.69***	.72***	.53***	.56***	-.68***	-.64***	-.61***	-.54***	.75***	-.55***	-.74***	-.69***	.75***		
18. BFI-N	-.56***	-.62***	-.61***	-.64***	-.60***	-.51***	-.60***	.71***	.61***	.63***	.65***	-.74***	.54***	.60***	.63***	-.58***	-.70***	
19. BFI-A	.21*	.25**	.31**	.25**	.26**	.18*	.22**	-.30**	-.27**	-.26**	-.28**	.30***	-.24**	-.30***	-.36***	.33***	.45***	-.40***
20. SINS	-.09	-.15	-.21*	-.13	-.10	-.08	-.14	.10	-.05	.08	.13	-.07	.18*	.10	.11	-.02	-.11	.20*
21. SDS	-.08	-.02	-.01	.02	.01	-.01	.04	-.04	.01	-.03	-.07	.03	-.11	-.01	-.20*	-.01	.06	-.19*
22. DUREL-IR	-.01	.12	.03	.11	.07	.16	.08	-.04	-.01	-.05	-.06	.08	-.06	.01	.06	.04	.01	-.05
23. DASS-D	-.67***	-.62***	-.65***	-.58***	-.59***	-.46***	-.49***	-.65***	.59***	.67***	.47***	-.68***	.51***	.64***	.59***	-.70***	-.69***	.59***
24. DASS-A	-.47***	-.51***	-.58***	-.37***	-.41***	-.23***	-.34***	.59***	.52***	.55***	.52***	-.53***	.44***	.55***	.60***	-.41***	-.54***	.53***
25. DASS-S	-.46***	-.49***	-.47***	-.43***	-.48***	-.32***	-.34***	.57***	.54***	.48***	.49***	-.55**	.42***	.50***	.57***	-.33***	-.53***	.58***
26. DASS-Total	-.62***	-.63***	-.67***	-.54***	-.57***	-.39***	-.46***	.69***	.64***	.65***	.56***	-.68***	.53***	.65***	.68***	-.57***	-.68***	.65***

Abbreviations: HFS-SF, Heartland Forgiveness Scale- Self-forgiveness sub-scale; SFFS, State Self-Forgiveness Scales – Feelings and Actions; SFFS-SB, Self-forgiving Beliefs; SCS-CSR, Self-Compassion Scale-Compassionate Self-Responding; SCS-SK, Self-Kindness; SCS-CH, Common Humanity; SCS-M, Mindfulness; SCS-USR, Uncompassionate Self-Responding; SCS-SJ, Self-Judgment; SCS-I, Isolation, SCS-O, Overinvolved thinking, SCS-Total, Self-compassion Scale Total Score; SSGS-G, State Shame and Guilt Scale-Guilt; SSGS-S, Shame; PANAS-NA, Positive And Negative Affect Scale-Negative Affect; PANAS-PA, Positive Affect; TTPAS-SC, Two Types of Positive Affect Scale-Safe/Content Scale; BFI-N, Big Five Inventory-Neuroticism; BFI-A, Big Five Inventory-Agreeableness; SINS, Single Item Narcissism Scale; SDS, Social Desirability Scale; Durel-IR, Duke University Religion Index- Intrinsic Religiosity; DASS-D Depression Anxiety Stress Scale – Depression; DASS-A, Anxiety; DASS-S, Stress; DASS-Total, Total score. [†] $n = 124$; $p. = < .05$, ** $p. = < .01$, *** $p. = < .001$

Table 4.7. Pearson bivariate correlations between all the independent, dependent, mediating and control variables ($n = 141$)

	19	20	21	22	23	24	25	26
1. HFS-SF								
2. SFFS-FA [†]								
3. SFFS-SFB [†]								
4. SCS-CSR								
5. SCS-SK								
6. SCS-CH								
7. SCS-M								
8. SCS-USR								
9. SCS-SJ								
10. SCS-I								
11. SCS-O								
12. SCS- TOTAL								
13. SSGS-G								
14. SSGS-S								
15. PANAS-NA								
16. PANAS-PA								
17. TTPAS-SW								
18. BFI-N								
19. BFI-A								
20. NAR	-.35***							
21. SDS	.52***	-.33***						
22. DUREL-IR	-.13	-.15	.18*					
23. DASS-D	-.24**	.03	-.07	.07				
24. DASS-A	-.23**	-.02	.14	.15	.66***			
25. DASS-S	-.33***	-.21*	.09	.09	.58***	.72***		
26. DASS-Total	-.31***	-.07	.11	.11	.87***	.89***	.85***	

Abbreviations: HFS-SF, Heartland Forgiveness Scale- Self-forgiveness sub-scale; SFFS, State Self-Forgiveness Scales – Feelings and Actions; SSFS-SB, Self-forgiving Beliefs; SCS-CSR, Self-Compassion Scale-Compassionate Self-Responding; SCS-SK, Self-Kindness; SCS-CH, Common Humanity; SCS-M, Mindfulness; SCS-USR, Uncompassionate Self-Responding; SCS-SJ, Self-Judgment; SCS-I, Isolation, SCS-O, Overinvolved thinking, SCS-Total, Self-compassion Scale Total Score; SSGS-G, State Shame and Guilt Scale-Guilt; SSGS-S, Shame; PANAS-NA, Positive And Negative Affect Scale-Negative Affect; PANAS-PA, Positive Affect; TTPAS-SC, Two Types of Positive Affect Scale-Safe/Content Scale; BFI-N, Big Five Inventory-Neuroticism; BFI-A, Big Five Inventory-Agreeableness; SINS, Single Item Narcissism Scale; SDS, Social Desirability Scale; Durel-IR, Duke University Religion Index- Intrinsic Religiosity; DASS-D Depression Anxiety Stress Scale – Depression; DASS-A, Anxiety; DASS-S, Stress; DASS-Total, Total score. [†] $n = 124$; * $p. = < .05$, ** $p. = < .01$, *** $p. = < .001$

4.4.4 Mediation results.

In order to examine the mediating effect of CSR and USR upon the self-forgiveness and psychological health variables (psychological distress, shame and guilt), and having established that age, SES, agreeableness and neuroticism were the key socio-demographic and personality variables that were likely to have a confounding effect upon the analysis, a series of three hypotheses were proposed.

It was predicted that trait self-forgiveness would predict reductions in psychological distress, shame and guilt, and that these predicted relationships would be mediated by the combined effects of the bifactor model (CSR, USR), negative affect, positive affect and safe / content affect. It was also proposed to repeat the analysis using the single factor, SCS total scale.

In order to test these hypotheses, a series of six parallel mediation analyses were undertaken using the PROCESS (3.0) macro with Model 4 (Hayes, 2018b). PROCESS also allows researchers to test for parallel mediators as covariates, and the identified correlated socio-demographic and personality variables (age, SES, agreeableness and neuroticism) were controlled for within the mediation analyses using this function. It is noted that simple single-mediator models could have been undertaken, but this would have confounded the estimates of the indirect effects for each mediator not included in the model. Undertaking a multiple mediation model facilitates the comparison of the indirect effects of each mediator, allowing for studies to be replicated (Montoya & Hayes, 2017).

Hypothesis 1

The first hypothesis stated that after controlling for those demographic and personality variables that correlated with trait self-forgiveness and psychological distress, it was predicted that the relationship between trait self-forgiveness would predict reductions in psychological distress, and that this relationship would be mediated by the combined effects of CSR, USR, negative affect, positive affect and safe / content affect.

Results from the parallel mediation analysis indicated that the model accounted for 55.0.% of variance between trait self-forgiveness and psychological distress ($R^2 = .55$, $F(5, 135) = 29.59$, $p = <.00001$) when controlled for age, SES, neuroticism and agreeableness. Of these covariates neuroticism, $\beta = 1.78$, 95% CI [1.09, 2.48], $t = 5.06$, $p = <.00001$, and age $\beta = .33$, 95% CI [0.03, 0.63], $t = 2.19$, $p = .03$, had significant effects upon the model.

Trait self-forgiveness significantly predicted a decrease in psychological distress, $\beta = -1.18$, 95% CI [-1.76, -.59], $t = -3.98$, $p = <.001$. When the direct effects compassionate self-responding, uncompassionate self-responding, negative affect, positive affect and safe / content affect were added to the model, the relationship between trait self-forgiveness and psychological distress became non-significant $\beta = -.47$, 95% CI [-1.26, .32], $t = -1.26$, $p = .24$, indicating that mediation had occurred (figure 4.5 overleaf)

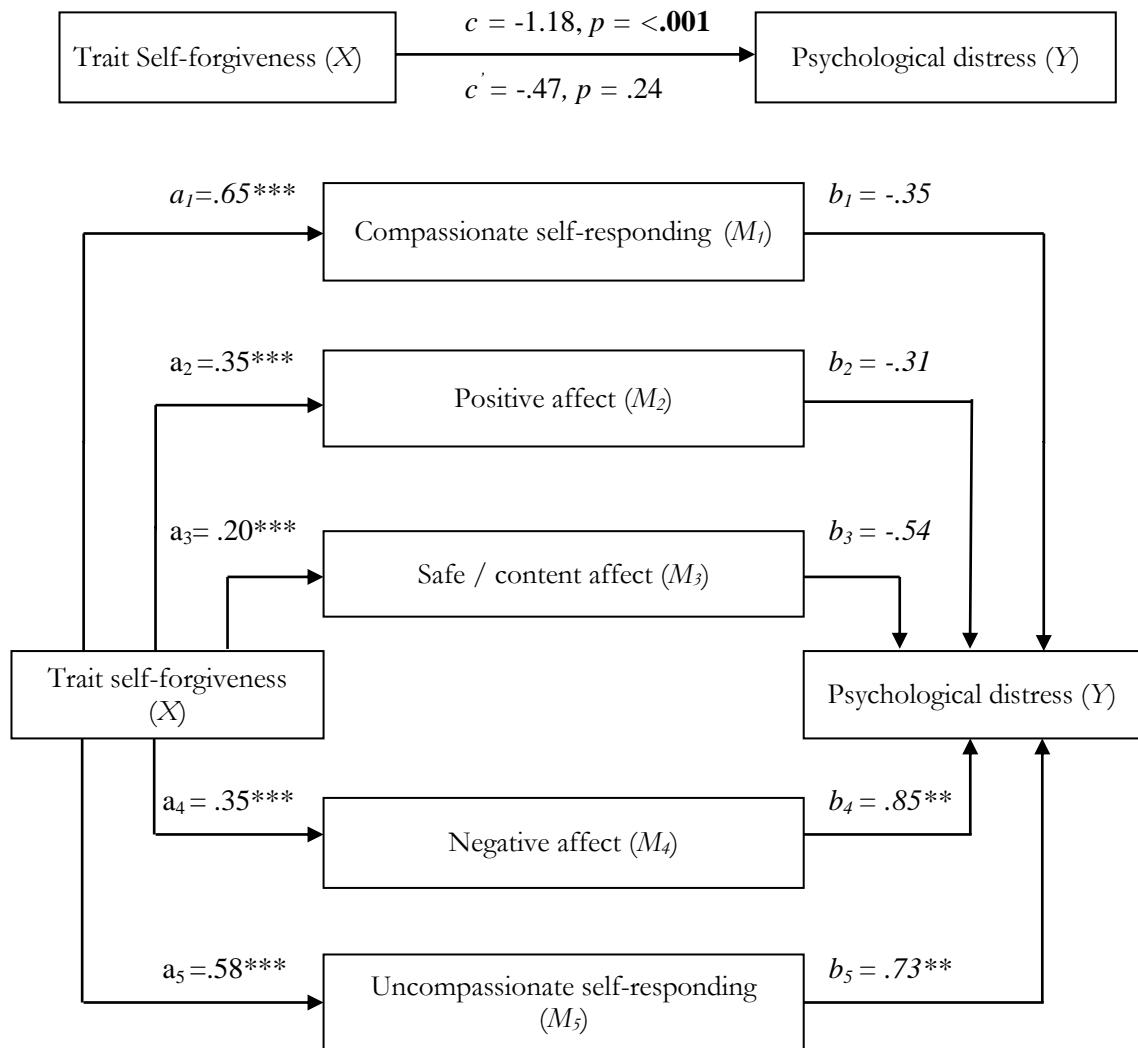


Figure 4.5. A path diagram of trait self-forgiveness as a predictor of psychological distress, mediated by compassionate self-responding, uncompassionate self-responding, safe / content affect, positive affect and negative affect.^a

Notes: ^a Models include controls for age, SES, agreeableness, and neuroticism.

c = total effect, c' = direct effect. a_1, a_2, a_3, a_4, a_5 = regression coefficients of X_1, X_2, X_3, X_4, X_5 ,

respectively. b_1, b_2, b_3, b_4, b_5 = regression coefficients of M_1, M_2, M_3, M_4, M_5 respectively. * $p < .05$, ** $p < .01$, *** $p < .001$.

A 95% bias-corrected confidence interval based on 10,000 bootstrap samples (table 4.8 overleaf) indicated that the total completely standardised effect of trait self-forgiveness on psychological distress through uncompassionate self-responding and negative affect was $\beta = -.20$, 95% CI [-0.03, -.15]. The effects of uncompassionate self-responding (a_5b_5), $\beta = -.12$, 95% CI [-0.20, -.05] and negative affect (a_4b_4), $\beta = -.08$, 95% CI [-0.17, -.02] yielded the largest effect size, followed by compassionate self-

responding (a_1b_1), $\beta = -.06$, 95% CI $[-.03, .15]$, positive affect (a_2b_2), $\beta = -.03$, 95% CI $[-.10, .02]$, and safe / content affect (a_3b_3), $\beta = -.03$, 95% CI $[-.11, .06]$.

These results indicated that the effects of uncompassionate self-responding and negative affect mediated the association between trait self-forgiveness and decreasing psychological distress.

Table 4.8. Path coefficients, indirect effects, and 95% bias-corrected confidence intervals of the SCS bifactor model, safe/content affect, positive affect and negative affect with trait self-forgiveness predicting psychological distress using 10,000 bootstrap samples ($n = 141^a$)

Path	Effect	LLCI	ULCI	SE	<i>t</i>	<i>p</i> -value
Total effect (<i>c</i>)	-1.18	-1.77	-.59	.27	-3.97	<.001
Direct effect (<i>c'</i>)	-.47	-1.26	.32	.40	-1.17	.24
<i>a</i> ₁ (HFS - CSR)	.65	.47	.83	.09	7.19	<.0001
<i>a</i> ₂ (HFS - PA)	.35	.18	.51	.08	4.20	<.0001
<i>a</i> ₃ (HFS - SCA)	.20	.12	.27	.04	5.30	<.0001
<i>a</i> ₄ (HFS - NA)	-.35	-.52	-.18	.09	-4.07	<.001
<i>a</i> ₅ (HFS - USR)	-.58	-.79	-.37	.11	-5.40	<.0001
<i>b</i> ₁ (CSR - DASS-T)	.35	-.17	.87	.26	1.32	.19
<i>b</i> ₂ (PA - DASS-T)	-.32	-.96	.32	.32	-0.99	.32
<i>b</i> ₃ (SCA - DASS-T)	-.54	-2.20	1.11	.83	-0.65	.52
<i>b</i> ₄ (NA - DASS-T)	.85	.17	1.53	.34	2.48	.01
<i>b</i> ₅ (USR - DASS-T)	.73	.29	1.16	.22	3.27	<.01
Completely standardised indirect effect(s) of X on Y:						
Total effect	-.20	-.35	-.06	.07		
<i>a</i> ₁ <i>b</i> ₁	.06	-.03	.15	.04		
<i>a</i> ₂ <i>b</i> ₂	-.03	-.01	.02	.03		
<i>a</i> ₃ <i>b</i> ₃	-.03	-.11	.06	.04		
<i>a</i> ₄ <i>b</i> ₄ [#]	-.08	-.17	-.02	.04		
<i>a</i> ₅ <i>b</i> ₅ [#]	-.12	-.20	-.05	.04		

Notes: ^a Models include controls for age, SES, agreeableness, neuroticism. *c* = total effect, *c'* = direct effect. *a*₁, *a*₂, *a*₃, *a*₄, *a*₅ = regression coefficients of *X*₁, *X*₂, *X*₃, *X*₄, *X*₅, respectively. *b*₁, *b*₂, *b*₃, *b*₄, *b*₅ = regression coefficients of *M*₁, *M*₂, *M*₃, *M*₄, *M*₅ respectively. [#] = significant mediating variable. *a*₁ = self-forgiveness - compassionate self-responding, *a*₂ = self-forgiveness - positive affect, *a*₃ = self-forgiveness - safe / content affect, *a*₄ = self-forgiveness - negative affect, *a*₅ = self-forgiveness - uncompassionate self-responding. *b*₁ = compassionate self-responding – psychological distress, *b*₂ = positive affect – psychological distress, *b*₃ = safe / content affect – psychological distress, *b*₄ = negative affect – psychological distress, *b*₅ = uncompassionate self-responding - psychological distress.
[#] = significant mediating effect

Abbreviations: LLCI, bootstrapping lower limit confidence interval, ULCI, bootstrapping upper limit confidence interval, SE, standard error with heteroscedasticity correction 3 (HC3).

Hypothesis 1b

Hypothesis 1b stated that after controlling for those demographic and personality variables that were found to correlated with trait self-forgiveness and psychological distress, it was predicted that the relationship between trait self-forgiveness would predict reductions in psychological distress, and that this relationship would be mediated by the combined effects of the SCS total score, negative affect, positive affect and safe / content affect.

Results from the parallel mediation analysis indicated that the model accounted for 55.0.% of the variance between trait self-forgiveness and psychological distress ($R^2 = .55$, $F(5, 135) = 29.59$, $p = <.0001$) when controlled for age, SES, neuroticism and agreeableness. Of these covariates increased neuroticism, $\beta = 1.78$, 95% CI [1.09, 2.48], $t = 5.06$, $p = <.0001$, and age $\beta = .33$, 95% CI [.03, .63], $t = 2.19$, $p = .03$, had significant effects upon the model.

It was found that trait self-forgiveness significantly predicted a decrease in psychological distress, $\beta = -1.18$, 95% CI [-1.76, -.59], $t = -3.98$, $p = <.001$. When the direct effects of the SCS total scale, negative affect, positive affect and safe / content affect were added to the model the relationship between trait self-forgiveness and psychological distress became non-significant $\beta = -.42$, 95% CI [-1.25, .41], $t = -1.00$, $p = .32$, indicating that mediation had occurred (figure 4.6 overleaf)

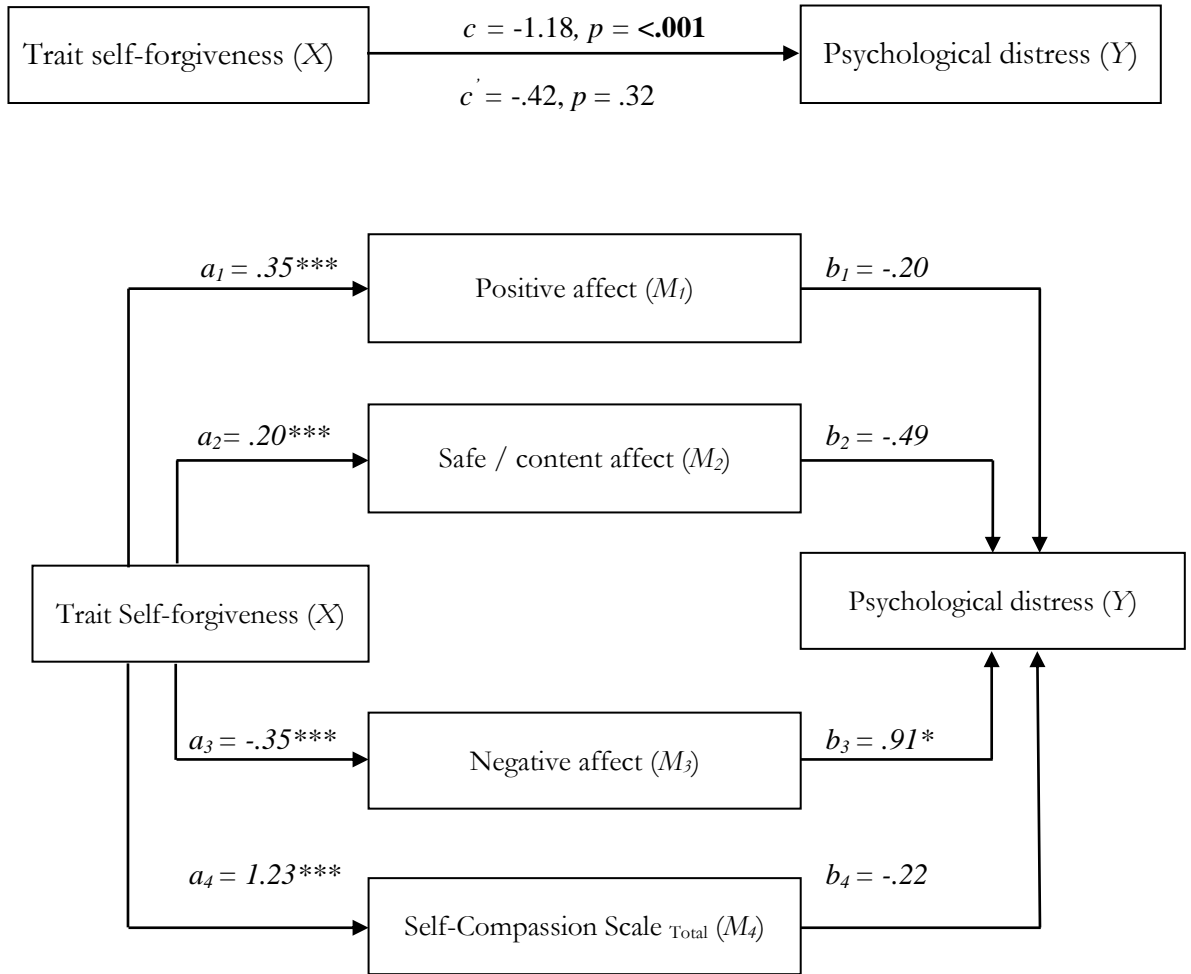


Figure 4.6. A path analysis model of trait self-forgiveness as a predictor of psychological distress, mediated by the SCS total scale score, safe affect, positive affect and negative affect.^a

Notes. ^a Models include controls for age, SES, agreeableness, and neuroticism. c = total effect, c' = direct effect. a_1, a_2, a_3, a_4 = regression coefficients of X_1, X_2, X_3, X_4 , respectively. b_1, b_2, b_3, b_4 = regression coefficients of M_1, M_2, M_3, M_4 , respectively.

* $p < .05$, ** $p < .01$, *** $p < .001$.

A 95% bias-corrected confidence interval based on 10,000 bootstrap samples indicated that the total completely standardised effect of trait self-forgiveness on psychological distress through all of the mediating variables was $\beta = -.21$, 95% CI [- .36, -.08]. The effects of the negative affect (a_4b_4), $\beta = -.09$, 95% CI [- .19, -.02] and SCS total score (a_5b_5), $\beta = -.08$, 95% CI [- .19, .03] yielded the largest effect sizes, followed by safe content affect (a_2b_2), $\beta = -.03$, 95% CI [- .11, .06], and positive affect (a_1b_1), $\beta = -.02$, 95% CI [- .09, .04].

These results indicated that the effects of negative affect alone mediated the association between trait self-forgiveness and decreasing psychological distress (table 4.9).

Table 4.9. Path coefficients, indirect effects, and 95% bias-corrected confidence intervals for the SCS-Total score, safe/content affect, positive affect and negative affect predicting psychological distress using 10,00 bootstrap samples ($n = 141^a$)

Path	Effect	LLCI	ULCI	SE	<i>t</i>	<i>p</i> -value
Total effect (<i>c</i>)	-1.18	-1.77	-.59	.30	-3.97	<.001
Direct effect (<i>c'</i>)	-.42	-1.25	.41	.42	-1.00	.32
<i>a</i> ₁ (<i>HFS</i> - <i>PA</i>)	.35	.18	.51	.08	4.20	<.0001
<i>a</i> ₂ (<i>HFS</i> - <i>SCA</i>)	.20	.12	.27	.04	5.30	<.0001
<i>a</i> ₃ (<i>HFS</i> - <i>NA</i>)	-.35	-.52	-.18	.09	-4.07	<.001
<i>a</i> ₄ (<i>HFS</i> - <i>SCS-T</i>)	1.23	.95	1.50	.14	8.75	<.0001
<i>b</i> ₁ (<i>PA</i> - <i>DASS-T</i>)	-.20	-.86	.45	.33	-.61	.54
<i>b</i> ₂ (<i>SCA</i> - <i>DASS-T</i>)	-.49	-2.17	1.20	.85	-.57	.57
<i>b</i> ₃ (<i>NA</i> - <i>DASS-T</i>)	.91	.19	1.62	.36	2.51	<.01
<i>b</i> ₄ (<i>SCS-T</i> - <i>DASS-T</i>)	-.22	-.54	.10	.16	-1.38	.17
Completely standardised indirect effect(s) of X on Y:						
Total indirect effect	-.21	-.36	-.08	.07		
<i>a</i> ₁ <i>b</i> ₁	-.02	-.09	.04	.03		
<i>a</i> ₂ <i>b</i> ₂	-.03	-.11	.06	.04		
<i>a</i>₃<i>b</i>₃[#]	-.09	-.19	-.02	.04		
<i>a</i> ₄ <i>b</i> ₄	-.08	-.19	.03	.06		

Notes: ^a Models include controls for age, SES, agreeableness and neuroticism. *c* = total effect, *c'* = direct effect. [#] = mediating variable. *a*₁, *a*₂, *a*₃, *a*₄ = regression coefficients of *X*₁, *X*₂, *X*₃, *X*₄, respectively. *b*₁, *b*₂, *b*₃, *b*₄ = regression coefficients of *M*₁, *M*₂, *M*₃, *M*₄, respectively. *a*₁ = trait self-forgiveness - positive affect, *a*₂ = trait self-forgiveness - safe / content affect, *a*₃ = trait self-forgiveness - negative affect, *a*₄ = trait self-forgiveness - self-compassion total score. *b*₁ = positive affect - psychological distress, *b*₂ = safe / content affect - psychological distress, *b*₃ = negative affect - psychological distress, *b*₄ = self-compassion total score - psychological distress. **p* < .05, ***p* < .01, ****p* < .001.

Abbreviations: LLCI, bootstrapping lower limit confidence interval; ULCI, bootstrapping upper limit confidence interval; SE, standard error with heteroscedasticity correction 3 (HC3).

Hypothesis 2.

The second hypothesis stated that after controlling for those demographic and personality variables that were found to correlated with trait self-forgiveness and shame, trait self-forgiveness would predict reductions in shame, and that this relationship would

be mediated by the combined indirect effects of compassionate self-responding, uncompassionate self-responding, negative affect, positive affect and safe / warm affect.

Results from the parallel mediation analysis indicated that the model accounted for 57.1% of variance between trait self-forgiveness and shame ($R^2 = .57.1$, $F(5, 135) = 45.71$, $p = <.0001$) when controlled for age, SES, neuroticism and agreeableness. Of these covariates only neuroticism, $\beta = .23$, 95% CI [.12, .34], $t = 4.08$, $p = <.001$, had a significant effect upon the model (see Figure 4.7).

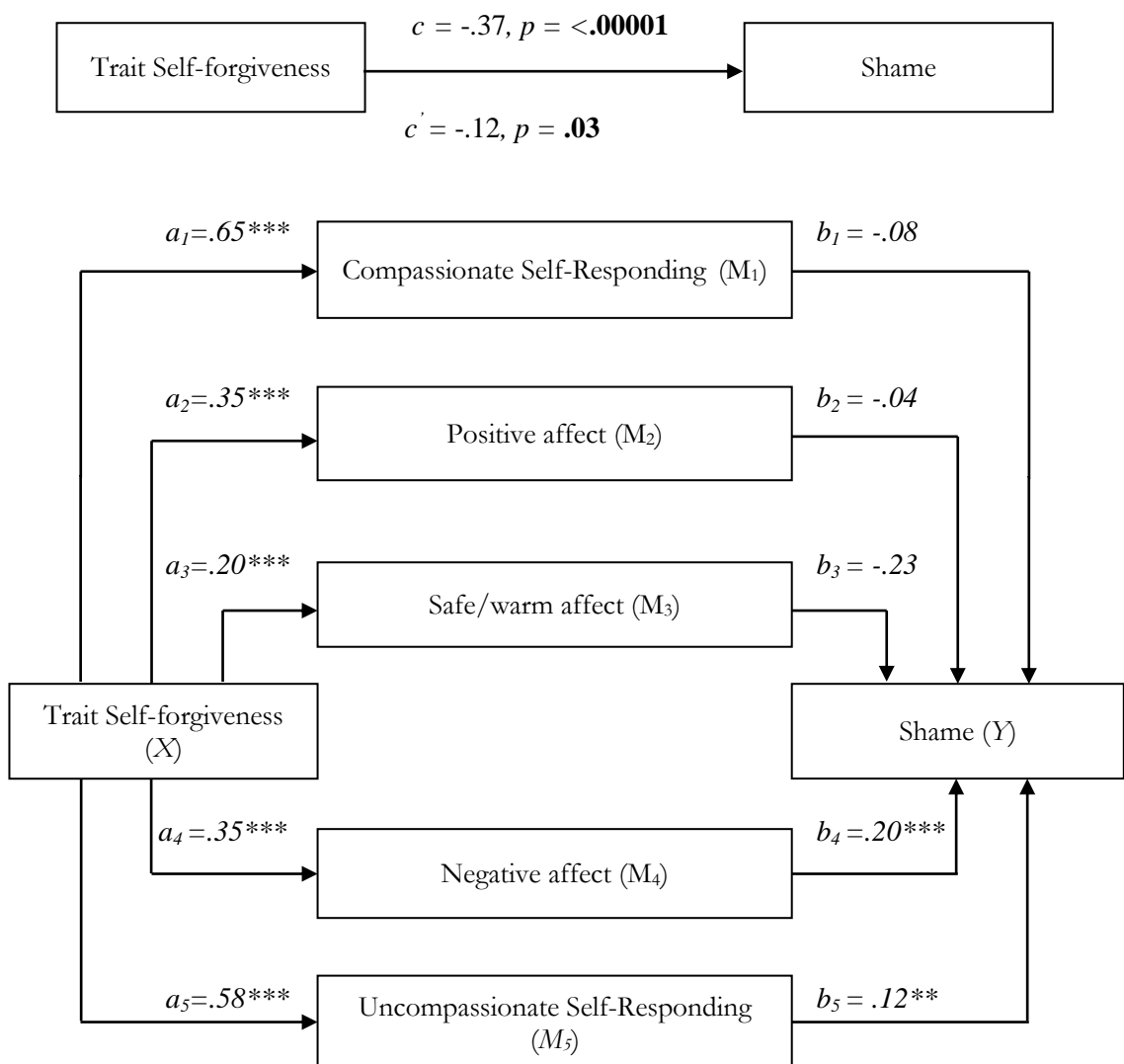


Figure 4.7. A path analysis model of trait self-forgiveness as a predictor of shame, mediated by compassionate self-responding, uncompassionate self-responding, safe / content affect, positive affect and negative affect.^a

Notes. ^a Models include controls for age, gender, SES, culture, religiosity / spirituality, agreeableness, neuroticism, narcissism, and social desirability. c = total effect, c' = direct effect. a_1, a_2, a_3, a_4 = regression coefficients of X_1, X_2, X_3, X_4, X_5 respectively. b_1, b_2, b_3, b_4, b_5 = regression coefficients of M_1, M_2, M_3, M_4, M_5 , respectively. * $p < .05$, ** $p < .01$, *** $p < .001$.

It was found that trait self-forgiveness significantly predicted a decrease in shame, $\beta = -.37$, 95% CI [-.45, -.29], $t = -9.11$, $p = <.00001$, and that when the direct effects of compassionate self-responding, uncompassionate self-responding, negative affect, positive affect and safe / content affect were added to the model, the relationship between trait self-forgiveness and shame remained significant, $\beta = -.12$, 95% CI [-.23, -.01], $t = -2.21$, $p = .03$, indicating that partial mediation had occurred (see Table 4.10).

Table 4.10. Path coefficients, indirect effects, and 95% bias-corrected confidence intervals of the SCS bifactor model safe/content affect, positive affect and negative affect with trait self-forgiveness predicting shame using 10,00 bootstrap samples ($n = 141^a$)

Path	Effect	LLCI	ULCI	SE	<i>t</i>	<i>p</i> -value
Total effect (<i>c</i>)	-.37	-.45	-.29	.04	-9.10	<.0001
Direct effect (<i>c'</i>)	-.12	-.23	-.01	.05	-2.21	.03
<i>a</i> ₁ (HFS – CSR)	.65	.47	.83	.09	7.19	<.0001
<i>a</i> ₂ (HFS – PA)	.35	.18	.51	.08	4.20	<.0001
<i>a</i> ₃ (HFS – SCA)	.20	.12	.27	.04	5.30	<.0001
<i>a</i> ₄ (HFS – NA)	-.35	-.52	-.18	.09	-4.07	<.001
<i>a</i> ₅ (HFS – USR)	-.58	-.79	-.37	.11	-5.40	<.0001
<i>b</i> ₁ (CSR – Shame)	-.08	-.17	.01	.05	-1.73	.09
<i>b</i> ₂ (PA – Shame)	-.04	-.16	.08	.06	-.64	.47
<i>b</i> ₃ (SCA – Shame)	-.23	-.48	.02	.13	-1.84	.07
<i>b</i> ₄ (NA – Shame)	.20	.09	.32	.06	3.52	<.001
<i>b</i> ₅ (USR – Shame)	.12	.03	.21	.04	2.78	<.01
Completely standardised indirect effect(s) of X on Y:						
Total indirect effect	-.36	-.48	-.24	.06		
<i>a</i> ₁ <i>b</i> ₁	-.07	-.15	.01	.04		
<i>a</i> ₂ <i>b</i> ₂	-.02	-.08	.03	.03		
<i>a</i> ₃ <i>b</i> ₃	-.06	-.14	.00	.04		
<i>a</i>₄<i>b</i>₄[#]	-.10	-.19	-.04	.04		
<i>a</i>₅<i>b</i>₅[#]	-.10	-.18	-.03	.04		

Notes: ^a Models include controls for age, SES, agreeableness, neuroticism, *c* = total effect, *c'* = direct effect. *a*₁, *a*₂, *a*₃, *a*₄, *a*₅ = regression coefficients of *X*₁, *X*₂, *X*₃, *X*₄, *X*₅, respectively. *b*₁, *b*₂, *b*₃, *b*₄, *b*₅ = regression coefficients of *M*₁, *M*₂, *M*₃, *M*₄, *M*₅ respectively. *a*₁ = trait self-forgiveness - compassionate self-responding, *a*₂ = trait self-forgiveness - positive affect, *a*₃ = trait self-forgiveness - safe / content affect, *a*₄ = trait self-forgiveness - negative affect, *a*₅ = trait self-forgiveness - uncompassionate self-responding. *b*₁ = compassionate self-responding – shame, *b*₂ = positive affect – shame, *b*₃ = safe / content affect – shame, *b*₄ = negative affect – shame, *b*₅ = uncompassionate self-responding - shame. [#] = significant mediating effect.

Abbreviations: LLCI, bootstrapping lower limit confidence interval, ULCI, bootstrapping upper limit confidence interval, SE, standard error with heteroscedasticity correction 3 (HC3).

A 95% bias-corrected confidence interval based on 10,000 bootstrap samples indicated that the total completely standardised effect of trait self-forgiveness on shame through compassionate self-responding, uncompassionate self-responding, safe / content affect, positive affect, and negative affect was $\beta = -.36$, 95% CI [-.48, -.24]. The effects of negative affect (a_4b_4), $\beta = -.10$, 95% CI [-.19, -.04], uncompassionate self-responding (a_5b_5), $\beta = -.10$, 95% CI [-.18, -.03], and compassionate self-responding (a_1b_1), $\beta = -.07$, 95% CI [-.15, .01], yielded the largest effect sizes, followed by safe / content affect (a_3b_3), $\beta = -.06$, 95% CI [-.14, .00], and positive affect (a_2b_2), $\beta = -.02$, 95% CI [-.08, .03].

These results indicated that that negative affect and uncompassionate self-responding had partially mediated the association between trait self-forgiveness and decreasing shame.

Hypothesis 2b

Hypothesis 2b stated that after controlling for those demographic and personality variables that were found to correlate with trait self-forgiveness and shame, it was predicted that trait self-forgiveness would predict reductions in shame, and that this relationship would be mediated by the combined effects of the SCS total score, negative affect, positive affect and safe / content affect.

Results from the parallel mediation analysis indicated that the model accounted for 57.1% of variance between trait self-forgiveness and shame ($R^2 = .57$, $F(5, 135) = 45.71$, $p = <.00001$) when controlled for age, SES, neuroticism and agreeableness. Of these covariates only neuroticism, $\beta = .23$, 95% CI [.17, .34], $t = 4.08$, $p = <.001$, had significant effects upon the model.

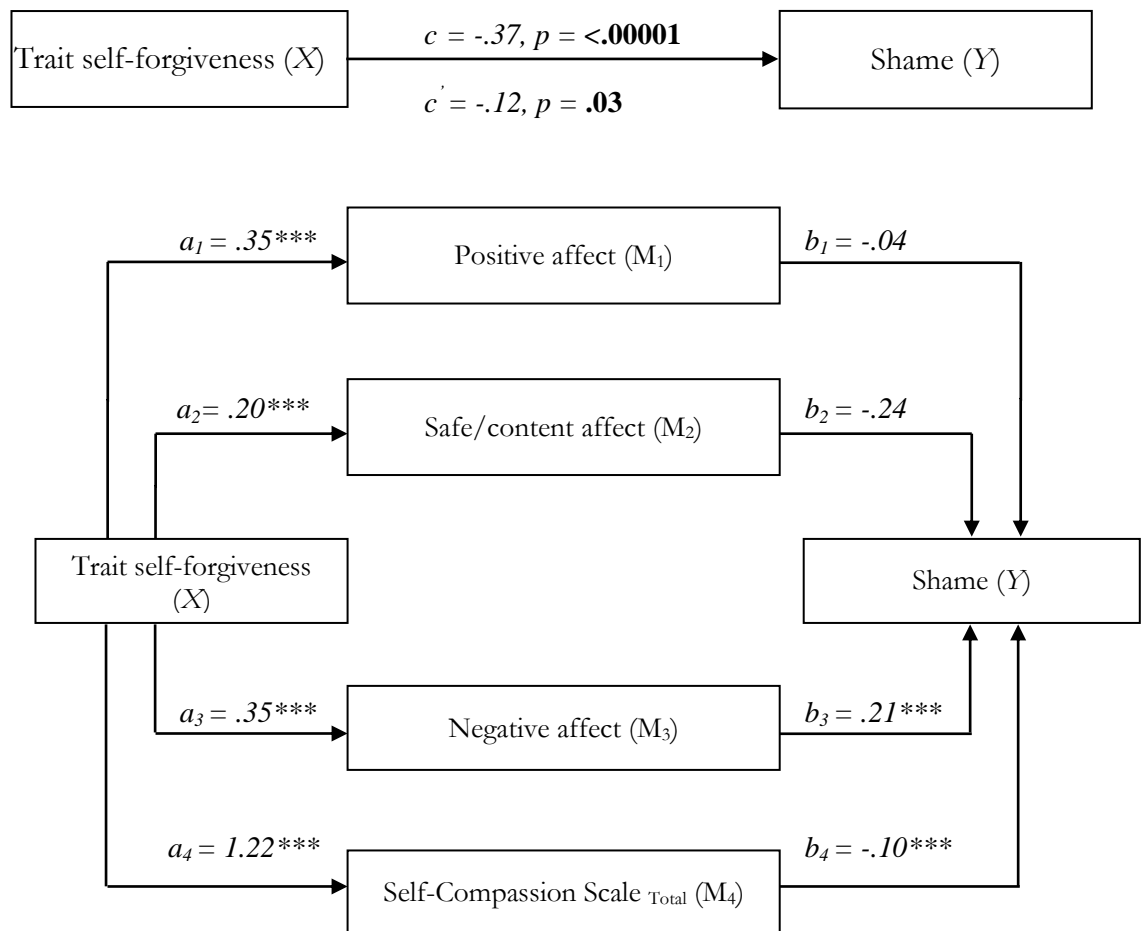


Figure 4.8. A path analysis model of trait self-forgiveness as a predictor of shame, mediated by the self-compassion scale total, safe / content affect, positive affect and negative affect.^a

Notes. ^a Models include controls for age, SES, agreeableness, and neuroticism. c = total effect, c' = direct effect. a_1, a_2, a_3, a_4 = regression coefficients of X_1, X_2, X_3, X_4 , respectively. b_1, b_2, b_3, b_4 = regression coefficients of M_1, M_2, M_3, M_4 , respectively. * $p < .05$, ** $p < .01$, *** $p < .001$.

It was found that trait self-forgiveness significantly predicted a decrease in shame, $\beta = -.37$, 95% CI $[-.45, -.29]$, $t = -9.11$, $p < .00001$, and that when the direct effects compassionate self-responding, uncompassionate self-responding, negative affect, positive affect and safe / content affect were added to the model the relationship between trait self-forgiveness and shame remained significant $\beta = -.12$, 95% CI $[-.23, -.01]$, $t = -2.21$, $p = .03$, indicating that partial mediation had occurred (figure 4.8 above).

A 95% bias-corrected confidence interval based on 10,000 bootstrap samples indicated that the total completely standardised effect of trait self-forgiveness on shame through the self-compassion scale total score, safe / content affect, positive affect and

negative affect was $\beta = -.35$, 95% CI [-.47, -.24]. The effects of the Self-compassion scale total score (a_5b_5), $\beta = -.17$, 95% CI [-.25, -.08], negative affect (a_4b_4), $\beta = -.10$, 95% CI [-.19, -.04] yielded the largest effect sizes, followed by safe / content affect (a_3b_3), $\beta = -.07$, 95% CI [-.14, .00], and positive affect (a_2b_2), $\beta = -.02$, 95% CI [-.08, .03].

These results indicated that the self-compassion total score and negative affect had partially mediated the association between trait self-forgiveness and decreasing shame (table 4.11).

Table 4.11. Path coefficients, indirect effects, and 95% bias-corrected confidence intervals of the SCS single factor model safe/content affect, positive affect and negative affect with trait self-forgiveness predicting shame using 10,00 bootstrap samples ($n = 141^a$)

Path	Effect	LLCI	ULCI	SE	<i>t</i>	<i>p</i> -value
Total effect (<i>c</i>)	-.15	-.20	-.10	.03	-5.94	<.0001
Direct effect (<i>c'</i>)	-.03	-.08	.02	.03	-1.08	.028
<i>a</i> ₁ (HFS - PA)	.17	.08	.26	.05	3.79	<.001
<i>a</i> ₂ (HFS - SCA)	.08	.03	.12	.02	3.46	<.001
<i>a</i> ₃ (HFS - NA)	-.14	-.23	-.05	.05	-3.01	<.01
<i>a</i> ₄ (HFS - SCS-T)	.58	.42	.74	.08	8.60	<.0001
<i>b</i> ₁ (PA - Shame)	-.03	-.15	.08	.06	-0.58	.56
<i>b</i> ₂ (SCA - Shame)	-.28	-.53	.04	.12	-2.28	.20
<i>b</i> ₃ (NA - Shame)	.21	.09	.34	.06	4.88	<.001
<i>b</i> ₄ (SCS-T - Shame)	-.11	-.16	-.07	.02	-4.68	<.0001
Completely Standardised Indirect effects						
Total indirect effect	-.35	-.47	-.24	.07		
<i>a</i> ₁ <i>b</i> ₁	-.02	-.08	.03	.03		
<i>a</i> ₂ <i>b</i> ₂	-.07	-.14	.00	-.03		
<i>a</i>₃<i>b</i>₃[#]	-.10	-.18	-.04	.04		
<i>a</i>₄<i>b</i>₄[#]	-.17	-.25	-.08	.04		

Notes: ^a Models include controls for age, SES, agreeableness, and neuroticism., *c* = total effect, *c'* = direct effect. *a*₁ = Self-Forgiveness - Positive Affect, *a*₂ = Self-Forgiveness - Safe / Content Affect, *a*₃ = Self-Forgiveness - Negative Affect, *a*₄ = Self-Forgiveness – Self-Compassion Total Score. *b*₁, Positive Affect – Guilt, *b*₂, = Safe / Content Affect – Guilt, *b*₃, = Negative Affect – Guilt, *b*₄ = Self-Compassion Total Score Safe - Guilt. *a*₁, *a*₂, *a*₃, *a*₄ = regression coefficients of *X*₁, *X*₂, *X*₃, *X*₄, respectively. *b*₁, *b*₂, *b*₃, *b*₄ = regression coefficients of *M*₁, *M*₂, *M*₃, *M*₄, respectively. **p* < .05, ***p* < .01, ****p* < .001. [#] = partially significant mediating effect.

Abbreviations: LLCI, bootstrapping lower limit confidence interval, ULCI, bootstrapping upper limit confidence interval, SE, standard error with heteroscedasticity correction 3 (HC3).

Hypothesis 3.

The third hypothesis stated that after controlling for those demographic and personality variables that were found to correlated with trait self-forgiveness and guilt, trait self-forgiveness would predict reductions in guilt, and that this relationship would be mediated by the combined indirect effects of compassionate self-responding, uncompassionate self-responding, negative affect, positive affect and safe / warm affect.

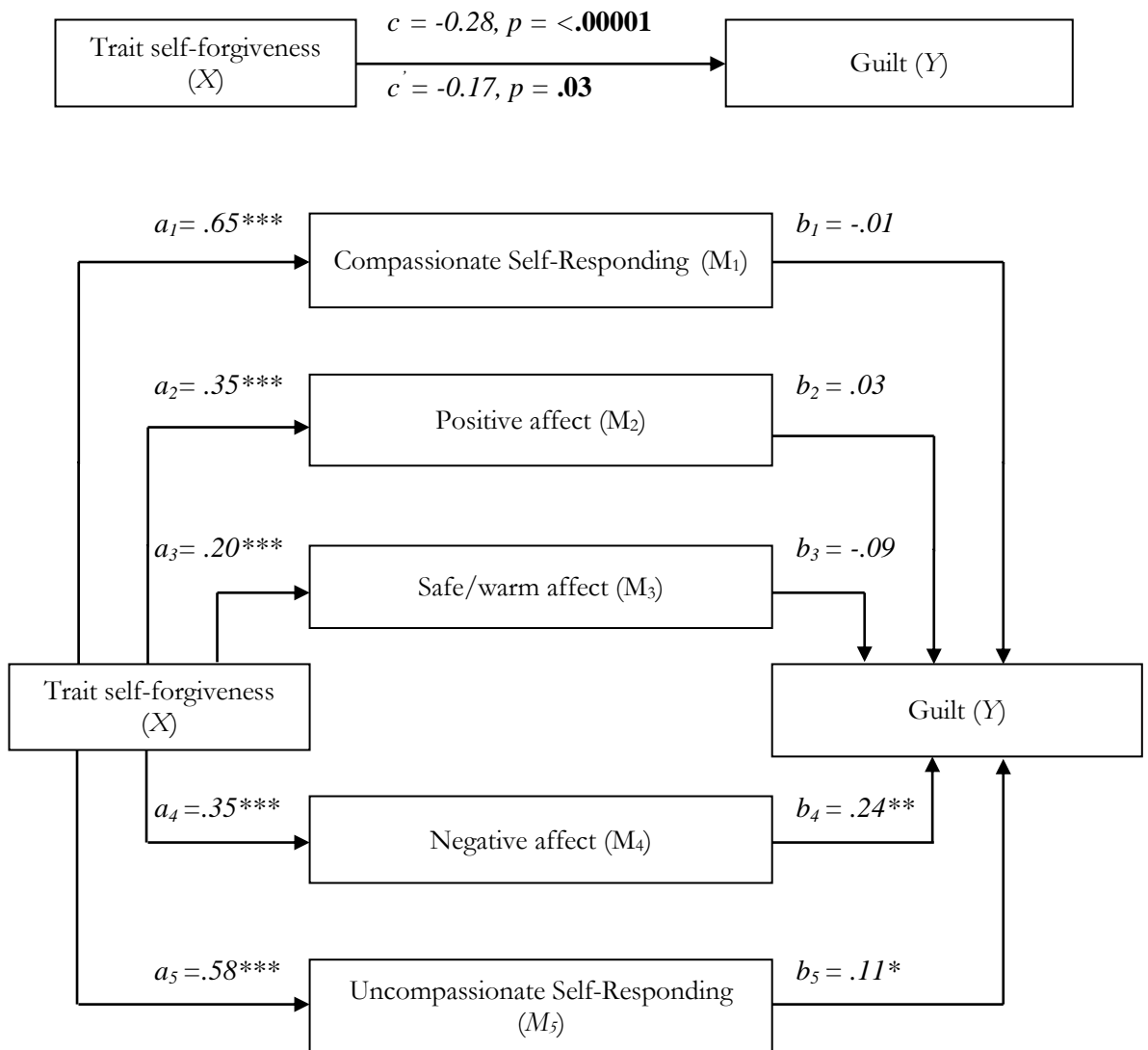


Figure 4.9. A path analysis model of trait self-forgiveness as a predictor of guilt, mediated by compassionate self-responding, uncompassionate self-responding, safe / content affect, positive affect and negative affect.^a

Notes. ^a Models include controls for age, SES, culture, agreeableness and neuroticism. c = total effect, c' = direct effect. a_1, a_2, a_3, a_4, a_5 = regression coefficients of X_1, X_2, X_3, X_4, X_5 , respectively. b_1, b_2, b_3, b_4, b_5 = regression coefficients of M_1, M_2, M_3, M_4, M_5 , respectively. * $p < .05$, ** $p < .01$, *** $p < .001$.

Results from the parallel mediation analysis indicated that the model accounted for 43.1% of variance between trait self-forgiveness and guilt ($R^2 = .43$, $F(5, 135) = 21.35$, $p = <.0001$) when controlled for age, SES, neuroticism and agreeableness. Of these covariates only neuroticism, $\beta = .22$, 95% CI [.06, .39], $t = 2.67$, $p = .01$, had a significant effect upon the model.

It was found that trait self-forgiveness significantly predicted a decrease in guilt, $\beta = -.28$, 95% CI [-.40, -.16], $t = -4.72$, $p = <.0001$, and that when the direct effects compassionate self-responding, uncompassionate self-responding, negative affect, positive affect and safe / content affect were added to the model, the relationship between trait self-forgiveness and guilt remained significant $\beta = -.17$, 95% CI [-.32, -.02], $t = -2.27$, $p = .03$, indicating that partial mediation had occurred.

A 95% bias-corrected confidence interval based on 10,000 bootstrap samples indicated that the total completely total standardised effect of trait self-forgiveness on guilt through compassionate self-responding, uncompassionate self-responding, negative affect, positive affect and safe /content affect was, $\beta = -.17$, 95% CI [-.33, -.01]. The effects of negative affect (a_4b_4), $\beta = -.13$, 95% CI [-.24, -.04] and uncompassionate self-responding (a_5b_5), $\beta = -.10$, 95% CI [-.22, -.00], and yielded the largest effect sizes, followed by safe / content affect (a_3b_3), $\beta = .03$, 95% CI [-.06, .12] positive affect (a_2b_2), $\beta = .02$, 95% CI [-.05, .08], and lastly compassionate self-responding (a_1b_1), $\beta = .01$, 95% CI [-.07, .11].

These results indicated that negative affect and uncompassionate self-responding, partially mediated the association between trait self-forgiveness and decreasing guilt (table 4.12 overleaf).

Table 4.12. Path coefficients, indirect effects, and 95% bias-corrected confidence intervals of the SCS bifactor model, safe/content affect, positive affect and negative affect with trait self-forgiveness predicting guilt using 10,00 bootstrap samples ($n = 141^a$)

Path value	Effect	LLCI	ULCI	SE	<i>t</i>	<i>p</i> -
Total effect (<i>c</i>)	-.28	-.40	-.16	.06	-4.72	<.0001
Direct effect (<i>c'</i>)	-.17	-.32	-.02	.07	-2.27	.03
<i>a</i> ₁ (<i>HFS</i> - <i>CSR</i>)	.65	.47	.83	.09	7.19	<.0001
<i>a</i> ₂ (<i>HFS</i> - <i>PA</i>)	.35	.18	.51	.08	4.20	<.0001
<i>a</i> ₃ (<i>HFS</i> - <i>SCA</i>)	.06	-.10	-.03	.04	5.30	<.01
<i>a</i> ₄ (<i>HFS</i> - <i>NA</i>)	-.35	-.52	-.18	.09	-4.07	<.001
<i>a</i> ₅ (<i>HFS</i> - <i>USR</i>)	-.58	-.79	-.37	.11	-5.39	<.0001
<i>b</i> ₁ (<i>CSR</i> - <i>Guilt</i>)	-.01	-.08	.11	.05	-.30	.76
<i>b</i> ₂ (<i>PA</i> - <i>Guilt</i>)	.03	-.09	.16	.06	.53	.59
<i>b</i> ₃ (<i>SCA</i> - <i>Guilt</i>)	.09	-.22	.40	.16	.56	.58
<i>b</i> ₄ (<i>NA</i> - <i>Guilt</i>)	.24	.10	.38	.07	3.37	<.01
<i>b</i> ₅ (<i>USR</i> - <i>Guilt</i>)	.11	.00	.22	.06	2.04	<.05
Completely Standardised Indirect effects						
Total indirect effect	-.17	-.33	-.01	.08		
<i>a</i> ₁ <i>b</i> ₁	-.01	-.07	.11	.05		
<i>a</i> ₂ <i>b</i> ₂	.02	-.05	.08	.03		
<i>a</i> ₃ <i>b</i> ₃	.03	-.06	.12	.04		
<i>a</i> ₄ <i>b</i> ₄ [#]	-.13	-.24	-.04	.05		
<i>a</i> ₅ <i>b</i> ₅ [#]	-.10	-.22	-.00	.05		

Notes: ^a Models include controls for age, SES, agreeableness, and neuroticism. *c* = total effect, *c'* = direct effect. [#] = partial mediating variable, *a*₁ = self-forgiveness- compassionate self-responding, *a*₂ = self-forgiveness - positive affect, *a*₃ = self-forgiveness - safe / content affect, *a*₄ = self-forgiveness - negative affect, *a*₅ = self-forgiveness - uncompassionate self-responding. *b*₁ = compassionate self-responding – guilt, *b*₂ = positive affect – guilt, *b*₃ = safe / content affect – guilt, *b*₄ = negative affect – guilt, *b*₅ = uncompassionate self-responding - guilt. *a*₁, *a*₂, *a*₃, *a*₄, *a*₅ = regression coefficients of *X*₁, *X*₂, *X*₃, *X*₄, *X*₅, respectively. *b*₁, *b*₂, *b*₃, *b*₄, *b*₅ = regression coefficients of *M*₁, *M*₂, *M*₃, *M*₄, *M*₅ respectively. **p* < .05, ***p* < .01, ****p* < .001.

Abbreviations: LLCI, bootstrapping lower limit confidence interval, ULCI, bootstrapping upper limit confidence interval, SE, standard error with heteroscedasticity correction 3 (HC3).

Hypothesis 3b

Hypothesis 3b stated that after controlling for those demographic and personality variables that were found to correlate with trait self-forgiveness and guilt, the relationship between trait self-forgiveness would predict reductions in guilt, and that

this relationship would be mediated by the combined effects of the SCS total score, negative affect, positive affect and safe / content affect.

Results from the parallel mediation analysis indicated that the model accounted for 43.1% of variance between trait self-forgiveness and guilt ($R^2 = .43$, $F(5, 135) = 21.35$, $p = <.00001$) when controlled for age, SES, neuroticism and agreeableness. Of these covariates only neuroticism, $\beta = .22$, 95% CI [.06, .39], $t = 2.67$, $p = .01$, had a significant effect upon the model (figure 4.10).

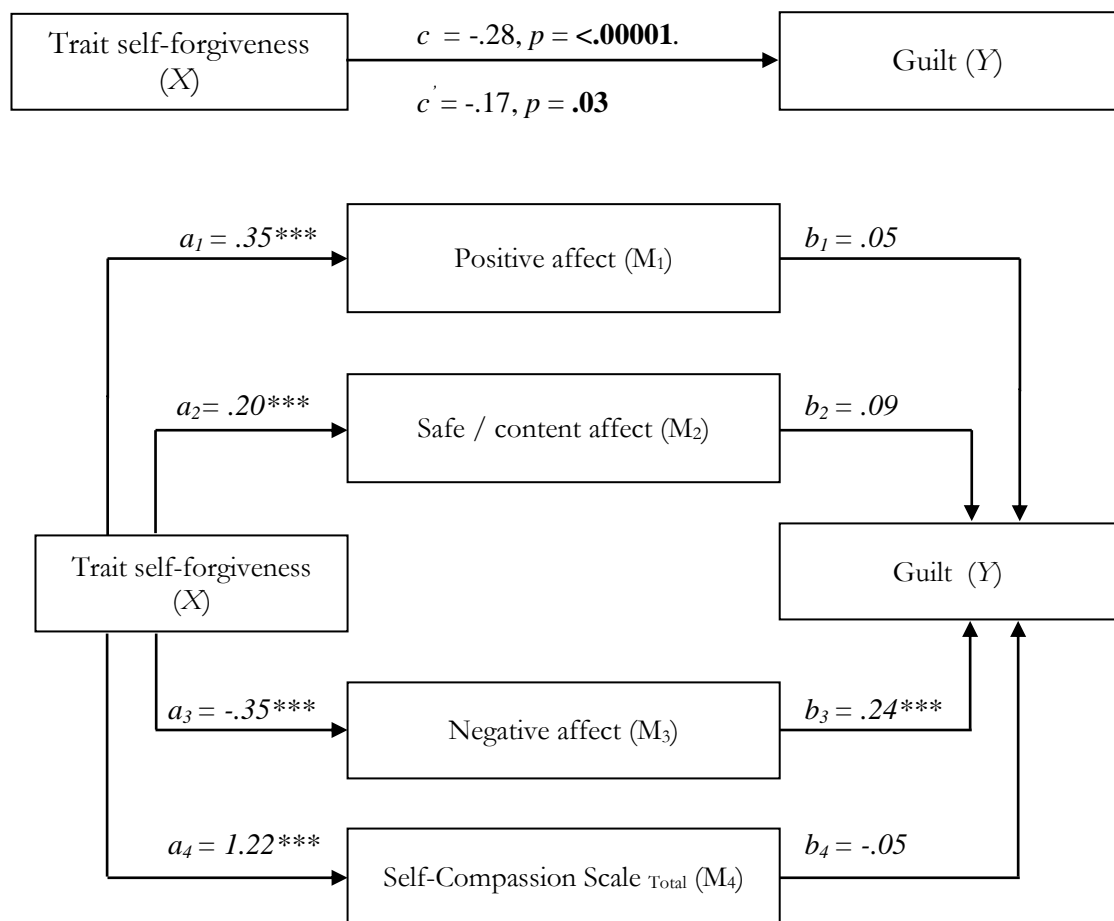


Figure 4.10. A path analysis model of trait self-forgiveness as a predictor of guilt, mediated by the SCS total scale score, safe / content affect, positive affect and negative affect.^a

Notes. ^a Models include controls for age, gender, SES, culture, religiosity / spirituality, agreeableness, neuroticism, narcissism, and social desirability. c = total effect, c' = direct effect. a_1, a_2, a_3, a_4 = regression coefficients of X_1, X_2, X_3, X_4 , respectively. b_1, b_2, b_3, b_4 = regression coefficients of M_1, M_2, M_3, M_4 , respectively. * $p < .05$, ** $p < .01$, *** $p < .001$.

It was found that trait self-forgiveness significantly predicted a decrease in guilt, $\beta = -.28$, 95% CI [-.40, -.16], $t = -4.72$, $p = <.00001$, and that when the direct effects of

the self-compassion total score, negative affect, positive affect and safe / content affect were added to the model, the relationship between trait self-forgiveness and shame remained significant $\beta = -.17$, 95% CI $[-.31, .02]$, $t = -2.24$, $p = .03$, indicating that partial mediation had occurred.

A 95% bias-corrected confidence interval based on 10,000 bootstrap samples indicated that the total completely standardised effect of trait self-forgiveness on guilt through compassionate self-responding, uncompassionate self-responding, negative affect, positive affect and safe /content affect was, $\beta = -.17$, 95% CI $[-.33, -.02]$. The effects of negative affect (a_3b_3), $\beta = -.13$, 95% CI $[-.24, -.05]$ and the self-compassion total score (a_4b_4), $\beta = -.09$, 95% CI $[-.22, -.04]$, and yielded the largest effect sizes, followed by safe / content affect (a_2b_2), $\beta = .03$, 95% CI $[-.06, .12]$ and positive affect (a_1b_1), $\beta = .02$, 95% CI $[-.04, .09]$.

These results indicated that negative affect and the SCS Total Scale partially mediated the association between trait self-forgiveness and decreasing guilt (see table 4.13 overleaf).

Table 4.13. Path coefficients, indirect effects, and 95% bias-corrected confidence intervals of the SCS single factor model, safe/content affect, positive affect and negative affect with trait self-forgiveness predicting guilt using 10,00 bootstrap samples ($n = 141^a$).

Path value	Effect	LLCI	ULCI	SE	<i>t</i>	<i>p</i> -
Total effect (<i>c</i>)	-.28	-.40	-.16	.06	-4.72	<.0001
Direct effect (<i>c'</i>)	-.17	-.31	.02	.07	-2.24	.03
<i>a</i> ₁ (<i>HFS</i> – <i>PA</i>)	.35	.18	.51	.08	4.20	<.0001
<i>a</i> ₂ (<i>HFS</i> – <i>SCA</i>)	.20	.12	.27	.04	5.30	<.0001
<i>a</i> ₃ (<i>HFS</i> – <i>NA</i>)	-.35	-.52	-.18	.09	-4.07	<.001
<i>a</i> ₄ (<i>HFS</i> – <i>SCS-T</i>)	1.23	.95	1.50	.14	8.75	<.0001
<i>b</i> ₁ (<i>PA</i> – <i>Guilt</i>)	.05	-.08	.17	.06	.74	.46
<i>b</i> ₂ (<i>SCA</i> – <i>Guilt</i>)	.09	-.22	.40	.16	.58	.56
<i>b</i> ₃ (<i>NA</i> – <i>Guilt</i>)	.24	.11	.38	.07	3.50	<.001
<i>b</i> ₄ (<i>SCS-T</i> – <i>Guilt</i>)	-.05	-.12	.02	.04	-1.40	.16
Completely Standardised Indirect effects						
Total indirect effect	-.17	-.33	-.02	.08		
<i>a</i> ₁ <i>b</i> ₁	.02	-.04	.09	.03		
<i>a</i> ₂ <i>b</i> ₂	.03	-.06	.12	.05		
<i>a</i> ₃ <i>b</i> ₃ [#]	-.13	-.24	-.05	.05		
<i>a</i> ₄ <i>b</i> ₄ [#]	-.09	-.22	-.04	.07		

Notes: ^a Models include controls for age, SES, agreeableness and neuroticism. *c* = total effect, *c'* = direct effect. *a*₁ = Trait self-forgiveness - Positive Affect, *a*₂ = Trait self-forgiveness - Safe / Content Affect, *a*₃ = Trait self-forgiveness - Negative Affect, *a*₄ = Trait self-forgiveness – Self-Compassion Total Score. *b*₁, Positive Affect – Guilt, *b*₂, = Safe / Content Affect – Guilt, *b*₃, = Negative Affect – Guilt, *b*₄ = Self-Compassion Total Score Safe - Guilt. *a*₁, *a*₂, *a*₃, *a*₄ = regression coefficients of *X*₁, *X*₂, *X*₃, *X*₄, respectively. *b*₁, *b*₂, *b*₃, *b*₄ = regression coefficients of *M*₁, *M*₂, *M*₃, *M*₄, respectively. **p* < .05, ***p* < .01, ****p* < .001.

Abbreviations: LLCI, bootstrapping lower limit confidence interval, ULCI, bootstrapping upper limit confidence interval, SE, standard error with heteroscedasticity correction 3 (HC3).

4.5 Discussion

Salient reviews of the self-forgiveness research by Worthington (2006), Strelan and Covic (2006), and more recent reviews by Woodyatt, et al., (2017a), Woodyatt et al., (2017b) and Toussaint et al., (2017) highlight that whilst considerable progress has been made within self-forgiveness research over the past decade, a number of consistent issues and problems remain to be resolved.

Firstly, it is encouraging that a number of models of self-forgiveness have been developed over the past decade (e.g. Enright et al., 1996; Hall & Fincham, 2005; McConnell, 2015; Cornish & Wade, 2015a; Toussaint et al., 2017), these models use different definitions and measures of self-forgiveness that tend to focus on the hedonic component of self-forgiveness. Furthermore, whilst some of these models have been subjected to evaluation (e.g. Hall & Fincham, 2008; Cornish & Wade, 2015b, Exline et al., 2011), these models have yet to be fully evaluated.

Secondly, whilst some longitudinal studies have been undertaken over the past decade (Fischer & Exline, 2010; Hall & Fincham, 2008, Woodyatt & Wenzel, 2013), cross-sectional research based upon student populations continues to dominate self-forgiveness research (Woodyatt et al., 2017a). Thirdly, whilst some models include links between self-punishment, self-compassion and self-forgiveness (Enright et al., 1996; Cornish & Wade, 2015) that reflect the need to transform negative feelings and emotions to positive feelings and emotions, the relationships between these constructs is poorly understood. For example, what are the barriers to this process? Are reductions in self-punishment or increases in self-compassion likely to have a greater impact upon psychological health? Taken together, the issues of causality between what appear to be key variables such as self-forgiveness, self-condemnation and self-compassion remain essentially unanswered. Finally, no models of self-forgiveness have yet been developed that reflect the constructs of self-compassion, self-punishment and negative and safe / positive affects, especially in relation to the stress and coping model. It is these issues and gaps in the literature that guided the first study and this current research.

The purpose of Study 1 was to examine key features of the researcher's proposed model that addressed the gaps in the literature. This involved examining the mediating effects of: a) *adaptive* restorative coping strategies (CSR: Compassionate Self-Responding) and positive affect (activating affect and safe/warm affect), and b) *maladaptive* retributive coping strategies (USR: Uncompassionate Self-Responding) and negative affect upon the predicted relationships between trait self-forgiveness and a range of associated psychological health variables (psychological distress, shame and guilt).

Due to the very recent psychometric controversy involving the factor structure of the Self-Compassion Scale (SCS), where Neff et al., (2018) recommended the use of the

single-factor (SCS total score) rather than the bifactor (USR and CSR) composite scales, it was decided to undertake analyses using both the single and bifactor models. This was in addition to the effects of negative, positive and safe/content affects upon the relationship between trait self-forgiveness and the psychological health variables. In line with the reviewed research, the effects of a range of demographic variables (age, gender, culture/ethnicity, class, and religiosity/spirituality) and personality variables (neuroticism, agreeableness, narcissism and social desirability) upon these analyses were also controlled for.

Testing these relationships involved undertaking three pairs of parallel mediation analyses. Each pair of analyses involved testing the mediating effects Neff's bifactor model, and the single-factor model, together with the mediating effects of negative affect, positive affect and safe/content affect upon the relationships between trait self-forgiveness with psychological distress, shame and guilt. It is noted that subsequent references to the strength of the mediation effects sizes are made in line with the recommendations of Kenny (2018).¹

What follows is a brief summary and discussion of the results of the first study that will be further discussed in relation to the results of Study 2 and 3 in Chapter 7.

Trait self-forgiveness and psychological distress

After controlling for the effects of age, SES, neuroticism and agreeableness, only neuroticism was found to have a consistent significant effect upon the single and bifactor models. The only exception being for the Study 1 analyses involving trait self-forgiveness and psychological distress that were mediated by the total indirect effects of USR and CSR and negative, positive and safe/content affect, where age and neuroticism were found to have a negative confounding effect upon the models. In the single-factor analyses, trait self-forgiveness and psychological distress were mediated by the total indirect effects of the SCS scale and negative, positive and safe/content affect. It is noted that the finding associating increased neuroticism with reduced levels of self-forgiveness and self-compassion is in keeping with previously reviewed research

¹ Kenny (2018) recommends the following criteria for interpreting indirect standardised effect sizes; small (.01), medium (.09) and large (.25).

(Barnard & Curry, 2011), whilst the negative association between these variables and age was not. Given the known influence of life satisfaction upon age with self-forgiveness and self-compassion (Allemant & Steiner, 2012), it is suggested that this result may be linked with the greater preponderance of depressed participants within the clinical sample and the impact of accumulated loss as we age (Fernandes & Paul, 2017).

In line with the recommendations of Hayes (2018a), bootstrapping was undertaken as it establishes the level of significance for an indirect effect. The results indicated that in the first analysis, USR and negative affect had a moderate effect on the relationships between trait self-forgiveness and psychological distress, whereas neither CSR, positive and safe / content affect were found to exhibit a significant mediating effect. In the second analysis, only negative affect was found to have a moderate effect on the relationships between trait self-forgiveness and psychological distress, with neither the SCS total score, or positive and safe / content affect exhibiting a significant mediating effect (table 4.14)

Table 4.14. The total effects and completely standardised indirect effects, associated with the six parallel mediations.

Independent and dependent variable association	Correlated mediating variables and effects						
	Total effect	USR	CSR	SCS	NA	PA	SCA
Trait self-forgiveness with psychological distress.	-.20*	.12*	.06	--	-.08*	-.03	-.03
Trait self-forgiveness with psychological distress.	-.21*	--	--	-.08	-.09*	-.02	-.03
Trait self-forgiveness with shame.	-.36*	.10*	-.07	--	-.10*	-.02	-.06
Trait self-forgiveness with shame.	-.35*	--	--	.17*	-.10*	-.02	-.07
Trait self-forgiveness with guilt.	-.17*	-.10*	.01	--	-.13*	.02	.03
Trait self-forgiveness with guilt	-.17*	--	--	-.09*	-.13*	.02	.03

Abbreviations: USR, Uncompassionate self-responding; CSR, Compassionate self-responding; SCS Total, Self-Compassion Scale – Total score; NA, Negative affect; PA, Positive affect.

* = Significant indirect effect ($p = <.05$).

Trait self-forgiveness and shame

After controlling for the effects of age, SES, neuroticism and agreeableness, only neuroticism was found to have a significant impact on the total effects of the models. The first analyses found that trait self-forgiveness and shame were partially mediated by the total indirect effects of USR and CSR and negative, positive and safe/content affect. In the second analyses, trait self-forgiveness and shame were partially mediated by the total indirect effects of the SCS scale and negative, positive and safe/content affect.

The results of bootstrapping indicated that in the first analyses, USR and negative affect had moderate effects on the relationships between trait self-forgiveness and shame, with neither compassionate self-responding or positive or safe / content affect exhibiting a significant mediating effect. In the second analysis, the SCS total score and negative affect were found to have a moderate effect on the relationships between trait self-forgiveness and shame, with neither positive or safe / content affect exhibiting a significant mediating effect.

Trait self-forgiveness and guilt

After controlling for the effects of age, SES, neuroticism and agreeableness, only neuroticism was found to have a significant effect upon the models. The first analyses found that trait self-forgiveness and guilt were partially mediated by the total indirect effects of USR and CSR and the negative, positive and safe/content affect. In the second analyses, trait self-forgiveness and guilt were partially mediated by the total indirect effects of the SCS scale and negative, positive and safe/content affect.

The results of bootstrapping (see Table 4.14) indicated that in the first analyses, USR and negative affect had moderate effects on the relationships between trait self-forgiveness and guilt, with neither CSR or positive or safe / content affect exhibiting a significant mediating effect. In the second analysis, negative affect and SCS Total Score were found to have a moderate effect on the relationships between trait self-forgiveness and guilt, with neither positive and safe / content affect exhibiting a significant mediating effect.

These results indicate that USR and especially negative affect appear to be key mediating variables effecting the relationship between trait self-forgiveness and psychological distress, and to a lesser extent the relationship between trait self-forgiveness and shame and guilt. In contrast the indirect effects of the SCS Total score and negative affect yielded the only significant effect upon the trait self-forgiveness with shame and guilt, leaving the relationship between trait self-forgiveness and psychological distress and shame being mediated by negative affect alone. In explaining these results it is important to note that in the case of the partially mediated models, the direct effect confidence intervals were just below zero, suggesting that a larger sample size may have resulted in fully mediated models.

With regard to the recent controversy into the use of the SCS scales and recommendations against the use of the bifactor model (Neff, et al., 2018) highlighted in the literature review. This current study found very similar results between the bifactor and single-factor models, suggesting that the psychometric properties of the SCS did not effect the results of the analyses, a finding that contradicts the results and recommendations of Neff, et al., (2018). By way of background, previous research into the use of the SCS (Costa, et al., 2015; Lopez, et al., 2015; Montero-Martin, et al., 2016) found evidence supporting the use of the bifactor scores with non-clinical samples but not clinical samples (Neff, et al., 2017). Whilst research into the psychometric properties of the SCS is ongoing, one possible explanation for the findings of Study 1 is that the sample was obtained from both clinical and non-clinical populations suggesting that it may be appropriate to continue to utilise the bifactor model with mixed clinical and non-clinical populations. Future studies that utilize larger sample sizes would need to be undertaken to test this proposition.

These results also indicate that neuroticism was the dominant confounding variable to influence the effects of the mediators upon the relationships between self-forgiveness and psychological health. A finding that appears reflective of the findings of a range of previously reviewed self-forgiveness studies (e.g. Leach & Lark, 2004; Maltby et al., 2001; Macaskill, 2012, Mauger, Perry, Freeman & Grove, 1992; Walker & Gorsuch, 2002; Strelan, 2017) and self-compassion studies (Neff, Rude & Kirkpatrick, 2007; Barnard & Curry, 2011). By way of explaining these findings, it was suggested in the literature review that it is useful to conceptualise personality traits as filters that shape one's perceptions of the transgressor, such as their ability to self-care,

and their worthiness and value. For example, an explanation for the negative associations between neuroticism, self-forgiveness and self-compassion could be that neuroticism makes transgressions feel more severe and painful. Furthermore, the self-condemnation that is felt about the transgression may lead to a preference for punishment rather than compassion, as compassion may be linked with condoning their behaviour (McCullough & Hoyt, 2002). Such a position may compromise individual's abilities to feel calm and reassure themselves because of increased painful affects (e.g. guilt, shame, anxiety, stress, depression).

One of the key findings of this study was that the combined effects of the USR sub-scales (self-judgment, isolation, and over-identification) and negative affect had a greater mediating effect upon the relationship between trait self-forgiveness and the psychological health variables than the CSR sub-scales (self-kindness, common humanity, and mindfulness) and positive and safe/content affect. Whilst the researcher is unaware of any comparative studies, these findings reflect the positive associations between the USR sub-scales and symptoms of depression in clinical samples (van Dam et al., 2011; Krieger et al., 2013), student samples (Mills et al., 2007), non-clinical samples (Ying, 2009; Hupfeld & Ruffieux, 2011). With the studies by Mills et al., (2007); Hupfeld and Ruffieux, (2011); van Dam et al., (2011); and Krieger et al., (2013) reporting stronger associations between the negative SCS sub-scales than the positive sub-scales and depression. More recently a systematic review and meta-analysis by Wilson, et al., (2018) confirmed this. Wilson et al., undertook a random effects analysis on the pre and post scores of SCS sub-scales with self-compassion linked interventions against controls, and found that the USR subscales demonstrated slightly stronger relationships than the positive sub-scales.

Having discussed the mediating effects of the SCS scale and the USR and CSR composite scales on the study findings, another key part of the proposed stress and coping model of self-forgiveness involved testing out Gilbert's (2005; 2009a) tripartite model of affect. This was undertaken through examining the mediating effects of negative affect, positive (activating) affect and safe / content affect upon the relationships between trait self-forgiveness and the psychological health variables (psychological distress, shame and guilt). The findings of this study suggest that in relation to the combined effects of the other mediating variables, negative affect played a consistent mediating role within the analyses, where as positive activating affect and

safe / content affect did not. This result is in keeping with the established associations between self-compassion and positive and negative affect (Leary, Tate, Adams, Allen & Hancock, 2007; Neff, Rude & Kirkpatrick, 2007; Yarnell & Neff, 2013), the self-forgiveness literature (Thompson et al., 2005; Yao, Chen, Yu & Sang, 2016; Romero, et al., 2006) as well as the influence that self-compassion has upon the regulation of negative affect and improved psychological health (Barlow et al., 2017; Diedrich et al., 2017; Findlay-Jones, 2015; Scoglio et al., 2015; Vettese et al., 2011).

The emergence of negative affect as a key mediator within this current study appears to confirm its importance upon the relationships between self-compassion self-forgiveness and psychological health (Barnard & Curry, 2011; Orth, et al., 2007; Strelan, 2017). However, within this current study this finding was not replicated with regard to positive affect and safe / content affect. Therefore, the findings of this current study do not appear to support Gilbert's (2005; 2009) tripartite model of affect, and suggest that in relation to the combined effects of the other mediating variables, positive activating affect and safe / content affect did not have a significant mediating effect upon the relationships between trait self-forgiveness and psychological distress, shame and guilt.

At present there are no comparative studies that have examined self-forgiveness, self-compassion and safe / content affect, making the negative findings of this study unique. Whilst safe / content affect was not found to have a mediating effect on the relationship between trait self-forgiveness and the psychological health variables, this current study did find that in comparison with positive and negative affect, safe / content was the most strongly positively correlated with trait self-forgiveness, USR, CSR, the SCS Total scale score, and as strongly negatively correlated with negative affect. These findings suggest more research is needed into the effects of safe / content affect upon self-compassion and self-forgiveness.

Summary

In summary, the findings of Study 1 indicated the importance of USR and negative affect upon the relationship between increasing trait self-forgiveness and improved psychological health. This was especially the case with regard to trait self-forgiveness and psychological distress (anxiety, depression and stress) where USR and

negative affect were found to mediate this relationship. With regard to the relationship between trait self-forgiveness with shame and guilt, USR and negative affect were found to partially mediate these relationships. When the confounding effects of a range of socio-demographic and personality variables were included in these analyses, neuroticism emerged as having a significant effect upon these analyses. Together these results suggest that the combined effects of self-judgment, isolation, over-involved thinking and negative affect work together when controlled for the influence of neuroticism, to affect relationship between trait self-forgiveness and psychological health. This was especially the case with regard to psychological distress (anxiety, depression and stress) and less so with shame and guilt. These findings will be further explored and discussed in relation to the findings of Study 2, where the interactions between what appear to be key variables will be explored over time.

CHAPTER 5.

5.0 Study 2

Researchers who have advanced the stress and coping literature to better understand the processes of self-forgiveness (Strelan & Covic, 2006; Worthington, 2006; Toussaint et al., 2017), and self-compassion (Allen & Leary, 2010; Sirois et al., 2015), point out that the literature is dominated by cross-sectional research whose findings are biased through the use of undergraduate psychology student samples. Therefore, there is a clear need for more longitudinal research using clinical samples if the greater advances in self-forgiveness and self-compassion research are going to be progressed over the next decade and beyond.

Having examined aspects of the stress and coping model of self-forgiveness, and bearing in mind these criticisms, it was decided to undertake a longitudinal study to better understand the causal relationships between the variables under study, as well as affording the opportunity to control for variables that may influence these relationships over time (Barker, Pistrang & Elliott, 2002). This purpose yielded two specific aims.

5.1. Study 2 aims

The first aim of Study 2 was to examine how the proposed model performed with a sample of clinical participants who has chosen to participate in a 12-week Compassion Focused Therapy (CFT) group. This was undertaken through evaluating changes in participant's measures of self-forgiveness, self-compassion, affects (positive, negative, safe/content), and a range of psychological health outcomes (psychological distress, shame, guilt) over four time points at assessment (T_0), week 1 (T_1), week 6 (T_2), and week 12 (T_3) of the CFT group. The potential confounding effects of the identified socio-demographic and personality variables upon the group analyses were also examined.

The second aim of the Study 2 was to examine the relationships between the change scores of the above variables at weeks 1, 6, and 12 of the CFT group. A process that involved three stages:

1. The proposed relationship between trait and state self-forgiveness and a range of psychological health variables (psychological distress, guilt and shame) will be examined.
2. The mediating effects of Neff's (2003b) bifactor model (Compassionate Self-Responding and Uncompassionate Self-Responding), in addition to the effects of negative, positive and safe/content affects will be examined upon the relationship between trait and state self-forgiveness and the psychological health variables.
3. The mediating effects of Neff's (2003b) single-factor model of self-compassion represented by the Self-Compassion Scale total scale score, in addition to the effects of negative, positive and safe/content affects will be examined upon the relationship between trait and state self-forgiveness and the psychological health variables

These two aims yielded three hypotheses.

5.2 Hypotheses

1. It will be expected that participants will report levels of trait and state self-forgiveness, self-compassion (compassionate self-responding, uncompassionate self-responding composite score) and psychological health (reduced psychological distress, shame and guilt) that will not significantly differ between the time they were assessed for the CFT group and when they started the CFT group
2. It will be expected that after controlling for the effects of correlated demographic and personality variables, participants will report increased levels of trait and state self-forgiveness, self-compassion (compassionate self-responding, and SCS total) scores and safe affect, and reduced levels of uncompassionate self-responding, negative affect and psychological distress, shame and guilt as a result of attending the CFT group.
3. It will be expected that as a result of participating in the CFT group, the

association between trait and state self-forgiveness and improved psychological health (reduced psychological distress, shame, guilt) will be mediated through changes in participants' self-compassion scores (compassionate self-responding and uncompassionate self-responding, SCS total) and positive affect, negative affect and safe/warm affect scores.

5.3. Method

5.3.1 Design

This second study utilised a quasi-experimental single group non-random repeated-measures design (Cook & Campbell, 1979; Barker, et al., 2002). As part of their enrolment for the 12-week CFT course, participants completed the Study 1 measures before joining the group (T_0), at the beginning of the group (T_1), at week six (T_2) and at the end of the group (T_3). Demographic questions were included at the point of being assessed for the group (O_D). Using the nomenclature first developed by Campbell and Stanley (1966), the design can be described as $O_{D0}O_1 X O_2 X O_3$ where “ $O_0 O_1 O_2 O_3$ ” refers to the assessments at T_0, T_1, T_2, T_3 , and each “X” represents the two halves of the CFT skills intervention covering sessions 1 to 6 and 7 to 12 respectively.

5.3.2 Participants

Participants attending one of the three Waitemata District Health Board (WDHB) rural Community Mental Health Teams (CMHT) within the Rodney area of Auckland City were approached and assessed for suitability to attend a 12-week group-based CFT programme. This was facilitated though asking them to give consent to enter Study 1 and complete the questionnaire booklet. It is noted that participants were reassured that they did not have to enter Study 1 to be considered for the CFT group, participants could complete the questionnaires as part of the normal group assessment process. Data collection occurred over a period of 14 months during which the CFT group was run on four occasions.

The CONSORT clinical trial guidelines (Moher, et al., 2010) recommend the use of a flow chart to explain how participants enter studies. The flow chart for this study

(Table 5.1 below) identifies that a total of 78 clinical participants were enrolled for Study 1 (T_0) and for potentially joining Study 2 and CFT group. Subsequently, 21 participants withdrew their consent to attend the CFT group, either because they moved out of area or decided not to attend, leaving 61 participants who chose to participate in the CFT groups. Of these participants, a further 4 participants were unable to attend the first session, leaving 57 participants who completed the session 1 measures (T_1), 41 of whom completed the measures at Week 6 (T_2), and 39 of these participants completed the measures at (T_3). A total of 39 participants completed the measures at all four time points, the results of which were subjected to a repeated-measures analysis.

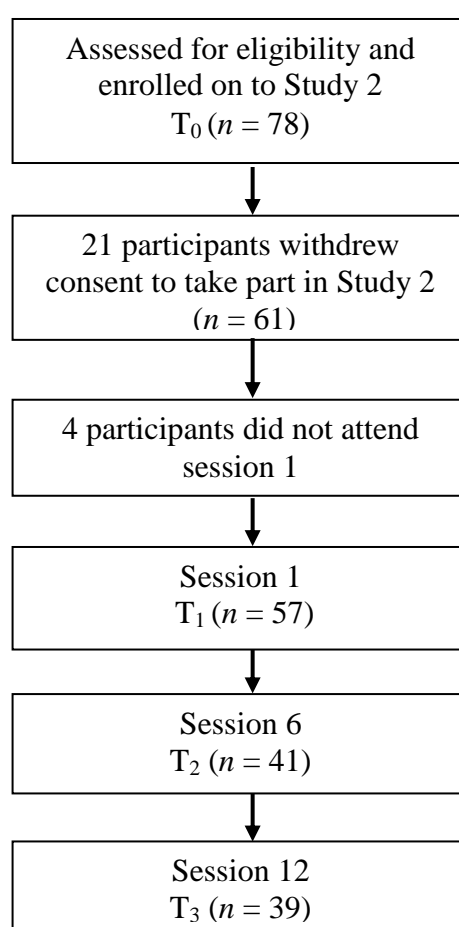


Table 5.1. Study 2 CONSORT flow chart

The mean age of participants enrolled into study 2 was 42.3 years ($SD = 11.35$), and the gender make up of the sample was 59% female 41% male which was slightly older and more gender balanced than Study 1 where the average age was 33.7 years ($SD = 12.9$) and 73% of the combined group were female. In order to identify whether the participant sample was reflective of the Auckland City population, comparisons were

made in relation to the NZ census data where available (Statistics New Zealand, 2013). Participants indicated that their relationship status was; Single (36.3 vs. 30.8% - sample), Married (48.8 vs. 28.2% - sample), De-facto relationship (12.8%), Divorced / Separated (24.6% vs. 28.2% - sample), and Widowed (0%).

Using the Level 1 New Zealand Statistical Standard for Ethnicity Classification (Statistics New Zealand, 2013), participants indicated that they came from a wide range of ethnic backgrounds, including; NZ/ European (52.3% vs. 79.5% - sample), Maori (10.7% vs. 10.8% - sample), Pacific Island peoples (14.6% vs. 2.6% - sample), Asian, (23.1% vs. 0% - sample), Middle Eastern / African / South American (1.9% vs. 0% - sample), and Other (7.1%). This meant that 12.9% of the sample were identified as coming from a collectivist culture and the remaining 87.1% were from a non-collectivist culture.

Using the eight occupational status criteria of the New Zealand Socioeconomic Index of Occupational Status Criteria 13, (Fahy, Lee, & Milne, 2017), participants identified that they came from the following socio-economic groups. The sample was very under-represented in terms of Managers (19.7% vs. 2.6% - sample); and Machinery Operators and Drivers (5.0% vs. 2.6% - sample), and over-represented in terms of Technicians and Trades Workers (11.4 vs. 23.1% - sample); Community and Personal Services Workers (7.9% vs. 12.8% - sample), and Sales Workers (9.1% vs. 12.8% - sample). The sample was equally represented in terms of Professionals (27.0% vs. 25.6% - sample); Clerical and Administrative Workers (13.3% vs. 12.8%) and Labourers (6.6% vs. 7.7% - sample).

Those who affiliated themselves with a religious or spiritual group identified themselves as Christian (47.6% vs. 43.6% - sample), no religion / Atheist / Agnostic (37.8% vs. 56.4 - sample). No one in the sample identified as coming from a Muslim, Jewish, Hindu, Sikh, Buddhist, or Other culture.

In summary, in comparison to the 2013 Auckland census data, the sample was five years older, than the average Aucklander (37 years). In addition, the sample comprised of two-thirds females to one-third males, contained fewer married people, who expressed lower levels of religious beliefs than the Auckland population. In terms of ethnicity, a greater number of participants identified themselves as NZ Europeans, an

equal number identified themselves as Maori, and fewer participants identified themselves as Pacific Peoples, Asians, African, Middle Eastern / South American. In terms of socio-economic groupings, comparisons to the Auckland population indicated a mixed picture. For example, the sample was very under-represented in terms of Managers and Machinery Operators and Drivers, and over-represented in terms of Technicians and Trades Workers, and Community and Personal Services Workers Sales Workers, but equally represented in terms of Professionals Clerical and Administrative Workers and Labourers.

5.3.3 Procedure

The study was based in the Rodney Adult Mental Health Service (RAMHS), which is part of Waitemata DHB. Participants were referred from the three CMHTs within RAMHS (Helensville, Red Beach, and Warkworth) and were assessed to confirm that they were suitable for the CFT group a process that involved enrolling in Study 1 provided they met the following criteria.

Inclusion criteria: Clients (18-65 years) who have been diagnosed with mood disorder and mild-moderate levels of depressive symptoms (with low risk) and who presented with symptoms of shame and self-criticism were asked if they wished to participate in the study.

Exclusion criteria: Participants who presented with the following issues were excluded from the group and the study. These included: An existing or past diagnosis of schizophrenia, current drug or alcohol abuse problems, high risk of harm to self/others; intellectual / developmental disabilities; or participants who had limited English language ability and whose physical or mental health, or whose mental or family/work commitments may compromise their ability to attend the CFT group.

Potential participants entered the study through two established DHB pathways (the Primary Care Pathway and the Recovery Pathway) that have historically been used to supply the existing CFT group that the researcher has been running in for the previous two years. The group utilised a manualised CFT approach (Kolts, 2011; 2014) that was adapted by the researcher the essence of which that is recognised within the CFT community as having high face validity (Gilbert, 2011). A session-by-session

outline of the CFT group can be found in table 5.2.

Table 5.2. Outlining the True Strength approach: A Compassion-Focused Therapy Approach for Working with Challenging Emotions (adapted from Kolts, 2014).

Session 1	Introduction to Compassion-Focused Therapy	<ul style="list-style-type: none"> • Introductions • The CFT approach to working with threat emotions. • Developing mindfulness and compassion • Homework: Mindful breathing
Session 2	The Three-Circles Model	<ul style="list-style-type: none"> • The three-circles model • Obstacles to the development of self-compassion • Homework: Mindful checking in diary
Session 3	Introduction to Compassion	<ul style="list-style-type: none"> • The compassionate-mind approach • Beginning imagery work • Homework: Compassionate self imagery
Session 4	Getting to Know the Threat Response	<ul style="list-style-type: none"> • Anger, anxiety and fear • Working with resistance to change our habits • Homework: Soothing-rhythm breathing
Session 5	Compassionate Thinking	<ul style="list-style-type: none"> • First steps to compassionate thinking • Changing self-criticism to compassionate correction • Homework: The threat emotion monitoring form
Session 6	Emotions and Attention	<ul style="list-style-type: none"> • What are emotions for and how do they work? • Understanding motives and emotions • Homework: Exploring our different emotions
Session 7	Learning to Change Difficult Patterns	<ul style="list-style-type: none"> • Difficult habits and the brain. • Compassion Mind attributes • Homework: Caring for yourself as a child and adult
Session 8	Compassionate Imagery	<ul style="list-style-type: none"> • Compassionate imagery • Obstacles to using imagery • Creating a safe place • Homework: Building a compassionate image
Session 9	Compassionate Letter Writing	<ul style="list-style-type: none"> • Developing compassionate letters • Compassionate letters to yourself • Homework: Writing a compassionate letter to Yourself
Session 10	Extending compassion and forgiveness to others	<ul style="list-style-type: none"> • What is forgiveness? • The costs and benefits of forgiveness • Barriers to forgiveness • The process of forgiveness • Homework: Forgiveness meditations.
Session 11	Extending compassion and forgiveness to ourselves	<ul style="list-style-type: none"> • Guilt and shame • Over-responsibility • The process of self-forgiveness. • Homework: The REACH process
Session 12	Working with Difficult Situations	<ul style="list-style-type: none"> • Working with Emotional Habits: The RAGE Model • Accepting and enduring • Skills review • A word in parting.

Following discussions and assessment within the WDHB treating team, potential participants who fulfilled the group entry criteria were invited to take part in the study by their Keyworker (Recovery Pathway) or Primary Care Liaison clinician (PCL pathway). Clients who were interested in participating were supported to read through the Patient Information Sheet (see Appendix B, pp. 397-400) and gain consent to participate in Study 1 (see Appendix B, p. 401) the results of which formed part of their clinical assessment. Cultural support was available if requested and participant's keyworkers or Primary Care Liaison clinician were very sensitive to the possibility of coercion and make it very clear that the client's decision to participate would have no influence on their access to WDHB services including the possibility of attending the CFT group. Additional time was offered to ensure that participants had enough time to consider their decision.

Once participants had indicated that they wished to take part in the study, they were asked to give consent for Study 2 (see Appendix B, p. 402) and their names were provisionally placed on the CFT group waitlist until the primary researcher had scored the assessment questionnaires and finally confirmed their suitability to take part in the study. Participants continued to take part in their recovery within the team through case working but did not participate in any psychological therapy prior to attending the CFT group. The average waiting time to start the CFT group was 9 weeks (range 4 to 14 weeks).

Once there were on average 18 people to commence the group (range 16-20) a letter was sent out the participant outlining when and where the group was going to take place, as well as some information about the CFT group (see Appendix E, pp. 414-417). Upon commencing the CFT group (week 1), participants were asked to recomplete the questionnaire booklet by an associate team member who was not involved in the research. Further data was collected using the same process at week 6 and 12 of the CFT group. All data was passed on to the Primary Researcher for processing where all data was de-identified. As part of the usual clinical process, participants were offered a review session a month after completing their questionnaires during which they were given feedback about their questionnaire outcomes the results of which were used to guide their recovery within the team. This part of the process did not form part of the research.

5.3.4 Measures

Participants were asked to complete the same non-copyrighted questionnaires in both Study 1 and 2. As these questionnaires have already been described in detail Chapter 4, Section 4.3.4, they will only be itemised here:

Independent variable

- Trait Self Forgiveness - Heartland Forgiveness Scale, HFS-S (Thompson, et al., 2005)
- State Self-Forgiveness – The State Self-Forgiveness Scale, SSFS (Wohl et al., 2008)

Dependent variables

- Psychological distress – DASS-21 (Lovibond & Lovibond, 1995).
- Shame and Guilt - The State Shame and Guilt Scale, SSGS (Marschall, Sanftner, & Tangney, 1994).

Potential mediating variables

- Self-Compassion, SCS (Neff, 2003). Compassionate Self-Responding (CSR), Uncompassionate Self-Responding (USR), and the Self-Compassion Scale Total Score (SCS-Total)
- Positive and Negative Affect – The Positive and Negative Affect Scale, PANAS (Watson, et al. 1988).
- The Safe/Content Affect sub-scale of the Two Types of Positive Affect Scale, TTPAS (Gilbert, et al., 2008).

Potential confounding variables.

- Socio-economic variables - age, gender, class, culture/ethnicity, religiosity / spirituality. Class was identified by participant's current or last occupation

according to the *New Zealand Socioeconomic Index of Occupational Status criteria-06*, (Milne, et al., 2013). Culture/ethnicity was identified according to the Level 1 classification (NZ European, Maori, Pacific Islander, Asian, Middle Eastern / African / South American, Other) devised by the NZ Statistical Standard for Ethnicity Classification (Statistics New Zealand, 2013). Religiosity/Spirituality was measured using the Intrinsic Religiosity (IR) sub-scale of the Duke University Religion Index, DUREL (Koenig & Bussing, 2010).

- Personality variables - The Neuroticism and Agreeableness scales of the Big Five Inventory, BFI (John, 1990). The Single Item Narcissism Scale, SINS (Konrath, et al., 2014). The Marlow Crowne Social Desirability Scale – Short Form 10, MCSDC-SF 10 (Straham and Gerbasi, 1972).

5.3.5 Analysis

The study analyses were performed in three stages; preliminary examination of the data, correlation analyses, and mediation analysis. The researcher analysed all data using SPSS-25 (IBM, 2017) where the alpha was set at $p. = <.05$.

The first stage of the analysis involved examining the independent, dependent, and mediating variable data from the 39 participants who returned data at assessment (T_0) and weeks 1 (T_1) in relation to the statistical assumptions associated with the Paired T-Test (Field, 2018). The same variable data from the same participants at weeks 1, 6, 12, (T_1 , T_2 , T_3) were then examined in relation to the statistical assumptions associated with One-Way Repeated-measures ANOVA outlined by Field (2018).

There were two reasons for using these separate analyses. Firstly, the time difference between T_0 and T_1 varied between participants, but on average was nine weeks, and was greater than the static six week time period between T_1 , T_2 and T_3 time-points. This created an unbalanced design that may have reduced the statistic power of the of a single repeated-measures ANOVA test that was used. Secondly, separating the analyses in this way would more clearly differentiate the T_0 and T_1 results from the CFT group results.

In line with the researcher's theoretical model in Study 1, and because of the possibility that these personality variables might change as a result of attending the group (Roberts, et al., 2007). The group data (T_1 , T_2 , T_3) were examined for significant correlations between the independent, dependent, and mediating variables and any of the static socio-demographic variables (age, gender, SES, culture) and changes in religiosity / spirituality, and in the personality variables (neuroticism, agreeableness, social desirability, narcissism). The data was checked for the assumptions for repeated ANCOVA, including normality (see Appendix A Tables A3 – A6, pp. 351-356), and linearity (Figures A14-A23, pp. 344-347) and were found to be suitable for undertaking One-Way Repeated-measures ANCOVA.

The second stage of the analysis involved creating change scores for the independent, dependent, and mediating and control variables. These were obtained through subtracting each participant's post-test data (week 12) scores from the pre-test data (week 1) scores. It is noted that the use of change scores has been criticised for their unreliability (see Gulisken, 1987 for a review). However, Trafimow (2015) points out that this assertion has subsequently been challenged by a number of researchers (e.g., Chiou & Spreng, 1996; Thomas & Zumbo, 2012) who assert that change scores are reliable under certain circumstances. These circumstances include, how reliable the measures are, the size of the true correlation of the change scores, and whether the variances are equal or unequal. Trafimow (2015) went on to undertake two types of analyses to examine the influence of these issues. Firstly, he assumed equal variances and explored the reliability of the difference scores as a function of the reliabilities of the individual tests and the true correlation. Secondly, after taking into account the possibility of unequal variances he explored the reliability of the difference scores as a function of; a), the reliabilities of the individual tests; b), the true correlation of the change scores; and c), the ratio of variances or standard deviations between the two tests. In conclusion, Trafimow (2015) found that.... *"the analyses demonstrate that, if the reliabilities of the individual tests are good, the reliability of the difference scores will be at least reasonable so long as the true correlation is not too large"* (p. 9). Trafimow went on to clarify that if the measures have good levels of reliability then the reliability of the change scores will be reasonable as long as the correlation between the change scores is below .90. The only exception to this would be if the variances of the two tests were very different, such as when the deviation ratio is 4, and even under these circumstances the reliability of the changes scores would still be reasonable.

Trafimow's recommendations were used to predict the reliability of changes scores before deciding to proceed with their use.

Correlational analysis

Given the importance of identifying covariate associations between the control variables (socio-demographic and personality variables) with the independent, dependent and mediating variables, appropriate correlations (Pearson, Point Biserial, Cramer's V) were initially undertaken.

Mediation analysis

As in Study 1, the PROCESS (3.0) macro (Hayes, 2018b) was used to examine the relationships between self-forgiveness with psychological distress, shame and guilt, and the effects of a range of mediators and the hypothesised covariates (socio-demographic and personality variables). However, the small sample size of this study necessitated that modifications were made to the analyses.

Firstly, potential covariates were identified through examining the change score correlation matrix to establish significant associations between the independent, dependent, and mediating and control variables. After consulting the guidelines provided by Pan, Liu, Mao and Yuan (2018) regarding establishing the necessary sample size when undertaking longitudinal mediation analyses, it was concluded that the small sample size of this study would likely preclude the use of any covariates within the mediation analyses.

Secondly, as in Study 1, it was also decided once more to undertake parallel multiple mediations using PROCESS Model 4. This decision was made because undertaking multiple mediations made it possible to compare the indirect effects of each mediator allowing for studies to be replicated (Montoya & Hayes, 2016).

In line with the recommendations of Hayes (2013), 10,000 bootstrap re-samples were used to estimate bias corrected CIs of the proposed models together with a correction (HC3) for heteroscedasticity (Hayes & Cai, 2007). As in Study 1, the total effects (c), total indirect effects (c'), and the completely standardised indirect effects

(ab_{cs}) will be reported. Given the relatively small sample size of used in this study, the results of this research will be interpreted conservatively in relation to the obtained effect sizes (Ma & Zeng, 2014; Fritz & Mackinnon, 2007).

5.4 Results

5.4.1 Preliminary examination of the study data

In the first stage of the analysis, the data at assessment (T_0) and weeks 1 (T_1), were examined to ensure that they met the assumptions for using a Paired T-Test. Then the data at weeks 1 (T_1), 6 (T_2) and 12 (T_3) were examined to ensure that the data met the parametric assumptions for Repeated-measures ANOVA (Field, 2018).

Using the (± 2.00) skewness and kurtosis statistic value cut off (see Trochim & Donnelly, 2006; Field, 2000; 2009; Gravetter & Wallnau, 2014) the majority of the variable distributions were found to be normally distributed (see Appendix A, Tables A3 – A6, pp. 344-347). In line with the recommendations of Field (2018), the negatively skewed variables were subjected to reflection and log transformation ($\log(X_1)$) and all the positively skewed variables were all subjected to a log transformation ($\log(X_1)$).

The second stage of the analysis involved creating change scores for participant's independent, dependent, mediating and control variables. These were obtained through subtracting each participant's post data (week 12) scores from the pre-test data (week 1) scores. As previously discussed, Trafimow's (2015) recommendations for establishing the reliability of changes scores were applied to the dataset. Trafimow asserts that if the measures have good levels of reliability (e.g., $> .80$, Field, 2018), then the reliability of the change scores will be reasonable as long as the correlation between the change scores is below .90. The only exception to this would be if the variances of the two tests were very different, such as when the deviation ratio is 4, and even under these circumstances the reliability of the changes scores would still be reasonable. Given that the test measures had an average Chronbach's alpha of .89, the average significant true correlation between the independent, dependent and the mediating variables was .42 with a range of .34 to .70 (see Table 5.3, p. 177), and the average deviation ratio between changes scores at T_1 and T_3 was .56 with a range of .03 to 1.20 (see table 5.5,

p. 180), the dataset fulfilled Trafimow's (2015) recommendations and it was appropriate to use the obtained change scores for the purposes of Study 2. These change scores were then subjected to the regression and mediation assumptions (tests of linearity, homoscedasticity and normality of estimation error) outlined by Hayes (2018a) and were found to be suitable for Mediation analyses (see Appendix A (figures A24 – A44, pp. 374-385).

5.4.2 Correlational results.

Given the need to identify associations between the control variables and the independent and dependent variables prior to undertaking further possible analyses (e.g. ANCOVA, mediations), the correlations between the socio-demographic variables (Week 1) and the change scores of the socio-demographic and personality variables were first examined. This was followed by a broader analysis between trait self-forgiveness and the mediating and dependent variables.

Socio-demographic variables

Because of the small sample size, using the guidelines of Bonett and Wright (2000), non-parametric correlational analyses were performed between the socio-demographic variables and the independent, dependent, mediating and the psychological health variables (see Appendix A, Table A7, p. 348). There were no significant correlations with gender, SES and culture. However, increasing age was correlated with increased changes in agreeableness ($\rho = .35, p < .05$) and increasing religiosity / spirituality was associated with changes in state self-forgiving beliefs ($\rho = .38, p < .05$). Importantly, these results suggest that the majority of the socio-economic variables were unlikely to have a confounding effect on the analyses.

Personality variables

Bivariate non-parametric correlations were performed on the personality variables with the independent, mediating and dependent variable change scores. A full correlation matrix of the independent, dependent and mediating variable change scores can be found in table 5.3, (p.177). The results indicated that changes in agreeableness were positively associated with changes state self-forgiveness (ave. $\rho = .52$) and

negatively associated with changes in neuroticism (ave. $\rho = -.45$). There were no significant associations between social desirability and narcissism with state self-forgiveness. Furthermore, none of the personality variable change scores were associated with changes in any of the mediating variables (self-compassion and affect variables), or changes in the dependent variables (shame, guilt, psychological distress).

Associations between self-forgiveness and the dependent and mediating variables

As recommended by Baron and Kenny (1986), in order to undertake Hypothesis 3 and mediations analyses, it was first necessary to demonstrate significant associations between the independent, dependent and mediating variable change scores.

Trait self-forgiveness

Changes in trait self-forgiveness were positively associated with changes in state self-forgiving actions ($\rho = .65, p < .0001$), state self-forgiving beliefs ($\rho = .42, p < .001$), compassionate self-responding ($\rho = .48, p < .001$), the SCS Total scale score ($\rho = .53, p < .0001$), and were negatively associated with changes in uncompassionate self-responding ($\rho = -.45, p < .001$), guilt ($\rho = -.35, p < .01$) and negative affect ($\rho = -.34, p < .01$). Trait self-forgiveness was not significantly associated with changes in shame, psychological distress, positive and safe / content affect.

State self-forgiveness

Changes in state self-forgiveness were positively associated with changes in compassionate self-responding (ave. $\rho = .52$) and the SCS total change score (ave. $\rho = .66$), and negatively associated with changes in the uncompassionate self-responding change scores (ave. $\rho = -.67$). Changes in state self-forgiveness were negatively associated with the shame change scores (ave. $\rho = -.41$), and changes in state self-forgiveness actions were negatively associated with guilt ($\rho = -.45, p < .001$), but the association between state self-forgiveness beliefs and guilt was not significant at the .05 level. Neither of the state self-forgiveness variable change scores were associated with the psychological distress change score. Finally, state self-forgiveness was negatively associated with changes in negative affect (ave. $\rho = -.45$), but only the state self-forgiving self-beliefs change scores were negatively associated with increased changes

in positive affect ($\rho = .42, p < .05$) and safe content affect, but the latter was not significant at the .05 level. It is noted that the majority of these non-significant associations between the self-forgiveness variables and shame, guilt, and the mediating variables apart from psychological distress were very close to significance and that a larger sample size may have led to these associations becoming significant.

In summary, it was found that the majority of the socio-demographic variables were uncorrelated with the independent, dependent and mediating variables and were unlikely to have a confounding effect on any subsequent analyses. With regard to the effects of the personality variables, decreasing neuroticism and increasing agreeableness were the only personality variables to be correlated with state self-forgiveness, suggesting that the effects of neuroticism and agreeableness were the only potential confounding variables likely to effect any subsequent ANOVA or meditational analyses.

With regard to the associations between trait self-forgiveness, state self-forgiving feelings and actions, and state self-forgiving self-beliefs and the dependent and mediating variables. Trait self-forgiveness was found to be significantly associated with all but five variables (shame, psychological distress, self-kindness, common humanity, and isolation). State self-forgiving feelings and actions was found to be associated with all but one variable (psychological distress), and state self-forgiving self-beliefs was found to be associated with all but two variables (guilt and psychological distress). The implications for these results will be revisited and discussed later in this chapter, but essentially these results meant that the number of mediations that could be undertaken to test hypothesis 3 were reduced.

Table 5.3. Spearman bivariate correlations between all the change scores of the independent, dependent, mediating and personality variables (N = 39)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
1. HFS-SF																						
2. SFFS-SFFA ¹	.65***																					
3. SFFS-SFB ¹	.42*	.59***																				
4. SFFS-Total ¹	.58**	.84***	.91***																			
5. SCS-CSR	.48**	.56**	.48**	.59***																		
6. SCS-USR	-.45**	-.67***	-.66***	-.72***	-.67***																	
7. SCS-TOTAL	.53**	.70***	.63***	.72***	.92***	-.89***																
8. SCS-SK	.31	.50**	.54**	.59***	.90***	-.69***	.86***															
9. SCS-CH	.31	.46**	.41*	.51**	.86***	-.52***	.75***	.70***														
10. SCS-M	.58**	.53**	.42*	.55**	.89***	-.60***	.82***	.71***	.68***													
11. SCS-SJ	-.47**	-.61***	-.55**	-.60***	-.63***	.89***	-.78***	-.63***	-.49**	-.57***												
12. SCS-I	-.29	-.52**	-.58**	-.62**	-.55***	.81***	-.78***	-.58**	-.51**	-.54***	.62***											
13. SCS-O	-.44**	-.58**	-.57**	-.64***	-.56***	.85***	-.76***	-.61***	-.44**	-.47**	.67***	.65**										
14. SSGS-G	-.35*	-.45**	-.25	-.40*	-.48**	.60***	-.62***	-.46**	-.38*	-.42**	.51**	.52**	.53***									
15. SSGS-S	-.27	-.40*	-.43*	-.47**	-.43**	.69***	-.60***	-.46**	-.25	-.37*	.60***	.62***	.51***	.60***								
16. DASS-21 _{Total}	-.18	-.11	.01	-.04	-.01	.21	-.18	-.03	-.04	-.08	.16	.13	.30	.32*	.36*							
17. PANAS-NA	-.34*	-.41*	-.50**	-.48**	-.48**	.58***	-.60***	-.49**	-.31	-.49**	.50**	.51**	.47**	.57***	.71***	.34*						
18. PANAS-PA	.25	.39*	.46*	.44*	.57***	-.50**	.59***	.46**	.61***	.50**	-.37*	-.49**	-.39*	-.34*	-.42**	-.17	-.32*					
19. TTPAS-SC	.16	.28	.29	.37*	.62***	-.52**	.62***	.60***	.59***	.45**	-.40*	-.49**	-.38*	-.43**	-.29	-.06	-.38*	.61***				
20. BFI-N	-.17	-.48**	-.43*	-.53**	-.17	.13	-.18	-.12	-.16	-.28	.16	-.03	.17	-.01	.18	.19	.17	-.31	-.19			
21. BFI-A	-.04	.43*	.62***	.53**	.01	-.28	.20	.20	.15	-.01	-.20	-.16	-.25	.04	-.23	-.09	-.20	.18	.18	-.61***		
22. SINS	-.07	-.23	-.24	-.34	-.06	.01	-.05	-.17	-.05	-.01	.03	.09	.08	.00	.03	-.14	.03	.17	.18	-.02	-.12	
23. SDS	-.02	.21	.31	.30	.03	-.20	.14	.14	.05	-.07	-.02	-.34*	-.17	-.24	-.21	-.38*	-.12	.01	-.03	-.06	.26	.05

Abbreviations: HFS-SF, Heartland Forgiveness Scale - Self-forgiveness sub-scale; SFFS-SFFA, State Self-Forgiveness Scale – Self-Forgiving Feelings and Actions; SFFS-SFB, State Self-Forgiveness Scale - Self-Forgiving Beliefs; SCS-CSR, Self-Compassion Scale-Compassionate Self-Responding; SCS-USR, Uncompassionate Self-Responding; SCS-Total, Self-Compassion Scale Total score; SCS-SK, Self-Kindness; SCS-CH, Common Humanity; SCS-M, Mindfulness; SCS-SJ, Self-Judgment; SCS-I, Isolation, SCS-O, Overinvolved thinking; SSGS-G, State Shame and Guilt Scale-Guilt; SSGS-S, Shame; DASS-21 Total, Depression, Anxiety and Stress Scales - Total score.; PANAS-NA, Positive And Negative Affect Scales-Negative Affect; PANAS-PA, Positive And Negative Affect Scales -Positive Affect; TTPAS-SCA, Two Types of Positive Affect Scale-Safe/Content Affect; BFI-N, Big Five Inventory-Neuroticism; BFI-A, Big Five Inventory-Agreeableness; SINS, Single Item Narcissism Scale; SDS, Social Desirability Scale.

¹ N = 32

* $p. = < .05$, ** $p. = < .01$, *** $p. = < .001$

5.4.3 Group results

Hypothesis one proposed that participant's capacities for trait and state self-forgiveness, self-compassion, (compassionate self-responding, uncompassionate self-responding composite score), and psychological health (reduced psychological distress, shame and guilt) would not differ significantly between the time participants were assessed for the CFT group and when they started the CFT group

In order to test this hypothesis, a Paired Samples T-Tests was undertaken on the self-forgiveness variables, self-compassion variables, the affect variables, and the psychological health variables at assessment (T₀) and at week 1 (T₁) of the CFT group. The results of these analyses yielded no significant differences between variables at assessment and starting the CFT group, indicating the stability of these variables outside of a psychological intervention (Table 5.4).

Table 5.4. The results of a Paired-Samples T-test upon the independent, mediating and dependent variables between the assessment time-point (T₀) and week 1 (T₁) of the CFT group. (*n* = 39)

Variable	Assessment (T ₀) M (SD)	Week 1 (T ₁) M (SD)	<i>t</i>	Sig (2-tailed)
Trait self-forgiveness	19.77 (6.52)	19.18 (6.25)	1.58	.12
State self-forgiving feelings and actions	15.00 (5.39)	14.13 (4.50)	1.34	.19
State self-forgiving self beliefs.	21.30 (6.23)	20.31 (6.56)	.77	.45
Compassionate self-responding	29.62 (8.48)	29.41 (8.36)	.48	.63
Uncompassionate self-responding	52.41 (7.33)	51.46 (9.24)	1.34	.63
SCS Total score	55.21 (13.34)	55.95 (14.69)	-1.02	.31
Positive affect	23.26 (6.86)	23.28 (6.70)	-.04	.97
Negative affect	34.26 (7.68)	33.97 (8.19)	.73	.47
Safe / content affect	8.23 (3.24)	8.49 (3.53)	-.97	.39
Shame	17.77 (4.25)	17.54 (4.88)	.59	.56
Guilt	18.95 (4.01)	18.67 (4.86)	.61	.54
Psychological distress	36.39 (11.75)	36.12 (12.72)	.23	.81

Notes: M, Mean; SD, Standard deviation.

Hypothesis two proposed that after controlling for the effects of the correlated socio-demographic and personality variables, participants' would report increased levels of trait and state self-forgiveness, self-compassion (compassionate self-responding, SCS

total) scores and safe affect, and reduced levels of uncompassionate self-responding, negative affect, psychological distress, shame and guilt as a result of attending the CFT group.

Due to the identified associations changes between the control variables agreeableness, neuroticism with state self-forgiveness, a One-Way Repeated-measures ANCOVA with Bonferroni correction post-hoc tests were conducted upon the independent variables (trait and state self-forgiveness) at weeks 1 (T_1), 6 (T_2) and 12 (T_3) of the CFT group. A One Way Repeated-measures ANOVA with Bonferroni correction post-hoc tests was undertaken upon the remaining variables, including the self-compassion variables (compassionate self-responding, uncompassionate self-responding, SCS composite score), the affect variables (positive, negative and safe / content affect) and the psychological health variables (psychological distress, shame and guilt) over the same group time points. The results of these analyses can be found in Table 5.5 overleaf.

The results of these group analyses demonstrated that participants reported significant increases in trait self-forgiveness, compassionate self-responding and self-compassion, and reductions in uncompassionate responding across weeks 1, 6 and 12 of the CFT group. Participants also reported significant increases in positive and safe / content affect and reductions in negative affect, and reductions in psychological distress, shame and guilt across the time-line of the CFT group.

Table 5.5. The results of a One-way repeated-measures ANOVA upon the independent, dependent and mediating variables identifying group differences between weeks 1, 6 and 12 of the CFT group. (N = 39).

	Time 1 M (SE)	Time 2 M (SE)	Time 3 M (SE)	
Trait self-forgiveness	19.18 (1.00)	23.23 (0.92)	25.62 (1.23)	$F(2, 76) = 21.02, p = <.0001.$
State Self-Forgiveness – Feelings and Actions ^{a#}	14.12 (0.79)	17.07 (0.81)	21.31 (0.90)	$F(2, 58) = 9.91, p = <.0001.$
State Self-Forgiveness – Self Forgiving Beliefs ^{a b #}	20.31 (1.04)	23.28 (1.04)	27.41 (0.97)	$F(2, 56) = 4.37, p = .017.$
Uncompassionate Self-Responding	51.46 (1.48)	47.95 (1.29)	41.38 (1.50)	$F(2,76) = 31.50, p = <.0001.$
Compassionate Self-Responding	29.41 (1.34)	34.69 (1.31)	39.74 (1.36)	$F(2, 76) = 25.38, p = <.0001.$
Self-Compassion Total	55.95 (2.35)	64.82 (2.28)	76.41 (2.64)	$F(1.67, 63.36) = 36.19, p = <.0001.$
Positive affect	23.28 (1.07)	26.00 (1.41)	28.46 (1.33)	$F(2, 76) = 7.75, p = .001.$
Negative affect	33.97 (1.31)	30.54 (1.45)	29.92 (1.39)	$F(2, 76) = 16.52, p = <.0001$
Safe / Content affect	8.37 (0.57)	9.29 (0.48)	11.47 (0.58)	$F(2, 74) = 18.69, p = <.0001$
Psychological distress	37.15 (12.48)	31.03 (14.26)	25.49 (13.48)	$F(2, 76) = 17.66, p = <.0001.$
Shame	17.54 (0.78)	14.38 (0.79)	12.44 (0.81)	$F(2, 76) = 22.36, p = <.0001.$
Guilt	18.67 (0.78)	16.54 (0.80)	14.46 (0.81)	$F(2, 76) = 14.35, p = <.0001.$

M, Mean; SE, Standard Error

^a ANCOVA analyses were performed upon these variables where the covariates appearing in the model were evaluated at the following values: Neuroticism = -4.16, Agreeableness = 2.34. Age = 41.25,

^b Religiosity / Spirituality = .81.

[#] $n = 32$

Furthermore, the results of the ANCOVA found that participants reported increasing levels of state self-forgiveness feelings and actions across weeks 1, 6 and 12 of the CFT group $F(2, 58) = 9.91, p = <.0001$. Whilst the addition of neuroticism had a significant effect on the model, $F(2, 58) = 3.85, p = .03$, the addition of agreeableness $F(2, 58) = 1.59, p = .21$, and age, $F(2, 56) = 1.75, p = .18$, did not have a significant effect. Participants also reported increasing levels of state self-forgiveness self-beliefs, between Weeks 1, 6 and 12, $F(2, 56) = 4.37, p = .02$. Whilst the addition neuroticism ($F(2, 56) = 3.65, p = .03$) had a significant effect on the model, the addition of agreeableness, ($F(2, 56) = 3.04, p = .055$), religiosity / spirituality $F(2, 56) = 3.03, p = .06$, and age $F(2, 56) = 2.43, p = .10$ did not have a significant effect. These results indicate that reductions in neuroticism alone had a significant effect upon participants reported levels of state self-forgiveness over the course of the group.

Mauchly's test indicated that the assumption of sphericity was violated in the case of two out of the twelve variables tested; Uncompassionate self-responding ($\chi^2(2) = 7.57, p = .023$) where the degrees of freedom were corrected using Huynh-Feldt estimates of sphericity (epsilon = .879), and the Self-compassion total score ($\chi^2(2) = 10.37, p = .006$), that was corrected using Huynh-Feldt estimates of sphericity (epsilon = .834). See Appendix A. Table A20 (p. 353), for full details.

Post-hoc results revealed significant differences in participants' reports in all of the self-forgiveness, self-compassion, affects, and the outcome scores between weeks 1 and 12 of the CFT group (table 5.6 overleaf). Participant's scores between week 1 and 6 had also improved significantly for all the variables apart from positive affect and safe /content affect where there was no significant improvement, however in both of these cases, participant's scores did increase significantly between week 6 and 12. In contrast, with trait self-forgiveness and positive affect there were significant improvements between weeks 1 and 6, but there was no significant difference in these variables between weeks 6 and 12. The full results can be found in Appendix A, Tables A8 – A19 (pp. 349-352).

Table 5.6. The results of a post-hoc Bonferroni analysis across weeks 1 to 6, weeks 6 to 12, and weeks 1 to 12.

	Week 1-6	Week 6-12	Week 1-12
HFS-SF	$p = <.0001$	$p = .078$	$p = <.0001$
SSFS-FA	$p = <.01$	$p = <.0001$	$p = <.0001$
SSFA –SFB	$p = <.01$	$p = <.0001$	$p = <.0001$
SCS-USR	$p = <.05$	$p = <.0001$	$p = <.0001$
SCS-CSR	$p = <.01$	$p = <.0001$	$p = <.0001$
SCS-Total	$p = <.0001$	$p = <.0001$	$p = <.0001$
PA	$p = .063$	$p = .33$	$p = <.01$
NA	$p = <.05$	$p = <.01$	$p = <.01$
SCA	$p = .30$	$p = <.0001$	$p = <.0001$
SSGS-S	$p = <.0001$	$p = <.05$	$p = <.0001$
SSGS-G	$p = <.05$	$p = <.05$	$p = <.0001$
DASS-42 Total	$p = <.05$	$p = <.05$	$p = <.0001$

Abbreviations: HFS-SF, Heartland Forgiveness Scale- Self-forgiveness sub-scale; SSFS, State Self-Forgiveness Scales – Feelings and Actions; SSFS-SB, Self-forgiving Beliefs; SCS-CSR, Self-Compassion Scale-Compassionate Self-Responding; SCS-USR, Uncompassionate Self-Responding; SCS-SJ, SCS-Total, Self-compassion Scale Total Score; SSGS-G, State Shame and Guilt Scale-Guilt; SSGS-S, Shame; PANAS-NA, Positive And Negative Affect Scale-Negative Affect; PANAS-PA, Positive Affect; SCA - Safe/Content Scale; DASS42-Total - Depression Anxiety Stress Scale 42 Total score

Overall, this suggests that participating in the 12-week CFT programme was associated with significant increases in participant’s capacity for trait and state self-forgiveness, self-compassion and compassionate self-responding, positive and safe / content affect, and reductions in uncompassionate self-responding, together with negative affect, shame, guilt and psychological distress. There were some variations between variables over time. For example, the significant improvements in positive affect and safe / content affect only occurred during the second half of the CFT group, whereas, significant changes trait self-forgiveness, psychological distress and positive affect only occurred during the first half of the CFT group. This suggests that improvements in trait self-forgiveness tended to stabilise during the second half of the group, whereas it took time for participants to develop safe / content affect, this being especially the case with positive affect.

5.4.4 Mediation results

Hypothesis three proposed that, as a result of participating in the CFT group, the association between trait and state self-forgiveness and improved psychological health

(reduced psychological distress, shame, guilt) would be mediated through changes in participants' self-compassion scores (compassionate self-responding and uncompassionate self-responding, SCS total) and positive affect, negative affect and safe/warm affect scores.

This hypotheses was tested using parallel mediation (Model 4) analyses that were run using the PROCESS (3.0) macro (Hayes, 2018b). In accordance with Hayes (2013), 10,000 bootstrap re-samples were used to estimate bias corrected confidence intervals (CIs) together with a correction (HC3) for heteroscedasticity (Hayes & Cai, 2007). The use of parallel mediator models enabled the comparative effects of mediators to be studied and allow for studies to be replicated (Montoya & Hayes, 2016).

As mentioned earlier in this chapter, before mediations can be undertaken, Baron and Kenny (1986) state that it needs to be established that the mediators under test are significantly correlated with both the independent and dependent variable change scores. A section of the previously run Spearman correlation matrix that examined this analysis follows (table 5.7).

Table 5.7. Results of Spearman correlations upon the change scores the self-forgiveness variables upon the psychological health, self-compassion, and the affect variables.

Variable	HFS-SF ¹	SSFS-FA ¹	SSFS-SB
Guilt	-.35*	-.45**	-.25
Shame	-.27	-.40*	-.43*
Psychological distress	-.18	-.11	.01
Uncompassionate self-responding	-.45**	.67***	-.66***
Compassionate self-responding	.48**	.56**	.48**
Self-compassion Total score	.53**	.70***	.63***
Negative affect	-.34*	-.41*	-.50**
Positive affect	.25	.39*	.46*
Safe / Content affect	.16	.28	.29

HFS-SF, Heartland self-forgiveness scale; SSFS-FA, State self-forgiveness scale – Feelings and actions; SSFS-SB, State self-forgiveness scale – Self-forgiving beliefs.

¹ $n = 39$.

* $p. = < .05$, ** $p. = < .01$, *** $p. = < .001$

In summary, these analyses indicated that it was possible to undertake four pairs of parallel mediations involving the SCS bifactor and single models. The first pair of

mediations included examining the association between trait self-forgiveness and guilt with the bifactor mediators compassionate and uncompassionate self-responding and negative affect; and the association between trait self-forgiveness upon guilt with the single-factor mediator self-compassion total score and negative affect.

The second pair of mediations included examining the association between state self-forgiving self-beliefs and shame with the bifactor mediators compassionate and uncompassionate self-responding and negative and positive affect; and the association between state self-forgiving self-beliefs upon guilt with the single-factor mediator self-compassion total score and negative and positive affect.

The third pair of mediations included examining the association between state self-forgiving feelings and actions and guilt with the bifactor mediators compassionate and uncompassionate self-responding and negative and positive affect; and the association between state self-forgiving feelings and actions with guilt with the single-factor mediator self-compassion total score and negative and positive affect.

The fourth pair of mediations included examining the association between state self-forgiving feelings and actions and shame with the bifactor mediators compassionate and uncompassionate self-responding and negative and positive affect; and the association between state self-forgiving feelings and actions with shame with the single-factor mediator self-compassion total score and negative and positive affect.

Parallel mediations

1. Trait Self-Forgiveness – Guilt (Bifactor Model).

Results from the parallel mediation analysis indicated that the model accounted for 13.7.% of variance between trait self-forgiveness and guilt ($R^2 = .14$, $F(1, 37) = 5.67$, $p = .02$).

It was found that trait self-forgiveness significantly predicted a decrease in guilt, $\beta = -.29$, 95% CI $[-.53, -.04]$, $t = -2.38$, $p = .03$, and that when the direct effects compassionate self-responding, uncompassionate self-responding and negative affect were added to the model the relationship between trait self-forgiveness and guilt became

non-significant $\beta = -.06$, 95% CI $[-.29, .17]$ indicating that mediation had occurred (see Figure 5.1).

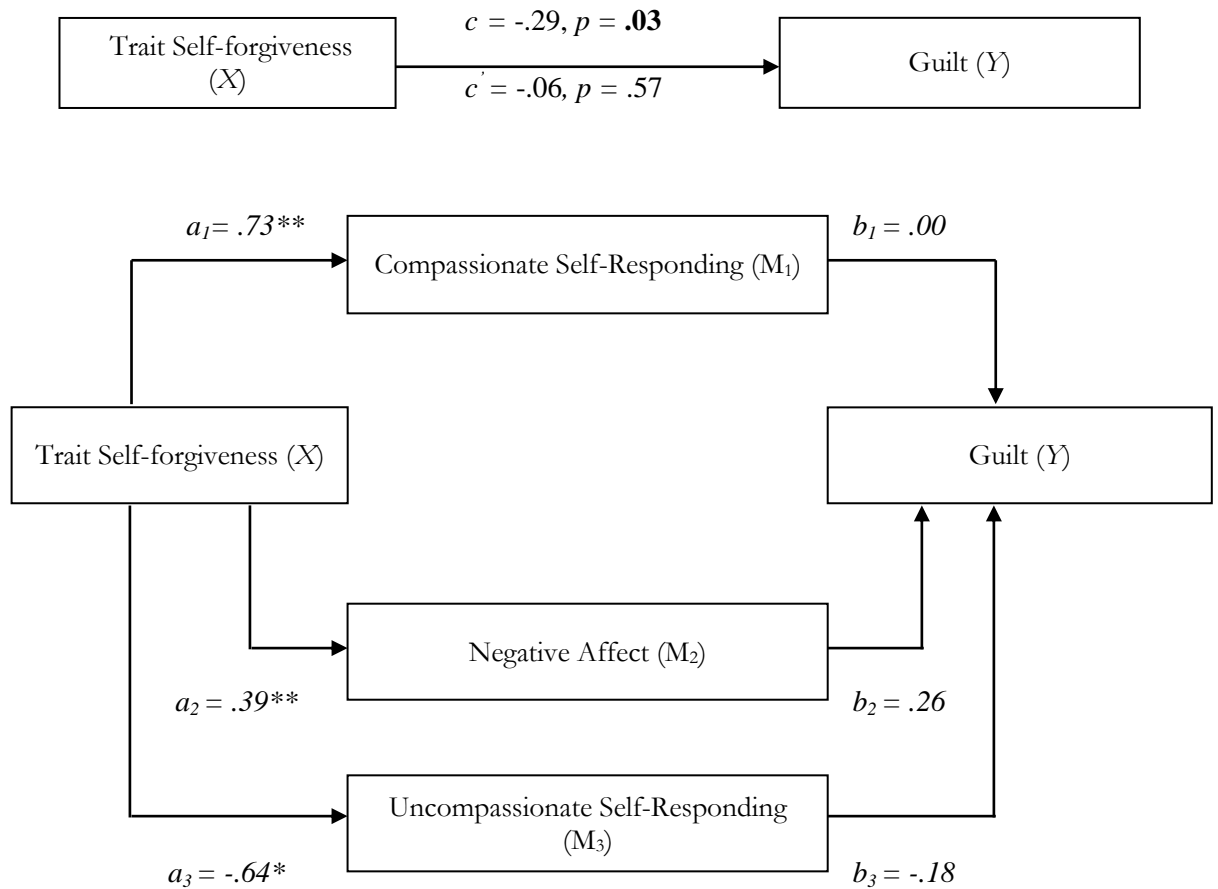


Figure 5.1. A path analysis model of trait self-forgiveness as a predictor of guilt, mediated by compassionate self-responding, uncompassionate self-responding and negative affect.

Notes: c = total effect, c' = direct effect. a_1, a_2, a_3 = regression coefficients of X_1, X_2, X_3 respectively. b_1, b_2, b_3 = regression coefficients of M_1, M_2, M_3 respectively. $*p < .05$, $**p < .01$, $***p < .001$.

A 95% bias-corrected confidence interval based on 10,000 bootstrap samples indicated that the total completely standardised effect of trait self-forgiveness on guilt through compassionate self-responding, uncompassionate self-responding and negative affect was $\beta = -.29$, 95% CI $[-.53, -.04]$. The effects of uncompassionate self-responding, $\beta = -.15$, 95% CI $[-.37, .11]$ and negative affect, $\beta = -.13$, 95% CI $[-.37, -.00]$ yielded the largest effect sizes, and compassionate self-responding the weakest effect size, $\beta = -.00$, 95% CI $[-.19, .25]$. These results indicated that the effects of negative affect alone mediated the association between trait self-forgiveness and decreasing guilt (see Appendix A, A21, p. 354).

2. Trait Self-forgiveness – Guilt (Single-factor model)

Results from the parallel mediation analysis indicated that the model accounted for 13.7% of total variance between trait self-forgiveness and guilt ($R^2 = .14$, $F(1, 37) = 5.67$, $p = .02$).

It was found that trait self-forgiveness significantly predicted a decrease in guilt, $\beta = -.28$, 95% CI $[-.53, -.04]$, $t = -2.38$, $p = .02$, and that when the direct effects of the SCS total score and negative affect were added to the model the relationship between trait self-forgiveness and guilt became non-significant $\beta = -.06$, 95% CI $[-.28, .16]$ $t = -.56$, $p = .58$, indicating that mediation had occurred (see figure 5.2).

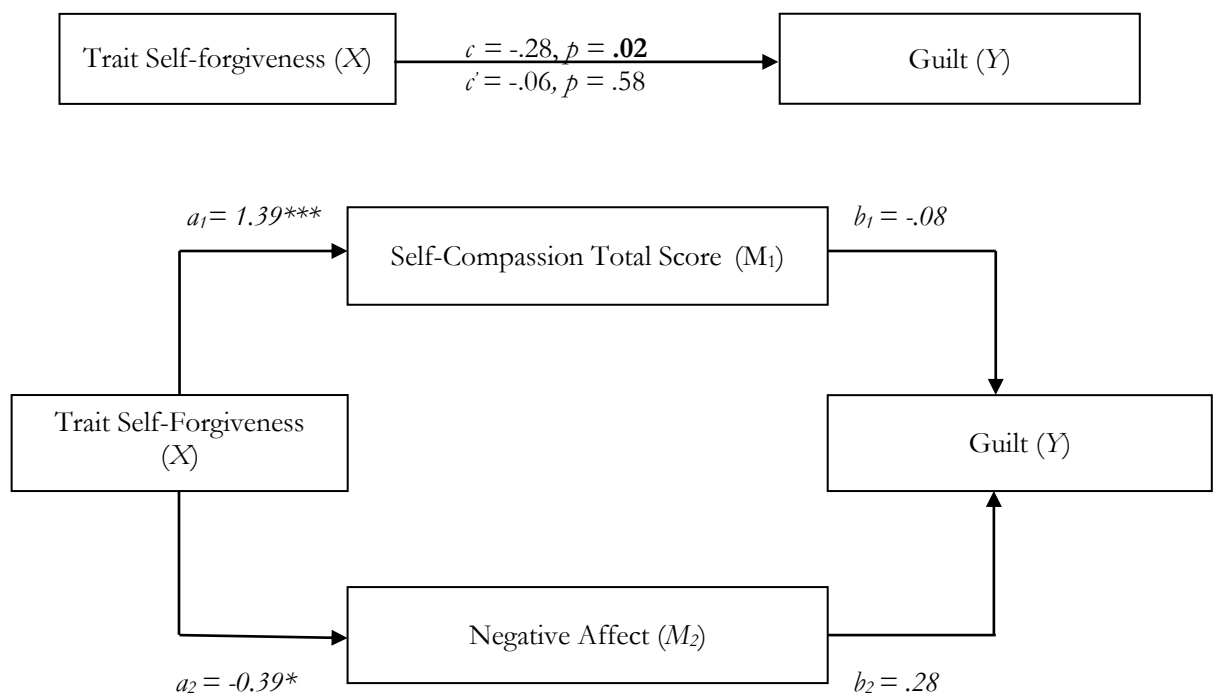


Figure 5.2. A path analysis model of trait self-forgiveness as a predictor of guilt, mediated by the SCS total scale score and negative affect.

Notes: c = total effect, c' = direct effect. a_1 , a_2 = regression coefficients of X_1 , X_2 , respectively. b_1 , b_2 = regression coefficients of M_1 , M_2 respectively. * $p < .05$, ** $p < .01$, *** $p < .001$.

A 95% bias-corrected confidence interval based on 10,000 bootstrap samples indicated that the total completely standardised effect of trait self-forgiveness on guilt through the SCS total score and negative affect was $\beta = -.29$, 95% CI $[-.55, -.06]$. The effects of the SCS total score, $\beta = -.15$, 95% CI $[-.37, .09]$ and negative affect, $\beta = -.14$, 95% CI $[-.39, -.00]$ yielded very similar effect sizes, but the effects of negative affect

alone mediated the association between trait self-forgiveness and decreasing guilt. (see Appendix A, Table A22, p. 355).

3. State Self-Forgiving Self-Beliefs – Shame (Bifactor model)

Results from the parallel mediation analysis indicated that the model accounted for 17.9% of variance between state self-forgiving self-beliefs and shame ($R^2 = .178$, $F(1, 30) = 6.36$, $p = .01$).

It was found that state self-forgiving self-beliefs significantly predicted a decrease in shame, $\beta = -.34$, 95% CI $[-.62, -.08]$, $t = -2.62$, $p = .01$, and that when the direct effects compassionate self-responding, uncompassionate self-responding and negative and positive affect were added to the model the relationship between state self-forgiving self-beliefs and shame became non-significant $\beta = -.11$, 95% CI $[-.06, .28]$, $p = .22$ indicating that mediation had occurred (see figure 5.3 overleaf).

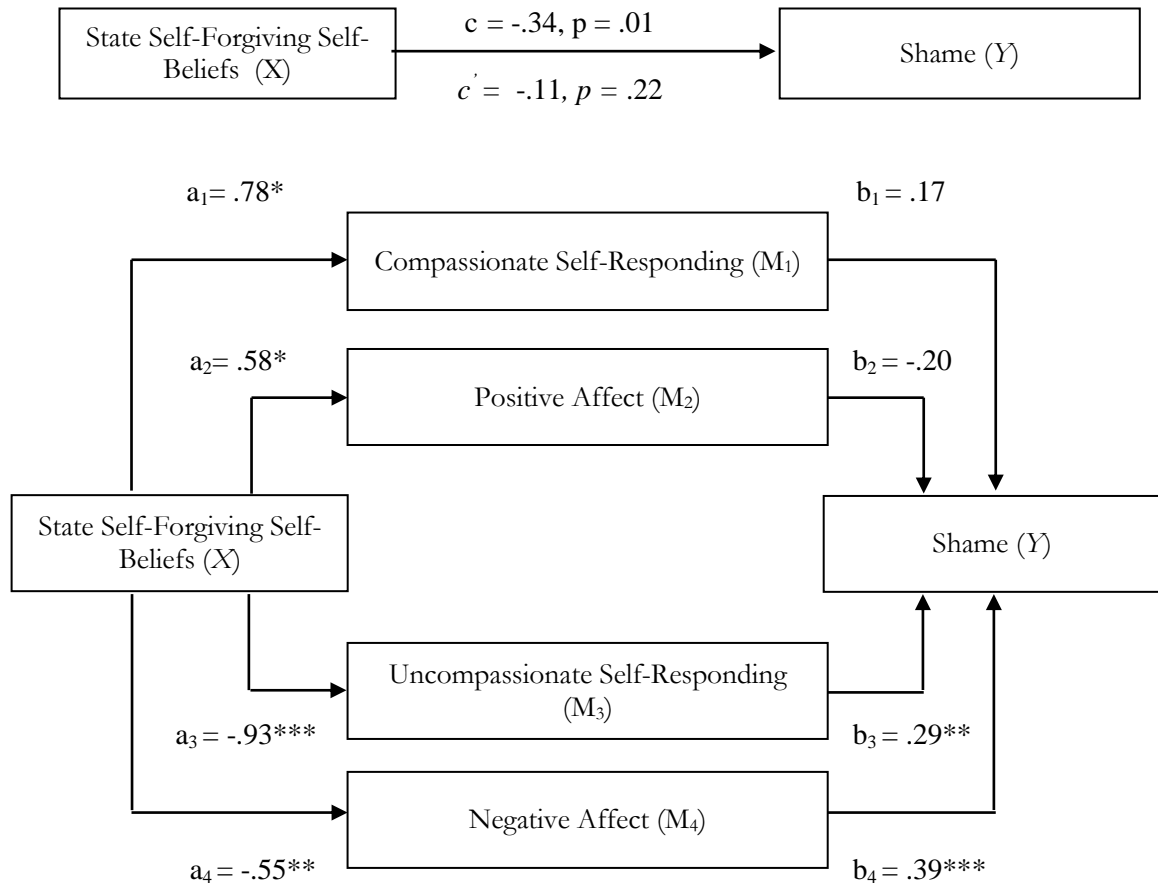


Figure 5.3. A path analysis model of state self-forgiving self-beliefs as a predictor of shame, mediated by compassionate self-responding, uncompassionate self-responding, negative affect and positive affect.

Notes: c = total effect, c' = direct effect. a_1, a_2, a_3, a_4 = regression coefficients of X_1, X_2, X_3, X_4 , respectively. b_1, b_2, b_3, b_4 = regression coefficients of M_1, M_2, M_3, M_4 respectively. $*p < .05$, $**p < .01$, $***p < .001$.

A 95% bias-corrected confidence interval based on 10,000 bootstrap samples indicated that the total completely standardised effect of state self-forgiving self-beliefs on shame through compassionate self-responding, uncompassionate self-responding, negative affect and positive affect was $\beta = -.55$, 95% CI $[-.82, -.31]$. The effects of uncompassionate self-responding, $\beta = -.32$, 95% CI $[-.57, -.06]$ yielded the largest effect size followed by negative affect, $\beta = -.26$, 95% CI $[-.45, -.11]$, followed by compassionate self-responding, $\beta = .16$, 95% CI $[-.07, .45]$, and positive affect, $\beta = -.14$, 95% CI $[-.19, .25]$. These results indicated that the effects of negative affect and uncompassionate self-responding mediated the association between state self-forgiving self-beliefs trait and decreasing shame (see Appendix A, Table A23, p. 356).

4. State Self-Forgiving Self-Beliefs – Shame (Single-factor model)

Results from the parallel mediation analysis indicated that the model accounted for 17.9% of variance between state self-forgiving self-beliefs and shame ($R^2 = .178$, $F(1, 30) = 6.36$, $p = .01$).

It was found that state self-forgiving self-beliefs significantly predicted a decrease in shame, $\beta = -.35$, 95% CI $[-.62, -.08]$, $t = -2.62$, $p = .01$, and that when the direct effects of the SCS total scale, and negative and positive affect were added to the model the relationship between state self-forgiving self-beliefs became non-significant $\beta = -.01$, 95% CI $[-.06, .32]$, $p = .93$ indicating that mediation had occurred (see figure 5.4).

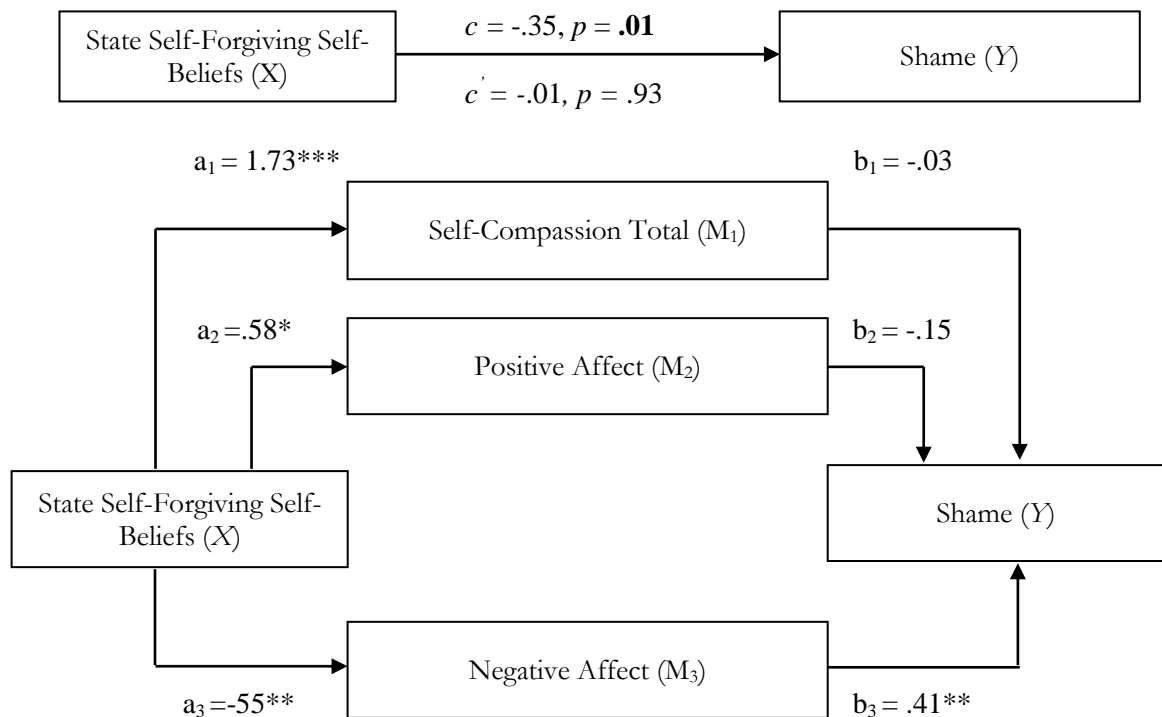


Figure 5.4. A path analysis model of state self-forgiving self-beliefs as a predictor of shame, mediated by the SCS total scale, negative affect and positive affect.

Notes: c = total effect, c' = direct effect. a_1, a_2, a_3 = regression coefficients of X_1, X_2, X_3 , respectively. b_1, b_2, b_3 = regression coefficients of M_1, M_2, M_3 , respectively. * $p < .05$, ** $p < .01$, *** $p < .001$.

A 95% bias-corrected confidence interval based on 10,000 bootstrap samples indicated that the total completely standardised effect of state self-forgiving self-beliefs on shame through the SCS total scale, negative affect and positive affect was $\beta = -.44$, 95% CI $[-.74, -.22]$. The effect of negative affect, $\beta = -.27$, 95% CI $[-.52, -.10]$, yielded

the strongest effect size, followed by positive affect, $\beta = -.11$, 95% CI $[-.38, .03]$, with the SCS total scale, $\beta = -.06$, 95% CI $[-.37, .21]$ yielding the smallest effect size. These results indicated that the effects of negative affect alone mediated the association between state self-forgiving self-beliefs and decreasing shame (see Appendix A, Table A24, p. 357).

5. State Self-Forgiving Feelings and Actions – Guilt (Bifactor model)

Results from the parallel mediation analysis indicated that the model accounted for 22.5% of variance between state self-forgiving feelings and actions and guilt, $R^2 = .225$, $F(1, 30) = 6.36$, $p = .03$.

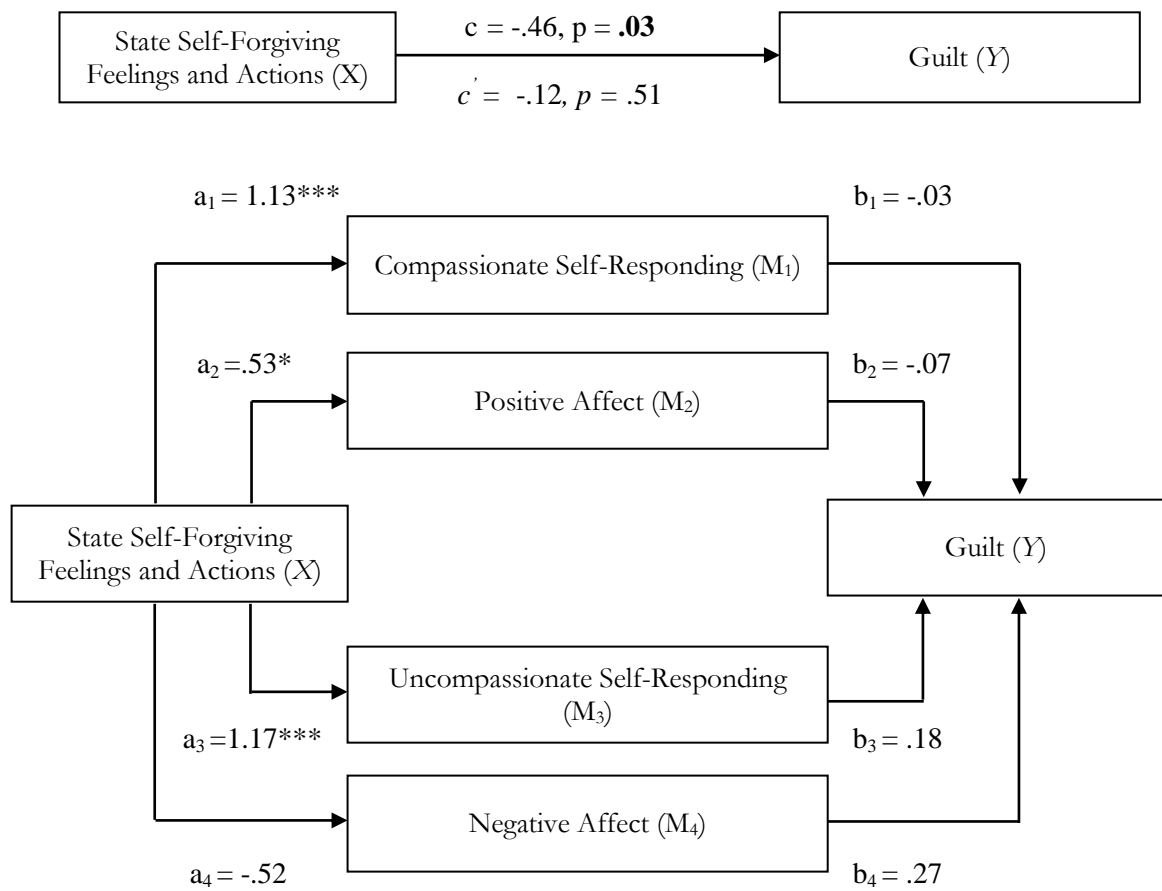


Figure 5.5. A path analysis model of state self-forgiving feelings and actions as a predictor of guilt, mediated by compassionate self-responding, uncompassionate self-responding, negative affect and positive affect.

Notes: c = total effect, c' = direct effect. a_1, a_2, a_3, a_4 = regression coefficients of X_1, X_2, X_3, X_4 , respectively. b_1, b_2, b_3, b_4 = regression coefficients of M_1, M_2, M_3, M_4 respectively. $*p < .05$, $**p < .01$, $***p < .001$.

It was found that state self-forgiving feelings and actions significantly predicted a decrease in guilt, $\beta = -.46$, 95% CI [-.86, -.06], $t = -2.36$, $p = .03$, and that when the direct effects compassionate self-responding, uncompassionate self-responding and negative and positive affect were added to the model the relationship between state self-forgiving feelings and actions and guilt became non-significant, $\beta = -.12$, 95% CI [-.49, .25], $p = .51$ indicating that mediation had occurred (figure 5.5 above).

A 95% bias-corrected confidence interval based on 10,000 bootstrap samples indicated that the total completely standardised effect of state self-forgiving feelings and actions on guilt through compassionate self-responding, uncompassionate self-responding, negative affect and positive affect was $\beta = -.35$, 95% CI [-.63, -.04]. The effect of uncompassionate self-responding, $\beta = -.21$, 95% CI [-.48, .28] yielded the largest effect size followed by negative affect, $\beta = -.14$, 95% CI [-.44, -.01], positive affect, $\beta = .04$, 95% CI [-.16, .17], and compassionate self-responding, $\beta = -.03$, 95% CI [-.27, .29] yielded the weakest effects. These results indicated that the effects of negative affect alone mediated the association between state self-forgiving feelings and actions and decreasing guilt (see Appendix A, Table A25, p.358).

6. State Self-Forgiving Feelings and Actions – Guilt (Single-factor model)

Results from the parallel mediation analysis indicated that the model accounted for 22.5% of variance between state self-forgiving feelings and actions and guilt, $R^2 = .225$, $F(1, 30) = 6.36$, $p = .03$.

It was found that state self-forgiving feelings and actions significantly predicted a decrease in guilt, $\beta = -.46$, 95% CI [-.85, -.06], $t = -2.35$, $p = .03$, and that when the direct effects of the SCS total scale, and negative and positive affect were added to the model the relationship between state self-forgiving feelings and actions became non-significant, $\beta = -.15$, 95% CI [-.51, .21], $p = .40$ indicating that mediation had occurred (see figure 5.6 overleaf).

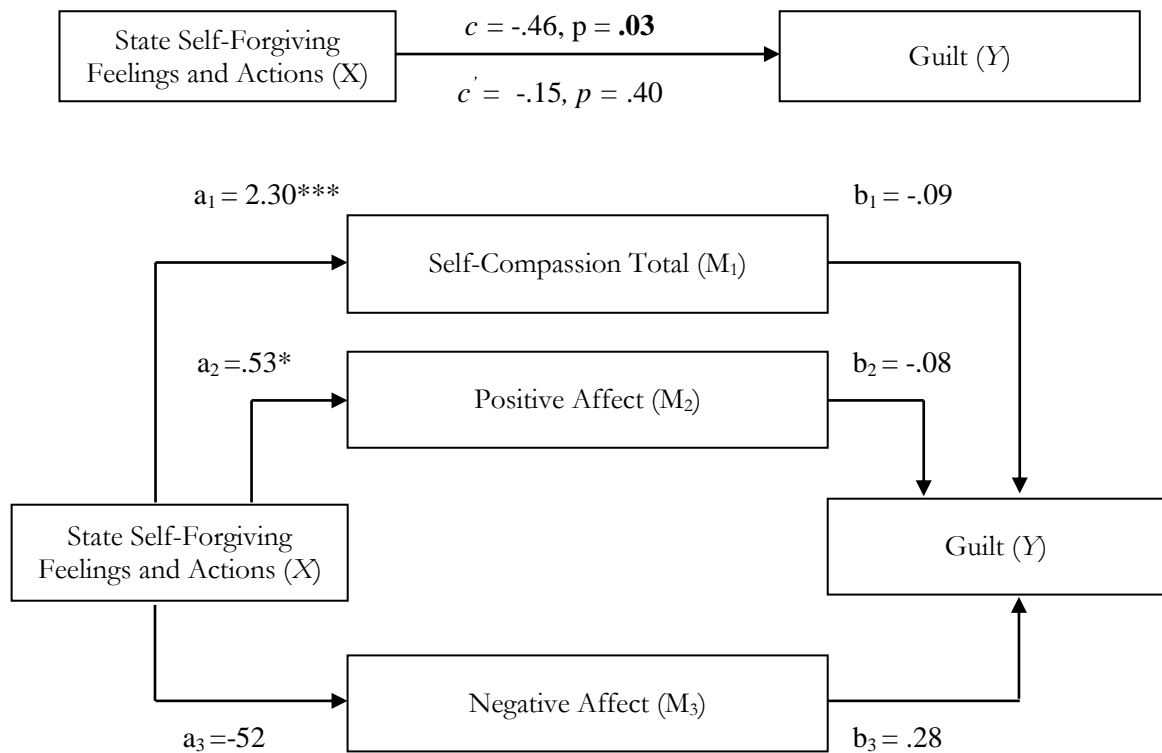


Figure 5.6. A path analysis model of state self-forgiving feelings and actions as a predictor of guilt, mediated by the SCS total scale score, negative affect and positive affect.

Notes: c = total effect, c' = direct effect. a_1, a_2, a_3 = regression coefficients of X_1, X_2, X_3 , respectively. b_1, b_2, b_3 = regression coefficients of M_1, M_2, M_3 , respectively. * $p < .05$, ** $p < .01$, *** $p < .001$.

A 95% bias-corrected confidence interval based on 10,000 bootstrap samples indicated that the total completely standardised effect of state self-forgiving feelings and actions self-beliefs through the SCS total scale, negative affect and positive affect was $\beta = -.32$, 95% CI [-.59, -.03]. The SCS total scale, $\beta = -.21$, 95% CI [-.49, .34] yielded the strongest effect size, followed by negative affect, $\beta = -.15$, 95% CI [-.44, -.01], with positive affect, $\beta = .04$, 95% CI [-.16, .17] yielding the smallest effect size. These results indicated that the effects of negative affect alone mediated the association between state self-forgiving feelings and actions and decreasing guilt (see Appendix A, Table A26, p. 359).

7. State Self-Forgiving Feelings and Actions – Shame (Bifactor model)

Results from the parallel mediation analysis indicated that the model accounted for 17.7% of variance between state self-forgiving feelings and actions and shame ($R^2 = .18$, $F(1, 30) = 6.35$, $p = .02$).

It was found that state self-forgiving actions significantly predicted a decrease in shame, $\beta = -.44$, 95% CI $[-.80, -.08]$, $t = -2.52$, $p = .02$, and that when the direct effects of compassionate self-responding, uncompassionate self-responding and negative and positive affect were added to the model the relationship between state self-forgiving feelings and actions and shame became non-significant $\beta = -.10$, 95% CI $[-.41, .21]$, $t = -2.52$, $p = .51$ indicating that mediation had occurred (see figure 5.7).

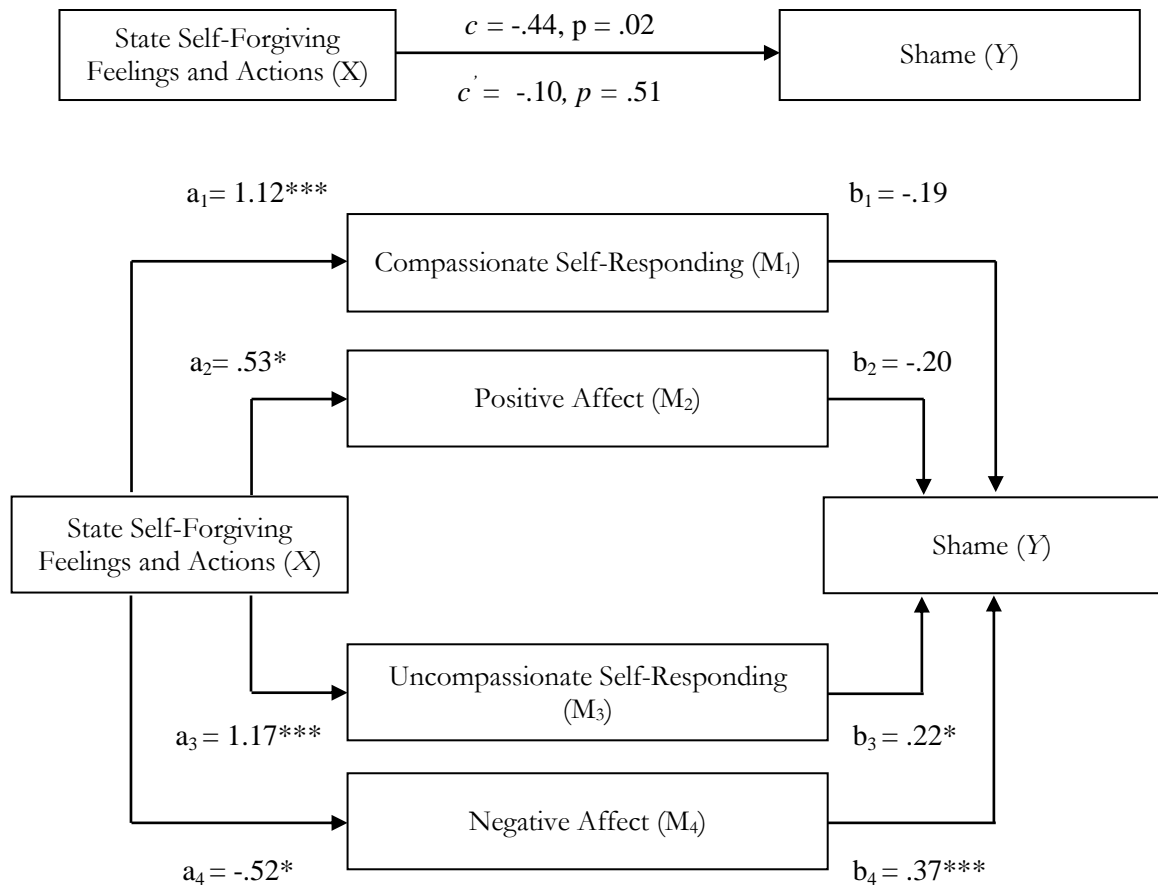


Figure 5.7. A path analysis model of state self-forgiving feelings and actions as a predictor of shame, mediated by compassionate self-responding, uncompassionate self-responding and negative affect and positive affect.

Notes: c = total effect, c' = direct effect. a_1, a_2, a_3, a_4 = regression coefficients of X_1, X_2, X_3, X_4 , respectively. b_1, b_2, b_3, b_4 = regression coefficients of M_1, M_2, M_3, M_4 respectively. $^*p < .05$, $^{**}p < .01$, $^{***}p < .001$.

A 95% bias-corrected confidence interval based on 10,000 bootstrap samples indicated that the total completely standardised effect of state self-forgiving feelings and actions on shame through compassionate self-responding, uncompassionate self-responding, negative affect and positive affect was $\beta = -.33$, 95% CI $[-.60, -.03]$. The effects of uncompassionate self-responding, $\beta = -.25$, 95% CI $[-.49, .05]$ and

compassionate self-responding, $\beta = .21$, 95% CI [-.04, .54] yielded the largest effect sizes, followed by negative affect, $\beta = -.18$, 95% CI [-.37, -.03], and positive affect, $\beta = -.10$, 95% CI [-.29, .25]. These results indicated that the effects of negative affect alone mediated the association between state self-forgiving feelings and actions and decreasing shame (see Appendix A, Table A27, p. 360).

8. State Self-Forgiving Feelings and Actions – Shame (Single-factor model)

Results from the parallel mediation analysis indicated that the model accounted for 17.7% of variance between state self-forgiving feelings and actions and shame ($R^2 = .18$, $F(1, 30) = 6.35$, $p = .02$).

It was found that state self-forgiving feelings and actions significantly predicted a decrease in shame, $\beta = -.44$, 95% CI [-.80, -.08], $t = -2.52$, $p = .02$, and that when the direct effects of the SCS total score and negative and positive affect were added to the model the relationship between state self-forgiving feelings and actions and shame became non-significant $\beta = -.16$, 95% CI [-.53, .23], $t = -.84$, $p = .41$ indicating that mediation had occurred (see figure 5.8 overleaf).

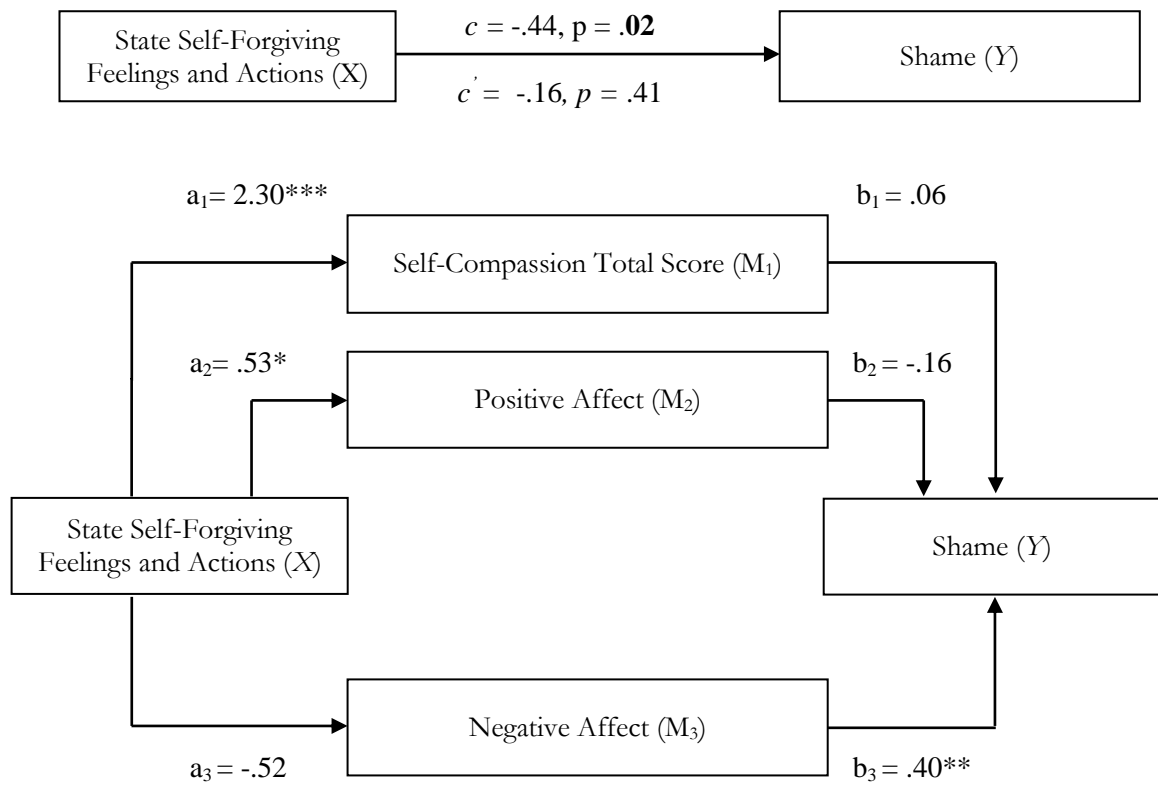


Figure 5.8. A path analysis model of state self-forgiving feelings and actions as a predictor of shame, mediated by the SCS total scale score, negative affect and positive affect.

Notes: c = total effect, c' = direct effect. a_1, a_2, a_3 = regression coefficients of X_1, X_2, X_3 , respectively. b_1, b_2, b_3 = regression coefficients of M_1, M_2, M_3 , respectively. $^*p < .05$, $^{**}p < .01$, $^{***}p < .001$.

A 95% bias-corrected confidence interval based on 10,000 bootstrap samples indicated that the total completely standardised effect of state self-forgiving feelings and actions on shame through the SCS total scale score and positive and negative affect was $\beta = -.27$, 95% CI $[-.55, -.01]$. The effects of negative affect yielded by far the strongest effect size, $\beta = -.20$, 95% CI $[-.43, -.03]$, followed by positive affect, $\beta = -.08$, 95% CI $[-.30, .02]$, and the SCS total scale score that yielded the weakest effect size, $\beta = .01$, 95% CI $[-.29, .39]$. These results indicated that the effects of negative affect alone mediated the association between state self-forgiving feelings and actions and decreasing guilt (see Appendix A, Table A28, p.361).

5.5 Discussion

Reviews of the self-forgiveness research by Worthington (2006), Strelan and Covic (2006), and more recent reviews by Woodyatt, et al., (2017a), Woodyatt et al., (2017b) and Toussaint et al., (2017) indicate that whilst considerable progress has been made within self-forgiveness research over the past decade, a number of consistent issues and problems remain to be resolved.

Firstly, it is encouraging that a number of self-forgiveness models have been developed over the past decade (e.g. Enright et al., 1996; Hall & Fincham, 2005; McConnell, 2015; Cornish & Wade, 2015a; Toussaint et al., 2017), but these models have yet to be properly evaluated (Cornish et al., 2017; Woodyatt et al 2017a). Secondly, cross-sectional research based upon student populations continues to dominate and very few longitudinal studies have been undertaken Woodyatt et al (2017b). Taken together this means that the issues of cause-and-effect between what appear to be key variables (e.g. self-forgiveness, self-compassion and self-condemnation) remain essentially unanswered. Finally, no models of self-forgiveness have yet been developed that reflect the constructs of CSR, USR, and negative and safe / positive affects, especially in relation to the stress and coping model. It was these issues and gaps in the literature that guided the first study and this current research.

After proposing and testing a theoretical model that addressed the gaps in the literature in Study 1, the researcher wanted to better understand the relationships between these variables over time. Consequently a second study was proposed to examine how the model performed longitudinally with clinical participants who had taken part in a 12-week intervention group designed specifically to increase participants' levels of self-compassion and positive and safe / content affects and reduce negative affects. It was expected that the findings of this second study would help answer a range of proposed hypotheses that aimed to provide more in-depth understandings into the relationships between the constructs under study and the expected processes of change. What follows is a brief summary and discussion of the CFT group results as well as the parallel mediations findings that were undertaken as part of Study 2.

5.5.1 Group results

The first hypothesis of Study 2 was formulated to enable the investigator to examine whether participants' test scores would naturally change during the waiting period between when they were first assessed for, and when they started the CFT group. Statistical analysis using paired T-Tests did not reveal any significant differences between these two time points for self-forgiveness, self-compassion, affects or psychological health variables. These results were as expected and reflect the relative stability of these constructs, and that participants did not receive any psychological input during this period. These results are consistent and supportive of previous self-forgiveness and self-compassion RCT treatment studies that used waitlist controls (Griffin, et al., 2014; Griffin, 2013; Neff & Germer, 2013).

The second hypothesis of Study 2 proposed those participants' capacities for self-forgiveness, self-compassion, affect and psychological health would improve as a result of participating within the CFT group. The results of a statistical analysis using repeated-measures ANOVA and ANCOVA demonstrated that participants reported significant increases in trait self-forgiveness, compassionate self-responding and self-compassion, and reductions in uncompassionate responding across weeks 1, 6 and 12 of the CFT group. Participants also reported significant increases in positive and safe / content affect and reductions in negative affect, and reductions in psychological distress, shame and guilt across the time-line of the CFT group. Whilst these findings appeared unrelated to the influence of potential control variables (age, agreeableness, religiosity), controlling for neuroticism did have a significant effect upon state self-forgiveness over the course of the CFT group. Findings which also reflects the findings of Brose et al., (2005) and Maltby et al., (2008) who found that of the Big-Five factors (Costa & McCrae, 1992), neuroticism was found to have the strongest associations with self-forgiveness.

These outcome findings are also consistent with previous conclusions drawn by Kirby et al., (2015), who undertook a meta-analysis that examined seven outcome variables in relation to the 12 RCT compassion focused interventions studies available at the time. Kirby et al reported significant moderate effect sizes for increases in compassion ($d = .559$), self-compassion ($d = .694$), and mindfulness ($d = .525$), and significant moderate reductions for depression ($d = .656$), anxiety ($d = .547$), life

satisfaction and happiness ($d = .540$), and a small to moderate effect size for psychological distress ($d = .374$). Given that study 2 utilised a clinical sample, the findings of this study appear to confirm Kirby's (2016) assertion regarding the effectiveness of CFT with clinical populations.

Study 2 has made a unique contribution to the CFT literature as this was the first CFT study to utilise measures of self-forgiveness. Whilst this makes the findings of this current study unique, it makes it hard to compare the study results with specific reference to any previous compassion-focused outcome research. Furthermore, in comparison with the self-compassion literature, there is very little outcome research on self-forgiveness. A recent review by Worthington, Griffin and Wade (2017) indicated that there were only six empirical studies of self-forgiveness interventions, and only one study by Cornish and Wade, (2015b) that utilised a measures of self-forgiveness and self-compassion, and this study was grounded in Emotion Focused Therapy (Greenberg, 2002) rather than CFT. Cornish and Wade (2015b) found that participants in the treatment condition reported higher levels of self-forgiveness and self-compassion, less self-condemnation and reduced psychological symptoms. These findings are consistent with the results of Study 2, suggesting that psychological health may improve through the acquisition of greater levels of self-forgiveness and self-compassion. It is noted that this finding is also reflective of the current researcher's model proposed in Study 1, and the work of Sirois, et al., (2015) and Toussaint et al., (2017) who independently proposed that increased self-compassion and self-forgiveness mediate the effects of self-critical thinking and lead to increased psychological well-being.

The findings of Study 2, linking improvements in self-forgiveness with improved psychological health reflects the findings of the recent review by Worthington et al., (2017) and the meta-analysis by Davis et al., (2015). For example, Worthington et al., (2017) conclude that self-forgiveness is a skill set that can be learnt, the effects of which can impact positively upon a range of mental health outcomes such as anxiety and depression. Furthermore, the meta-analysis by Davis et al., (2015) reviewed 65 study samples containing 17,939 participants that resulted in an aggregated a moderate effect size ($d = .45$) of self-forgiveness upon a range of psychological health variables involving measures of anxiety, depression, life satisfaction and quality of life.

In summary, the findings of Study 2 suggest that the participants benefitted significantly from taking part in the CFT group, with participants reporting significantly increased levels of self-forgiveness, self-compassion, positive and safe affect and improved psychological health involving reductions of psychological distress, shame and guilt. In conclusion, whilst the repeated measures design that was used precludes statements of causality, these positive results are consistent with findings from the CFT and the self-forgiveness outcome literature. Furthermore, Study 2 is unique in two aspects. Firstly, it is the only study to date that has directly examined the relationship between self-forgiveness and a range of psychological health variables over the course of a CFT intervention. Secondly, no other study has examined the influence of the positive and negative components of self-compassion, or the effects of positive, negative and safe / content affect over the course of a CFT intervention.

5.5.2 Mediation results

Having established that participants benefitted significantly from attending the CFT group, a third hypothesis was proposed. This was formulated to provide more in-depth understandings into the relationships between the constructs under study and the expected processes of change.

The third hypothesis stated that as a result of taking part in the CFT group, changes in the association between the participant's trait and state self-forgiveness and improved psychological health (reduced psychological distress, shame, guilt) would be mediated through changes in their self-compassion scores (compassionate self-responding and uncompassionate self-responding, SCS total), and in their positive affect, negative affect and safe/warm affect scores.

After establishing which of the independent and dependent variable change scores were significantly correlated with the mediating variable change scores (Baron and Kenny, 1986), this hypothesis was tested once more using parallel mediation analyses. It is noted that references to the strength of the mediation effects sizes were made in line with the recommendations of Kenny (2018)².

² Kenny (2018) recommends the following criteria for interpreting indirect effect sizes; small (>.01), medium (>.09) and large (>.25).

5.5.3 Parallel mediations

Correlational analyses yielded eight parallel mediation combinations, the results of which yielded some core findings and are summarised in Table 5.8.

Table 5.8. The total effects and completely standardised indirect effects, associated with the eight parallel mediations.

Independent and dependent variable association	Correlated mediating variables + effects					
	Total effect	USR	CSR	SCS - Total	NA	PA
Trait self-forgiveness with guilt	-.29	-.15	.00	--	-.13*	--
Trait self-forgiveness with guilt	-.29	--	--	-.15	-.14*	--
State self-forgiving self-beliefs with shame	-.55	-.32*	.16	--	-.26*	--
State self-forgiving self-beliefs with shame	-.44	--	--	-.06	-.27*	-.11
State self-forgiving feelings and actions with guilt	-.35	--	-.21	--	-.14*	.04
State self-forgiving feelings and actions with guilt	-.32	--	--	-.21	-.15*	.04
State self-forgiving feelings and actions with shame	-.33	-.25	.21	--	-.18*	.10
State self-forgiving feelings and actions with shame	-.27	--	--	.01	-.20*	-.08

Abbreviations: USR, Uncompassionate self-responding; CSR, Compassionate self-responding; SCS Total, Self-Compassion Scale – Total score; NA, Negative affect; PA, Positive affect. -- not correlated. * = Significant indirectly mediating variable ($p = <.05$).

The results of these parallel mediations indicated that trait self-forgiveness tended to predict smaller decreases in guilt effect sizes (range -.28 to -.29) compared to state self-forgiveness effect sizes with both shame and guilt (range -.34 to -.46). This finding may reflect the sensitivity of the state self-forgiveness scale (Wohl et al., 2008) in measuring improvements in the participant's self-beliefs and self-forgiving behaviour as progressed through the group. For example, the wording of the trait measure asks participants to focus upon tendencies towards self-forgiveness rather than considering their self-forgiving self-beliefs, feelings and responses that may change as a result of becoming more self-compassionate and less guilty and ashamed as they progressed through the CFT group.

Whilst the analysis revealed that all of these parallel mediations were mediated by their associated total indirect effects, bootstrapping results indicated that negative affect had the greatest indirect effect on the relationships between independent and dependent variables yielding moderate to strong effect sizes ($-.13$ to $-.26$) in the case of both the SCS single-factor and the bifactor models. The exception to this finding was the relationship between state self-forgiving feelings and actions with shame, where in addition to the negative affect, uncompassionate self-responding also had a strong mediating effect ($-.32$). These findings reflect that some of the strongest associations that were identified in this study were between the self-forgiveness and self-compassion variables. It may be that these findings reflect a bias within the self-forgiveness and self-compassion literature where they tend to be defined as hedonistic concepts involving the reduction of self-condemnation and the increase in positive affects. Alternatively the close relationships between self-compassion, self-criticism and depression demonstrated in Study 2, reflects recent reviews of self-criticism (e.g. Kannan & Levitt, 2013), and self-compassion, where self-criticism is often described as a dimension of depression (Gilbert, et al., 2004; Shahar, Engle, Hegde, Szepeswol & Arkowitz, 2012) and where the negative SCS scales have been identified as yielding stronger associations with depression (Korner et al., 2018).

It was noted in Study 1, that uncompassionate self-responding and negative affect emerged as mediators with regard to psychological distress but not shame and guilt, where they were found to only a partial mediating role. In Study 2, the mediating effect of negative affect was consistent, with uncompassionate self-responding only providing a mediating role between state self-forgiving self-beliefs with shame. However, further examination of the confidence intervals of the other mediations such as the mediating effect of CSR and USR upon state self-forgiving feelings and actions with guilt and shame, indicated many were just below zero suggesting that a larger study sample size may have resulted in these indirect effects becoming significant mediators. These results will be further explored and discussed in a later section.

The emergence of negative affect as a key mediator within this current study appears to confirm the importance of negative affect in the relationships within both the self-compassion and self-forgiveness literature (Barnard & Curry, 2011; Orth, et al., 2007; Davis et al., 2015). In comparison, in this study positive affect was found to be an inconsistent mediator, whilst and safe / content affect was consistently found not to

mediate the independent and dependent variables in spite of there being significant correlations between these variables. Therefore, the findings of this current study do not appear to wholly support Gilbert's (2005; 2009) tripartite model of affect. Specifically, that in relation to the combined effects of the other mediating variables, positive activating affect and safe / content affect in particular did not have a the significant mediating effect upon the relationships between trait and state self-forgiveness and psychological distress, shame and guilt.

Summary

In summary, the results of Study 2 suggest that participants reported that they had benefitted from taking part in the CFT group, with statistically significant increased levels of self-forgiveness, self-compassion, positive and safe affect and improved psychological health involving reductions of psychological distress, together with shame and guilt. Results that reflect the CFT and the self-forgiveness outcome literature. In order to provide a more in-depth understanding into the relationships between the constructs under study and the expected processes of change, parallel mediations were undertaken, the results of which yielded unique findings. Specifically, that changes negative affect had a medium mediating effect upon the relationships between trait self-forgiveness with guilt, state self-forgiving self-beliefs with shame, and state self-forgiving feelings and actions with guilt and shame. Results that broadly confirm and have advanced the findings of the few previous empirical studies that have linked self-forgiveness, self-compassion with changes in negative affect and improvements in psychological health (Matsuyuki, 2010; Griffin, 2014; Terzino, 2010; Inwood & Ferrari, 2018

CHAPTER 6

6.0. Study 3

Drawing upon the recommendations of Woodyatt et al (2017b), the first aim of Study 3 was to collect qualitative data to help contextualise the findings from the quantitative data obtained from Study 1 and Study 2. The second aim was to provide more detailed understanding of participants' experiences participating in the CFT group and the processes of change (Woodyatt & Gilbert, 2017).

6.1 Method

In addition to the quantitative methodology used in Study 1 and Study 2, in Study 3 it was decided to use a qualitative descriptive methodology using focus groups (Krueger & Casey, 2009) to collect data. This was undertaken for three reasons:

1. To act as an adjunct to the quantitative data collection methods through providing interpretations and explanations of the numeric data. For example, focus groups have high face validity and are useful in revealing understandings that are often difficult to access through directly answering questions within an interview or questionnaire format (Kitzinger, 2005; Liamputtong, 2007).
2. To provide in-depth understandings of hypothesised links between participants' perceptions, attitudes, beliefs and experiences of self-forgiveness, self-compassion and psychological health (Wilkinson, 1998; 2004). For example, focus groups offer researchers the opportunity to quickly access to a wide range of understandings and insights because they can offer a supportive environment to observe how participants interact in discussing sensitive issues (Underhill & Olmstead, 2003). Kitzinger (2005) asserts that how participant's communicate about topics of study can be empowering and *"may tell us as much, if not more about their knowledge and experience"* (p.58).

3. Finally, mixed methods approaches have been found to improve the validity of research findings (e.g., Freitas, Cunhan, Moscarola, 1996). Through triangulating previous research with both the study quantitative data and the qualitative data, it is possible to explore the links and discrepancies between what people indicate what they say and do (Conradson, 2005). This is especially important when undertaking research with participants who have experienced levels of shame and humiliation that may encourage them to present themselves in socially desirable ways (Frith, 2000; Liamputtong, 2007).

Whilst focus groups can precede and follow quantitative research, within the context of this study, the focus group method was conducted after quantitative data had been collected. In this way it was hoped to elicit participant's deeper ideas and reflections about the study constructs that developed during the course of the CFT group (Morgan, 1988; Kruger, 1994).

In terms of definition, Wilkinson (1998), quoting Beck, Trombetta and Shane, (1986), defines a focus group simply as “*an informal discussion among selected individuals about specific topics*” (p. 182). Wilkinson and subsequent reviewers of the focus group method (e.g., Wilkinson, 2004; Morgan, 2002; Kruger & Casey, 2009), tend to identify two types of focus group. The first type of focus group involves the use of a structured approach that is commonly involved in market research to seek specific answers to clients' questions. Whilst the second type utilises a less rigid structured approach that has been used extensively in social science research, and which seeks to understand participants' meanings about certain ideas or relationships between ideas. It is in relation to the latter that the method of the focus group was chosen for this study.

Whilst this data could have been obtained through individual interviews, focus groups offer a number of advantages. Firstly, focus groups enhance participation through peer interaction by eliciting ideas that might not emerge during individual interviews. Secondly, they provide an opportunity for participants to challenge each other's ideas resulting in collective sense-making that can be cultivated as it evolves. Thirdly, focus groups can reduce social compliance thus allowing the topic under study to be covered in more depth. Finally, focus groups have a greater capacity to minimise

interviewer talk-time whilst maximising participant talk-time (Wilkinson, 2004; Kidd & Parschall, 2000; Lederman, 1990).

6.1.1 Design

The design of the focus group followed the guidelines provided by Krueger and Casey (2009) who describe three stages of enquiry involving: planning, procedure (conducting the interviews) and analysis.

6.1.2. Planning

In undertaking designing and planning a focus group, Krueger and Casey point out that it is first important to establish the aims and objectives of the group. They go on to stress the importance of developing a focus group guide to plan the questions in order to meet these objectives.

Given the mixed method approach was taken, these aims and objectives reflected the hypotheses in Study 1 and Study 2. Krueger and Casey recommend that these objectives and questions reflect the four stages of the focus group (introductions, transition, in-depth investigation and closure) where there is shift in discussion from a general focus to a specific focus in relation to the study topics. Discussions with study stakeholders yielded a series of six topics that reflected the focus group objectives. From these discussions, a series of eight questions emerged that were then sequenced into a logical order. These questions were then piloted on three members of the first cohort of the CFT group resulting in an additional two questions (questions 8 and 9) being added in the final stage of the focus group to explore participant satisfaction. These included questions about what they had gained, liked and disliked about the group, as well as whether they had any ideas for improving the group. It is from this process that the final ten focus group questions emerged (see Table 6.1, overleaf).

Table 6.1. Outlining the focus group stages, aims / objectives and final questions that emerged from the design phase (taken from Kruger & Casey, 2009).

Focus group stage	Focus group aims and objectives	Focus group questions
Stage 1: Introduction.	To identify ideas and themes that have resonated with group members; a) without a specific focus, and b), in relation to themselves and their families.	1. Can you tell me what you have learnt as a result of participating in the group? 2. Can you tell me what you have learnt about yourself and your family (Whanau) as a result of participating in the group?
Stage 2: Transition	To identify participants' specific ideas about the links between developing their capacity for self-compassion and the impact that this has had on their beliefs about themselves and others.	3. How has learning about self-compassion affected your beliefs about yourself and others?
Stage 3: In-depth investigation	To identify participants' specific ideas about developing their capacity for self-compassion and the impact that this has had on their emotions. To identify participants' specific ideas about developing their capacity for self-compassion and the impact that this has had on their capacities for self-forgiveness To identify specific self-compassion skills that participants' feel will be helpful in sustaining their capacities for self-compassion and self-forgiveness.	4. How has learning about self-compassion affected you emotionally (e.g., anxiety, sadness, stress, shame, guilt)? 5. Can you tell me how learning about self-compassion has affected your ability to forgive yourself when you make mistakes? 6. Can you tell me what skills you have learnt in group that will help you to maintain your self-compassion and self-forgiveness in the future?
Stage 4: Closure	To summarise what has been discussed and clarify the understandings that have been reached	7. Of all the things we have talked about, what is the most important thing that you have learnt as a result of participating in the group? 8. Would you recommend the group and why? 9. Is there anything you would change about the group? 10. Have I missed anything out ... is there anything else that you want to say?

6.1.3. Procedure (conducting the interviews)

The focus groups took place in a community facility that was comfortable, accessible and confidential. Participants were seated in a U-shaped seating configuration with the principal researcher (the moderator) and co-facilitator (the assistant moderator) seated at the head of the table to ensure good eye contact with all participants. Recordings were made using a SONY ICD-PX440 digital audio conference recorder that was placed at the center of the table to also ensure a good recording of all of the participant's voices.

Of a total of 44 participants who attended the four CFT groups at week 1, 39 participants managed to complete the 12-week CFT group, all of whom all agreed to participate in a focus group that immediately followed the final session of each CFT group. The five participants who left the CFT group did so for various reasons (e.g. moved out of area, they decided that were not interested in the group focus, too anxious to attend) yielding a 8.9% drop out rate. It is noted that the audio-recording of the first focus group failed resulting in a loss of this focus group data ($n = 8$) leaving a final total of 31 participants from three focus groups whose data were available for analysis. It is noted that the socio-demographic breakdown of focus group participants (see Table 6.2 overleaf) was very similar to the clinical sample ($n = 80$), who started the CFT group at week 1 ($n = 44$), and those whose data was available for analyses ($n = 31$) upon completion of the group.

Table 6.2: A socio-demographic breakdown of participants in terms of age, gender, relationship status, ethnicity, socio-economic status and religious affiliation across the Clinical sample, the combined CFT group at week 1 (T₁), and the combined focus groups at week 12 (T₃).

	Clinical Sample <i>n</i> = 78	CFT group (Week 1) <i>n</i> = 44	Focus group (Week 12) <i>n</i> = 31
Age (years / SD)	40.5 (12.5)	41.2 (SD)	42.6 (SD)
Gender			
Male	30 (37.5%)	19 (38.0%)	16 (39.0%)
Female	50 (62.5%)	31 (62.0%)	26 (61.0%)
Relationship status			
Single	27 (33.8%)	16 (32.0%)	12 (29.3%)
Married	27 (33.8%)	14 (28.0%)	13 (31.7%)
De-facto relationship	10 (12.4%)	8 (16.0%)	5 (12.2%)
Divorced / Separated	16 (20.0%)	12 (24.0%)	11 (28.8%)
Widowed	0 (0%)	0 (0%)	0 (0%)
Ethnicity³			
NZ/ European	61 (76.2%)	39 (78.0%)	33 (80.5%)
Maori	8 (10.0%)	6 (12.0%)	5 (12.2%)
Pacific peoples	2 (2.5%)	1 (2.0%)	1 (2.4%)
Asian	1 (1.2%)	0 (0%)	0 (0%)
Latin American, Middle Eastern, African	1 (1.2%)	1 (2.0%)	1 (2.4%)
Other	7 (8.9%)	3 (6.0%)	2 (4.9%)
Socio-economic status⁴			
Managers	4 (5.0%)	3 (6.0%)	1 (2.4%)
Professionals	18 (22.5%)	12 (24.0%)	10 (24.4%)
Technicians and Trades Workers	14 (17.5%)	10 (20.0%)	11 (26.8%)
Community and Personal Services Workers	10 (12.5%)	7 (14.0%)	5 (12.2%)
Clerical and Administrative Workers	12 (15.0%)	6 (12.0%)	5 (12.2%)
Sales Workers	11 (13.8%)	7 (14.0%)	5 (12.2%)
Machinery Operators and Drivers	2 (2.5%)	2 (4.0%)	1 (2.4%)
Labourers	8 (10%)	1 (2.0%)	3 (7.2%)
Missing data	1 (1.3%)	0 (0%)	0 (0%)
Religious affiliation			
Christian	27 (33.8%)	20 (40.0%)	19 (46.3%)
Atheist/Agnostic	10 (12.5%)	0 (0%)	0 (0%)
Muslim	0 (0%)	1 (2.0%)	0 (0%)
Jewish	1 (1.3%)	0 (0%)	0 (0%)

³ Defined according to the Level 1 New Zealand Statistical Standard for Ethnicity Classification (Statistics New Zealand, 2005)

⁴ Defined according to the eight occupational status criteria of the New Zealand Socioeconomic Index (Milne, et al., 2013)

Hindu	0 (0%)	0 (0%)	0 (0%)
Sikh	0 (0%)	0 (0%)	0 (0%)
Buddhist	0 (0%)	5 (10.0%)	4 (9.8%)
Other	0 (0%)	0 (0%)	0 (0%)
None	41 (51.2%)	24 (48.0%)	18 (43.9%)
Missing data	1 (1.2%)	0 (0%)	0 (0%)

6.1.4. Analysis

Reviews of qualitative frameworks for collecting and analysing data in focus group research highlight that there is no preferred method of data analysis (Onwuegbuzie, Dickinson, Leech, & Zoran, 2009; Braun & Clarke, 2013).

Onwuegbuzie et al., (2009) and Braun and Clarke (2013) go on to summarise the range of analysis techniques that have been used in the analysis of focus group data, such as Constant Comparison Analysis (Glaser, 1978, 1992; Glaser & Strauss, 1967), Classical Content Analysis (Morgan, 1997, Krippendorff, 2004), Keywords-In-Context (Fielding & Lee, 1998), Interpretative Phenomenological Analysis (Smith & Osborn, 2003), Discourse Analysis (Potter & Wetherell, 1987) and Thematic Analysis (TA: Aronson, 1994; Boyzantis, 1998; Braun & Clarke, 2006). Of these methods, TA was the method of analysis chosen for this study because it is a valid approach that has been used extensively to analyse focus group data (Braun & Clark, 2013).

Braun and Clark developed the TA method that has been used extensively within qualitative psychological research and they define TA simply as “*a method for identifying, analysing, and reporting patterns (themes) within data*” (p. 6). Braun and Clarke (2013) point out that unlike other qualitative methods, TA is not tied to any particular theoretical or epistemological position and can be used across a range of approaches. Whilst TA has been criticised for its “anything goes” approach, its strength is that it allows researchers to access the richness of a data set. Furthermore, Braun and Clarke highlight that TA skills can be easily learnt and provides researchers with a powerful, flexible analytic approach that allows researchers the opportunity to undertake both a “bottom-up” experience-driven approach to develop a detailed understanding of phenomenology, experience and ideas, as well as a “top-down” theory-driven approach to explore the relationships between theory and ideas. Braun and Clarke also highlight that TA can be undertaken at a semantic or explicit level, or at a deeper latent or interpretative level (Boyzantis, 1998). In the case of this study, a

deductive and semantic approach was undertaken, as the researcher wanted to try and understand the reality of participants' descriptive experiences in relation to proposed theoretical relationships between self-forgiveness, self-compassion, affect and psychological health as a result of completing a CFT group intervention.

Braun and Clarke (2006) highlight that when undertaking TA research it is vital to be clear about the methodology that is being used and the rationale for its use. They highlight that qualitative research has been criticised for a lack of methodological rigor and transparency (Attride-Sterling, 2001). In response, Braun and Clarke (2006) developed a six-stage approach when undertaking TA analyses that is outlined in Table 6.3, which will be used to inform and clarify the data analyses applied in Study 3.

Table 6.3: Phases of thematic analysis (taken from Braun & Clark, 2006, p. 87)

Stage	Name	Process
1	Familiarising yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial codes.
2	Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3	Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4	Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a 'thematic map' of the analysis.
5	Defining and naming themes:	Ongoing analysis to refine the specifics of each and the overall story the analysis tells, generating clear definitions and names for each theme.
6	Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back to the analysis and the research question and literature, producing a scholarly report of the analysis.

The researcher began the first phase of the process by *becoming familiar* with the data through transcribing and de-identifying the content of the three focus groups recordings. Once complete the researcher began to critically making sense of the data,

the product was used as the basis for the second phase involving *generating initial codes*. Braun and Clarke (2013) define coding as “*a process of identifying aspects of the data that relate to your research question*” (p. 206). They go on to identify three types of coding: selective coding (specific instances of the phenomena that are of interest); complete coding (identifying anything that is of interest to the research questions) and researcher-driven latent codes that reflect conceptual and theory-driven interpretations of the data. Because the researcher wanted to undertake a data-driven ‘bottom-up’ approach to inform the quantitative studies, the researcher undertook complete coding in relation to each of the focus group questions.

Codes tend to be the same units of text (words or phrases) that are data-driven and reflect the semantic content of the data that are later organised into themes. In order to improve the validity and reliability of the codes and themes, Braun and Clarke (2013) recommend that at least two investigators come to an agreement about defining each code as well as perform separate analyses before coming to a consensus about the ‘best fit’ of analysis to answer the research question. This process has been termed ‘dialogical intersubjectivity’ (Sandelowski & Barroso, 2007). This involved the primary researcher and his supervisors (KvK and JF) independently reviewing the transcripts on repeated occasions then meeting to identify and review the codes and themes to a point where general agreement was obtained (Brinkmann & Kvale, 2015).

Having obtained agreement, the researcher began the third phase involving *Searching for themes*. Braun and Clarke (2006) state that a theme comprises a ‘central organising concept’ that tends to be composed of many coded ideas that ‘*capture something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set*’ (p. 82). They assert that developing themes from coded data is an active process that involves looking for areas of broad overlap between candidate themes. These themes were subsequently reviewed and revised with my supervisors to help improve their validity and reliability.

The fourth phase involved *Reviewing the themes* through using a process that Braun and Clarke term *Developing Analysis*. This process involved identifying a hierarchy of relating themes (overarching themes, themes and sub-themes) that can be visually mapped by developing thematic maps to explore their relationships. Braun and Clarke (2013) caution against developing too many themes and suggest that the process

should be guided by the aims of the research. In the case of this study it was decided to undertake a level of analysis at the sub-thematic level.

In the fifth phase, *Defining and naming themes*, the overarching themes, and sub-themes themes were re-defined in order to refine their focus, description and purpose. This process aimed to build a clear, meaningful picture to address the research questions that were to be laid out in the final written analysis.

The final and sixth phase involved *Producing the report* of the results that will now follow. The results will be described on a surface level through describing, explaining and illustrating the themes in relation to evidential patterns of data using textual examples. These findings will be presented in relation to the overarching, themes and sub-themes with reference to the available research literature. The results of the thematic analysis will now be presented in relation to major themes, themes and sub-themes of the data.

6.2 Results

The thematic analysis of the focus group data revealed two major themes:

1. Becoming self-compassionate and self-forgiving
2. The CFT group was beneficial

Each major theme will now be reviewed together with the themes and relevant sub-themes.

Major theme 1: Becoming self-compassionate and self-forgiving

The first major theme reflected participants becoming more familiar and reflective of the links between self-compassion and self-forgiveness. This theme related primarily to the insights that participants expressed about these concepts. Three themes comprised this major theme; *reduced barriers to self-compassion and self-forgiveness*; *benefits of becoming self-compassionate and self-forgiving*, and *reduced self-condemnation*. These themes and their related sub-themes are presented in figure 6.4 (overleaf), and will now be explored in more detail.

Table 6.4. Major theme 1: Becoming self-compassionate and self-forgiving

Major theme	Themes	Sub-themes
Becoming self-compassionate and self-forgiving	1. Reduced barriers to self-compassion and self-forgiveness	1.1 Greater understanding of self-compassion
		1.2 Self-compassion needs to be talked about.
		1.3 Everyone struggles.
	2. Benefits of becoming self-compassionate and self-forgiving	2.1 It's OK to be kind to myself
		2.2 Increased self-awareness
		2.3 It's OK to make mistakes and self-forgiveness can be helpful
		2.4 Self-compassion helps with self-forgiveness.
	3. Reduced self-condemnation	3.1 Awareness of common tendency towards self-condemnation
		3.2 Self-compassion can change perspective.
		3.3 Balanced compassionate thinking can be useful

Theme 1: Reduced barriers to self-compassion

The first theme, *reduced barriers to self-compassion and self-forgiveness* emerged from participants' comments about their growing understanding of self-compassion and self-forgiveness. This was in addition to their reported increased personal understanding about the presence and absence of these concepts in relation to their problems and difficulties.

1.1. Greater understanding of self-compassion

Focus group participants' responses suggested they developed a greater understanding of self-compassion as a result of participating in the CFT group. For example:

P1: "I have learnt that self-compassion unlocks a whole lot of ...[clears throat] ... pathways. You know like today when we were talking [looks at P5] ... using self-

compassion meant that you unlocked a whole lot of avenues that you could do to help yourself"

1.2. Self-compassion should be talked about.

Participants were in general agreement about the value and importance of self-compassion as an everyday life skill:

P2: "So self-compassion is a word that should be talked about every day... at the table... like empathy you know?'... I believe that this stuff should be in a simple form for our young ones"

P3: Well I am hearing more about it on the radio... It's part of the zeitgeist

Participants reported becoming more aware of the cultural and personal barriers to becoming self-compassionate. For example, one participant rejected the cultural bias linking self-compassion with being selfish, *"self-indulgence is not self-compassion!"*

1.3. Everyone struggles

Participants also became more aware that their personal struggles reflected similar struggles of other members of the group, and this reduced participants' sense of personal difference and isolation.

P2: "So more compassionate towards myself?... Because I was never like that and also being around everyone else here I have realised that I am not the only one who is on this journey. Everyone else is going through different journey but similar experiences."

P4: "That I am not actually abnormal, that there are a lot of people that have the same thoughts and feelings as I do... Things that made me think that I was so alien because of it..."

P5: "I feel less lonely ... errm ... in the group particularly. I don't have many people here in New Zealand so it has really made me feel less alone... and that

learning about self-compassion has helped me feel less alone. I understand what I am going through.

As the group progressed and these barriers reduced, participants reported increased positive beliefs about the value of self-compassion. Participants talked about reducing these barriers and developing positive beliefs about the value of self-compassion.

Theme 2: Benefits of becoming self-compassionate and self-forgiving

The second theme, *benefits of becoming more self-compassionate and self-forgiving* emerged from the data as the participants reported reducing their barriers to self-compassion through increasing their positive beliefs about self-compassion and that it was acceptable to be kind to themselves. Participants reported increasing self-awareness and personal understanding which enabled them to become more open to the possibility of making mistakes. Participants reported that the process of self-forgiveness was helpful in learning from and moving on from their mistakes and developing a greater emotional understanding and an increased capacity for balanced thought that they felt improved their psychological health and reduced their suffering. As a result, participants reported increased capacities for becoming self-compassionate and self-forgiving. These themes and their related sub-themes will now be explored in more detail.

2.1. It's OK to be kind to myself.

As the group progressed, participants expressed increasing positive beliefs about the value of self-compassion and reduced barriers to becoming kinder towards themselves.

P5: "I have learnt that it is actually OK to be kind to myself and that it is a good thing to have self-compassion."

P3: "Mine is really similar and that it is OK to give to yourself and that basically it exists and yes... that it is good to be kinder to yourself [uncomfortable laughter]."

One participant indicated an increased capacity for self-compassion because of increased positive self-worth and an awareness of negative self-beliefs, *“because [I am] not that bad a person!”*

2.2. Increased self-awareness

As participant’s awareness of the CFT groups common experiences developed, they became more aware, less self-critical, and more open and self-accepting.

P2: “So I am seeing that I need to be more compassionate towards myself and the way that I think about myself and my failings and all that... That it is just part of life. You know that you can move on from these things... it certainly been an important part for me.”

P6: “Less critical... Like you say more open... and understanding that there are people out there who do suffer from the same sort of situations.”

P7: “Well it makes it more acceptable to feel what we feel... kind of the right word to use... we used to joke about people like us you know... It is not necessarily that way.”

Furthermore, these insights promoted personal insights and understandings into participants’ emotional problems and symptoms.

P5: “I have more of an understanding of why I am the way that I am. OK that’s just one of the things that I have learnt. Yep. Learning more about the processes about why I feel anxious or depressed.... Erm... yes.”

This growing self-awareness enabled new learning, facilitated by the group therapy experience, as is reported in the next sub-section.

2.3. It’s OK to make mistakes, and self-forgiveness can be helpful.

In this sub-theme, participants reported a growing awareness of their capacity for making mistakes and the possibility of learning from and accepting their mistakes.

P4: “Everyone learns from their mistakes... and that it is OK to make mistakes.

In this regard, participants became more aware of the process of self-forgiveness and how it can help deal with mistakes and transgressions:

P8: “...I can use it for me and I can use it for other people.”

P9: “Yes I’d agree with that to... because some things can’t be forgiven but to realise it does give you a bit of peace within your mind... even if you have to say it over and over to yourself. It definitely works.”

P10: “Yes I’d agree, like you, I didn’t think that there were things that I could actually forgive so it’s nice to know that you have actually got a process... that you can progress to self-forgiveness.”

2.4. Self-compassion helps with self-forgiveness

Participants’ comments suggested they became more aware of how self-compassion facilitates self-forgiveness and reduce the barriers towards self-forgiveness through an increasing awareness of the powerful negative influence of self-condemnation.

P2: “I believe that it [self-compassion] has helped me to be more patient about the process... it has helped me to come to terms with forgiveness. I am still not quite there but I am on the right track... errm compassion and empathy for others... I have always had that for others but I have always been hard on myself... and it is right if you say enough bad things to yourself you end up believing it in the end.”

In contrast, participants also expressed their growing awareness of humanity’s capacity for making mistakes and imperfection, and how such understanding, empathy and self-kindness has been helpful in developing a personal narrative that involves becoming more accepting and forgiving of their mistakes, the mistakes of others and their responsibility to reduce personal suffering.

P6: "We are all human... We all make mistakes."

P11: "Errm... I think I'm not perfect but neither is anyone else. So we are all just learning and growing. It has helped me to be able to forgive myself... better."

P2: "...we are all human... we all make mistakes. If we don't learn from them we keep making the same ones... and for me to say what I am saying now would have been totally impossible in the beginning. But it is about owning it and being responsible."

P5: "Errm... now I can have a conversation.... I can put that conversation starter in my head now ... a back and forth discussion ... whereas before it would be "oh you are rubbish!" Now it is like... "well no you are not" ... but in a less antagonistic way ... that's what I am trying to say. Yes."

Theme 3: Reduced self-condemnation

The third theme, reduced self-condemnation emerged as participants became more aware of their capacity for self-condemnation and how self-compassion and self-compassionate thinking can ease self-condemnation through reducing self-criticism and blame, and increasing psychological health.

3.1. Awareness of common tendency towards self-condemnation

One of the similar experiences that participants became aware of was the common tendency towards self-condemnation and the costs of this response.

P2: "Yep. I have learnt that I was pretty brutal on myself and that I was using all the wrong tools to analyse my life and my situation.... and the things that have happened."

3.2. Self-compassion can change perspective.

In this sub-theme, participants reflected on the idea that self-compassion affords a more positive and balanced perspective to work through problems rather than being cold and self-critical and repeating the same mistakes.

P6: “To place a positive perspective on the situation and to work through the problem with compassion instead of being so hard and critical and analytical you know? Just ease down on it and be gentle and nurture the thought as opposed to being so hard.”

P12: “Yes I believe that I can change my perspectives and do things differently and not go down that same path and make those same mistakes time and time again... so that is nice to know that I am moving away from those repetitive mistakes.”

Participants linked this shift towards a more balanced and positive perspective that reduced their tendency to self-blame.

P13: “That it is not all my fault.”

P13: “Just that there are some aspects of my life that ... where I have been very hard on myself and blamed myself for but that really it was not in my control, and from doing the course my perspective on things has changed for the better.”

This was especially the case with regard to thinking linked to over-responsibility, and how self-judgment, biased thinking and unresolved anger complicates self-forgiveness and psychological well-being.

P5: “I have learnt not to take things personally if I feel that my sister does not make an effort to stay in touch with me. To recognise that she has her own responsibilities and struggles to.”

P5: "You know that there are things that have happened to me to that I am unhappy about but I realise that there are some things that I am not at fault for. Other people made a choice and you just happened to be caught up in that."

P5: "You are not self-incriminating yourself for something that you had no control over... You are putting the blame squarely... squarely on the people who made the choice to do that and it releases a lot of tension out of the body"

P14: "Just that there are some aspects of my life that ... where I have been very hard on myself and blamed myself for but that really it was not in my control. And from doing the course my perspective on things has changed for the better. Just accepting that sometimes that things are outside of your control and my natural instinct was to internalize it and blame myself ... and I think that I am a bit different now."

3.3. Balanced compassionate thinking can be useful

In contrast in this sub-theme, participants further developed their awareness of their negative thinking and the benefits of balanced and kind thinking upon psychological well-being.

P15: "Yes... I have found it really useful in weighing up the reality of the anxiety ... you know whether it is actually something that may happen or whether I am blowing things out of proportion. So that's been really good."

P16: "My anxiety has lowered a bit... being more mindful and more balanced."

P17: "The same too... less anxious "

P18: "So my anxiety level ... being in the group and hearing other people's situations ... right from the first group when we did the relaxation thing really helped ... so that is one thing I have learnt yes. So just to relax more and just take it easy and not getting totally worked up ... about things."

In summary, the first major theme reflected the process of becoming self-compassionate and self-forgiving that is reflected in the following thematic map (see figure 6.1).

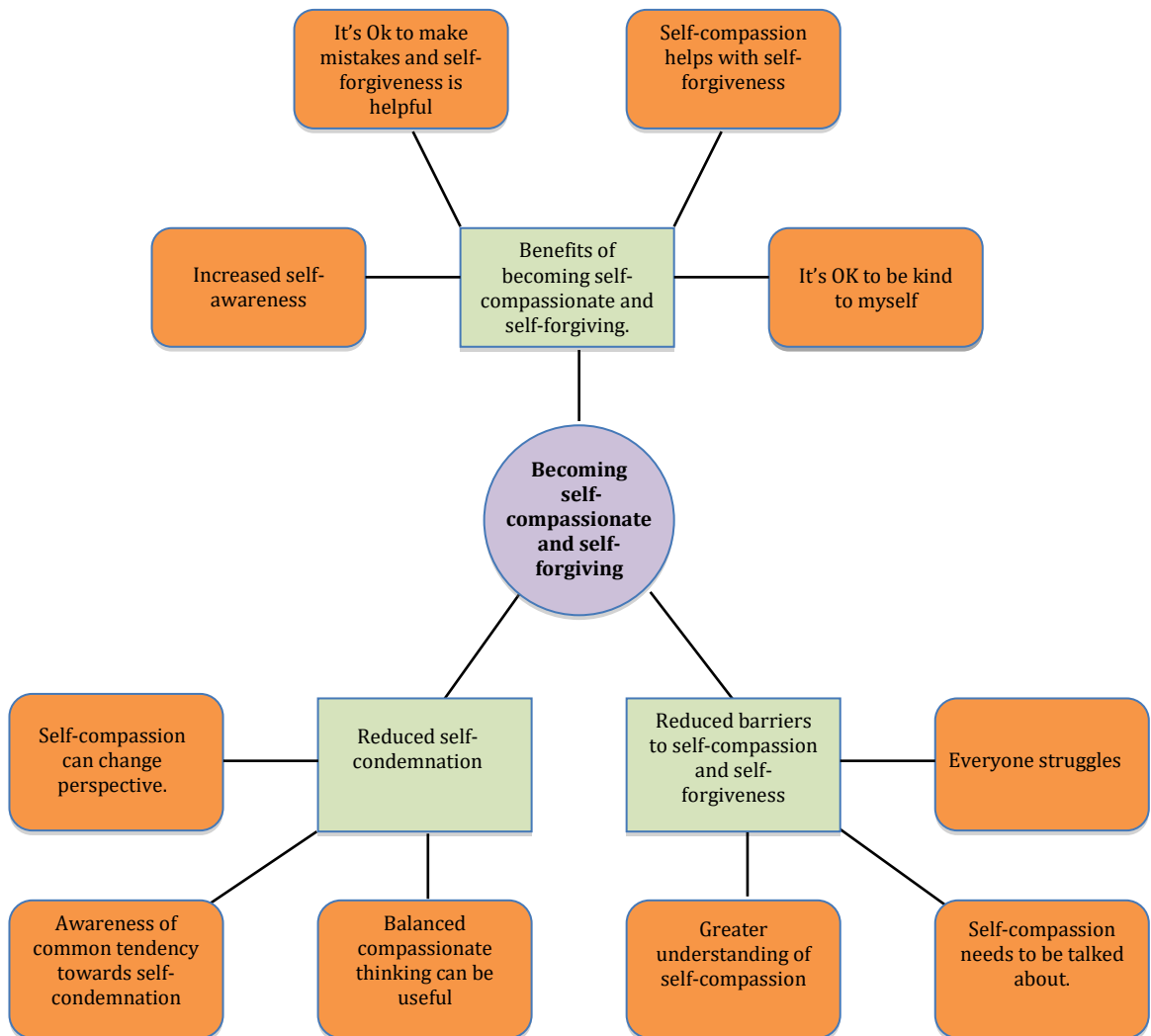


Figure 6.1. A thematic map outlining the first major theme; becoming self-compassionate and self-forgiving.

Note. Sub-themes are in the orange boxes. The themes are in the green boxes, and the major theme is in the central purple circle.

Within this major theme, *becoming self-compassionate and self-forgiving*, participants identified sub-themes that reflected the first theme, reduced barriers to becoming self-compassionate and self-forgiving. For example, participants identified greater understandings of what self-compassion is, as well as the value of self-compassion as an everyday life skill to help with coping with life stressors. Furthermore, participants reported that they had developed more positive beliefs about

the value of self-compassion and became aware of the influence of negative cultural beliefs that they held about self-compassion (e.g., that becoming self-compassionate is not self-indulgent). This shift in belief was aided through the growing awareness that their personal struggles reflected similar struggles to other members of the group, and importantly this led to a reduced sense of personal difference and isolation between group members that was validating and increased a sense of safety within the group.

Within the context of increasing positive beliefs about self-compassion and self-forgiveness and that self-kindness and self-forgiveness were acceptable. Participants also reported an increased self-awareness of common experiences such as their tendency towards self-criticism that promoted more open conversations and learning about their emotional problems and symptoms. Within this growing sense of safety and commonality, participants felt more open and able to talk about the mistakes that they had made within their lives. Participants learnt about the common human tendency towards anger, self-condemnation and the associated costs for their psychological health. Through their own personal and group experiences, they became aware how self-compassion and self-compassionate thinking aids the process of self-forgiveness through offering a kinder, more balanced perspective that reduces perceptions of over-responsibility, negative thinking, self-condemnation and self-blame that complicated their psychological health.

Major theme 2: The CFT group was beneficial

The thematic analysis of the focus group data identified a second major theme; *the CFT group was beneficial*. This theme reflected participants' experiences of the group as actively facilitating change and enabling skill-building. From this major theme, three themes emerged from the analysis. Firstly, that *the CFT group had facilitated personal change*; secondly that *CFT skills facilitated personal change*, and thirdly, that participating in the group yielded a range of *personal outcomes*.

These themes and their related sub-themes are presented in table 6.5 overleaf, and will now be explored in more detail.

Table 6.5. Major theme 2: The CFT group was beneficial.

Major theme	Themes	Sub-themes
The CFT group was beneficial	1. The CFT group facilitated personal change	1.1 Willingness to change
		1.2 Owning it and being responsible.
		1.3 Change is a continuous and hopeful process
		1.4 Group support helps establish new skills.
	2. CFT skills facilitated personal change.	2.1 Greater understanding, awareness and perspective.
		2.2 Self-compassion skills were calming and helpful.
		2.3 Using skills to become self-forgiving
	3. Personal outcomes	3.1 I can manage my emotions and suffering
		3.2 I can manage my mind and my thoughts
		3.3 I have greater self-confidence and self-acceptance
		3.4 I can say no to others

Theme 1: The CFT group facilitated personal change

The first theme, the CFT group had facilitated therapeutic change, emerged from participants' reports of being willing to change. Furthermore, that the changes that they made required ownership and responsibility and were part of an ongoing process of personal change that gave them hope for their future. Finally, that the process of change within the group was facilitated through group support that helped participants establish new skills.

1.1. *Willingness to change*

In this sub-theme, participants who completed the 12-week CFT group generally indicated that they had benefited from attending the group also expressed the importance of being willing to change.

P19: "...You have to come to the group..."

P7: "...With an open mind"

P19: "Well not just an open mind but a willingness to change yourself"

P7: "Yes"

P19: "That I find is the biggest thing... if you are not willing to change then it does not matter what group you are going to, you are still not going to get anything out of it."

One participant expressed a level of regret associated with not undertaking more of the group homework tasks from which they may have gained a better outcome.

P9: "By participating more and doing my homework ... I may have got more out of it... I'm not saying that I didn't get good stuff from it, i'm just saying that if I had done all that like my mate over here has done I might look as happy as he does (laughs... much laughter by all)."

Some participants also reflected upon those members who were not so ready to change, some of whom left the group, emphasising the importance of participants needing a willingness to change. For example;

P9: "If you sit in judgment upon other people... I think it causes disharmony within the group... and I think that it works better when people like that are not involved because with self-compassion it's not about thinking that you are right and know it all"

P20: "You know but it was the desire to change that got me here and sometimes you have just got to patiently wait for the other person ... you know... and if you push it on them then they tend to run away. You have to say gosh I really learnt something interesting!"

1.2. Owning it and being responsible.

Those participants who completed the group generally reported that they had learnt to help themselves and not rely on others for acceptance. They also emphasized the importance of taking ownership and being responsible for making changes in their own lives.

P2: "it is about owning it and being responsible ... and that's when the time comes... and it gets tough ... and I know it is only temporary ... and I know that I can get through it to the other side with or without the one's that I love because I want to be alive."

P11: "I have actually learnt that I can actually help myself emotionally and that I don't have to rely on my family for support to get that acceptance... so I have developed more self-worth I suppose that that can actually come from myself."

P12: "Just because someone is treating you poorly ... it does not mean that you have to accept it and just because other people behave like that does not mean that you have to behave like that or that you have to accept it. You can actually say no... errm... that "I don't like what you are saying" or "what are you doing." You have that choice."

These participants experienced taking ownership and being responsible as an active process.

1.3. Change is a continuous and hopeful process

In addition to acknowledging that psychological health was a personal responsibility, in this sub-theme, participants also acknowledged that personal change was a continuous and hopeful process.

P10: "I know that I have a long way to go... particular things have triggered my understanding of them... and I know that I will get there and that there will be setbacks and eventually I will get there."

P21: "I have been here that much ... so because I have come to a point where I actually have hope of getting to stage where I can actually live a happier life in the future... I am not there yet but I do have hope."

1.4. Group support helps develop new skills

Participants also noted that being in a supportive group that was adaptive to their learning styles had been helpful in establishing new skills that could be used in an ongoing way.

P4: "Its been huge ... yes .. really really big. We were talking about before it such an amazing group of people ... The support and the non-judgment we have received ... it been really big to take on the stuff that you are trying to teach us."

P21: "Everyone learns in different ways ... the course has got a lot of ... for every... for different learning styles."

Participants also felt that they would utilise their newly acquired skills at times of relapse.

P6: "Like you say it does actually give you something to look at ... it would be good when you start going down again to look through this yet again to know that you have been there you have done that and you have got the tee shirt... Why are you sliding back down? OK... You have got tools in your toolkit to try and deal with it."

Theme 2: CFT skills facilitated personal change.

In the second theme, participants highlighted that particular *CFT skills facilitated personal change*. Specifically, participants highlighted the importance of developing understanding and awareness as a precursor to utilising self-compassion and self-forgiveness skills in facilitating personal change.

2.1. Greater understanding, awareness and perspective

Developing greater understanding and awareness, and an increased a sense of perspective emerged as crucial themes in the process of becoming more able to emotionally connect to a point where emotional regulation, compassionate thinking and forgiveness became more possible.

P5: "I am looking at mum and dad in a different way ... first it was hard ... I just could not understand it.. my emotional state.. but now the more that I have focused on my emotional state I have opened my heart to forgiveness... it has just naturally taken over... and the pain and the anxiety that they have caused has slowly dissipated and I assume that it is because of all those negative feelings have been replaced by more compassionate feelings... I am more understanding... more open."

P22: "Just being able to understand that there is often a bigger picture to my emotional reactions. Sometimes in the moment you just can't understand that but with hindsight you can see that there was actually a lot going on ... and understanding that."

P5: "I have more of an understanding of why I am the way that I am. OK that's just one of the things that I have learnt. Yep. Learning more about the processes about why I feel anxious or depressed...."

P3: "That the brain's evolution has left us with remnants of a brain that is highly reactive but which can be tempered through understanding how we react as we are reacting"

2.2. Self-compassion skills are calming and helpful

In this sub-theme, participants' responses suggested that they valued the body-focused interventions such as soothing breathing that are used in CFT to ground and calm the mind and act as a basis for developing a more self-compassionate rather than self-critical narrative. Others found that some exercises such as letter writing helped them to actively express themselves.

P5/P6/P7/P8 – “The breathing thing... the breathing thing” (together).

P10: “Breathing definitely calms me.”

P7: “Talking to myself”

P4/P7: “In a kind way” (together).

P5: “I found the meditative sort of exercises really good. The breathing and the visualising . Even the mandarin thing... the smell of everything is really all encompassing so you really start to focus ... and now I can have a conversation... whereas before it would be “oh you are rubbish!” Now it is like... “well no you are not” ... but in a less antagonistic way.”

P21: “I found the letter writing helpful”

P22: “Yes I found the letter writing more productive and helpful than sitting here trying to fantasise about the person that I want to be.”

2.3. Using skills to become self-forgiving

Within the context of self-forgiveness, participants indicated that they combined grounding skills (e.g., breathing exercises) and compassionate attributes and skills (e.g. sensitivity, empathy), with more focal forgiveness skills such as the responsibility pie to calmly deal with feelings of over-responsibility and become self-forgiving:

P23: “The breathing exercises and also that pie wedge... I found that very helpful. Err not to be so over-responsible and look at other factors.”

P22: “Yes I found the pie chart really helpful. I tend to take all the responsibility all the time and I realize that just naming the other thing... just breaks down that ... “oh it’s all my fault!” all the time.”

P24: “Errm ... just how to stay calm... and how to forgive after difficult situations rather than take the blame for everything.”

This ability to regulate emotions and understand the context in which transgressions occurred promoted the necessary empathy and understanding in order for forgiveness and self-forgiveness to occur.

P5: “Working through the steps and the pie chart .. and being able to work through my understanding again of the situation which then helps me... erm... to be self-forgiving ... and also in terms of my family ... having an understanding of why they are so emotionally cold... and doing the whole... How did they get this way? ... and... what is their story? You know why? ... and forgiving them... because they have got their own reasons for what they did. It doesn't mean that I forget you know that it happened ... but that it has happened ... and that's where I am... you know and forgive them for that and ... just be content for how things are now and how not to make that... make what I am now going through worse.”

Finally, it is important to note that participants felt that the 12-week format of the group could have been extended to 16 weeks as this would have facilitated greater learning about the self-forgiveness skills that were the focus of the last two group sessions.

Theme 3: Personal outcomes

The third and final theme arose from the participants' reflections about their development of personal awareness and skills that had facilitated a range of psychological capacities including being able to manage emotions and suffering, improved mental management, greater self-confidence and self-worth, and capacity for assertiveness.

3.1. I can manage my emotions and suffering.

In this sub-theme, participants reported a greater capacity for emotional regulation through having developed greater emotional openness and emotional understanding, which together with the skills they had learnt enabled them to calm their emotions and manage their suffering. For example, one participant reported that she had become more able to emotionally open to her suffering.

P25: "I think it's like ... growing up with years of abuse I just swept my emotions under the covers and then I just pushed down pushed down and doing this course has helped me face some of that .. that it's not just a bad childhood... everyone has a bad childhood" and now I am more tearful about it and I was not tearful about it at the time." [laughs uncomfortably]

Other participants were more able to manage emotions with emotions such as gratitude through a developing awareness of human suffering.

P20: "Errm... I don't know I just feel that I have developed... even though I knew that world is difficult place and that everyone suffers at some point in their life I just feel like it became a little bit more real after having gone through and done the lessons and the video's and things. I thought that was very helpful. I have even seen a couple of things on line about people that you might think that they are having an amazing life and you find out... wow... they have had some pretty powerful things that they suffered through to. You know? So it's ... dealing with suffering is important."

3.2. I can manage my mind and my thoughts

In addition, participants reported an increased awareness and reduced tendency for over-involved thinking, bias and judgment as the group progressed that aided their mental management.

P3: "I can look for strength from within by changing the degree to which I react to negative thoughts."

This theme of increased mental management continued, with participants highlighting that they found particular skills such as remaining present-focused and utilising reassuring compassionate thinking, helpful with regard to becoming more independent and autonomous.

P2: "The thing that I have to try and remember is focus on the here and now... don't focus on the past and what happened or focus on the future about what might or might not happen... just focus on the here and now (sounds of group

agreement) focus on what you are doing. Focus on how you are reacting to, the things around you. Is it something that you can control or is it a normal reaction to the way that shit happens.”

P26: “I feel that my anxiety has gone down quite a lot... It is obviously still there but I am more compassionate to myself ... you know if I am running late I have more realistic thinking like “people are going to understand ... or you can explain a situation ... I have been challenging myself to go different routes and you know going to new places ... going to mall at Christmas time which is crazy.”

3.3. I have more self-confidence and self-acceptance

In this sub-theme, a number of participants reported that their increased capacity for self-compassion and reassurance had helped them to develop greater self-confidence and self-acceptance.

P2: “So yes there has been lots of different emotions but now it is having that grit and determination to work through the tough times.”

P27: “To have developed my self-confidence... that I am OK. That I have been given the tools to think in a different way in different situations. There has been a flow on effect ... It has improved my self-confidence.”

P21: “I have actually learnt that I can actually help myself emotionally and that I don’t have to rely on my family for support to get that acceptance... so I have developed more self-worth I suppose that that can actually come from myself.”

P7: “I’m starting to see myself as the strong person that I used to see myself as. I can feel that energy coming back about me. I still have days when I am really really tired but you know I have just got that ... enthusiasm I guess again for life. You know I can take time and look at a sunset and really enjoy it and... hmm yes... but it is OK if I have down days as well... and that it is OK if I really want to spend a day in bed if I need to and not beat myself up about it.”

3.4. I can say no to others

With these reports of increasing self-confidence, self-worth, and participants also reported a greater capacities for managing interpersonal conflict through assertiveness.

P12: “We can be very hard on ourselves... quite judgmental and we can be judgmental upon others as well you know? You have got to define ... look into it... just because someone is treating you poorly ... it does not mean that you have to accept it and just because other people behave like that does not mean that you have to behave like that or that you have to accept it. You can actually say no... errm... that “I don’t like what you are saying” or “what are you doing.” You have that choice.”

P5: “I have become more aware of... erm... how I should be treated. It is really difficult trying to break away from that... and the more that I have becoming more self-compassionate ... and I am becoming... I haven’t changed as a person... I still feel that I am a kind person... But I am starting to put up a “no wall” if that’s how to put it. So saying... “No I am afraid I am not going to do that!”

In summary, the second major theme reflected participants’ general perception that attending the CFT group was beneficial. This is depicted by the following thematic map (figure 6.2 overleaf).

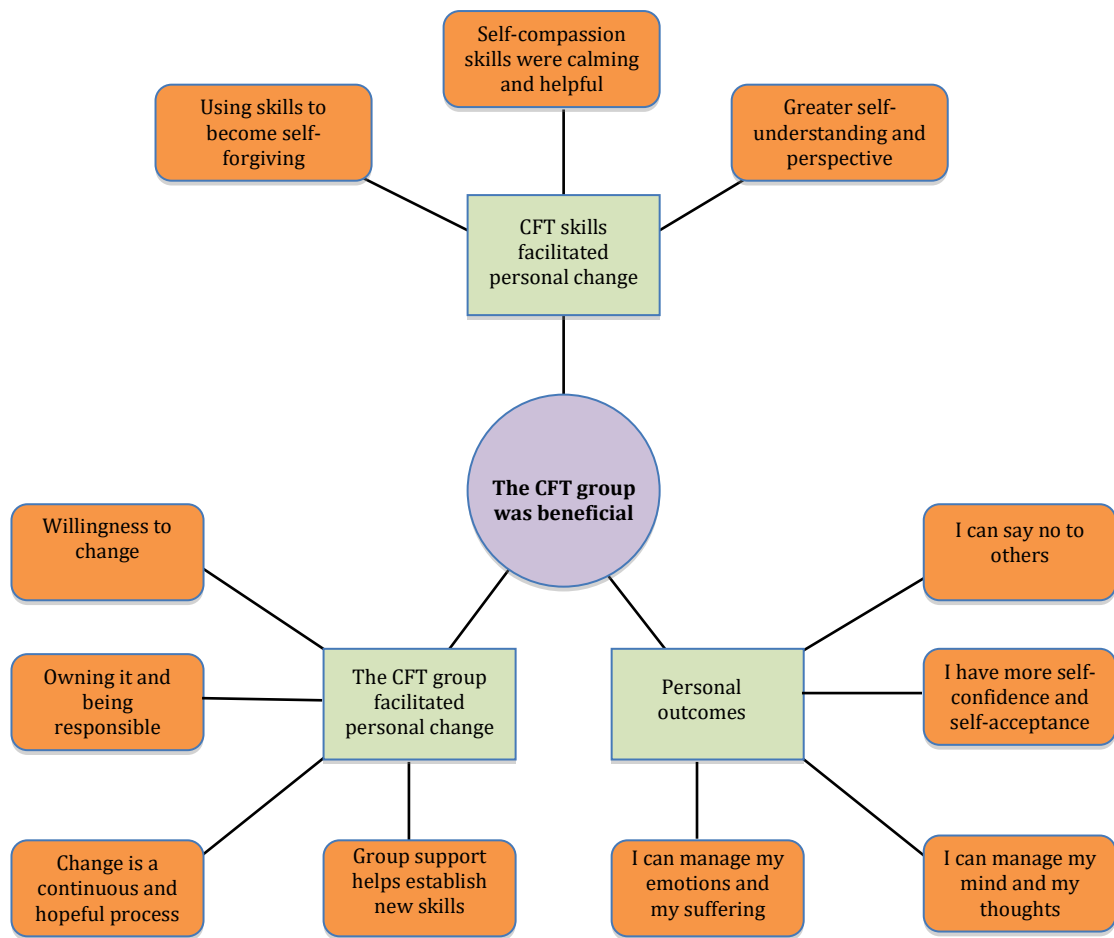


Figure 6.2. A thematic map outlining the second major theme; the CFT group was beneficial.

Note. Sub-themes are in the orange boxes. The themes are in the green boxes, and the major theme is in the central purple circle.

Within this second major theme, *the CFT group was beneficial*, participants identified that taking part in the CFT group had facilitated therapeutic change. In order to facilitate personal change, participants highlighted that they had needed a willingness to change that required them to take personal ownership and responsibility for their problems in a way gave them hope for their future self-management. Furthermore, participants' felt that the support that they received within the group was helpful in establishing the skills that they needed to manage their issues and problems and at times of relapse.

Participants also highlighted that particular CFT skills facilitated change. For example, participants noted the importance of developing understanding, awareness and

a greater sense of perspective as a precursor to becoming more able to emotionally connect with themselves to a point where their capacities for emotional regulation, self-compassionate thinking and forgiveness and self-forgiveness became more possible. Participant's indicated that they combined grounding skills (e.g., breathing exercises) and compassionate attributes and skills (e.g. sensitivity, empathy), with focal forgiveness skills to calmly deal with feelings of over-responsibility and regulate the associated affect (e.g., guilt, anger) that enabled self-forgiveness to occur.

In the final theme, personal outcomes, participants reported improvements in a range of psychological capacities. This included being able to better manage their emotions and suffering through developing greater openness to understanding their emotions, that together with the skills learnt, enabled participants to calm their emotions and reduce their suffering. Specifically, participants reported reduced tendencies for over-responsibility, cognitive bias and self-blame that aided their capacity to better manage their minds. Participants highlighted that they found particular skills such as remaining present-focused and utilising reassuring compassionate thinking, helpful with regard to developing their self-confidence, self-acceptance and assertiveness.

In the next section the results of this thematic analysis will be briefly discussed and explored in relation to the previously reviewed literature

6.3 Discussion

Research that was reviewed in the introductory chapter highlighted that very few studies have examined the effect of self-compassion and positive and negative affects upon the relationships between self-forgiveness and improved mental health outcomes (e.g. guilt, shame). In response, the researcher proposed a stress and coping model of self-forgiveness as an alternative theoretical model for unifying and guiding self-forgiveness and self-compassion research, an approach that required the use of quantitative methodologies. The broad aim of the first study was to develop and test the model using a cross-sectional design, and then in a second study, examine how the model performed longitudinally as a result of participants attending a 12-week group designed to increase their capacity for self-compassion. Whilst the numerical data that these studies would yield would be very useful in answering a range of proposed hypotheses, the aim of the third study was to provide qualitative data to help

contextualise these numerical findings and provide a more detail in-depth understanding of the relationships between the constructs under study and the expected processes of change. This approach reflects the recommendations of Woodyatt et al., (2017b) who call for researchers to utilise more varied measurement and observational approaches such as qualitative methodologies.

What follows is a summary of Study 3, with the knowledge that as far as the researcher is aware, it the first study to undertake a thematic analysis of the relationship between self-forgiveness and self-compassion. This third study identified two major themes that will now be discussed in some detail, prior to their integration with the findings of the first two studies in the subsequent general discussion chapter (Chapter 7) that follows this current chapter.

Becoming self-compassionate and self-forgiving

As a result of participating in the CFT group, participants identified the first theme '*reduced barriers to self-compassion and self-forgiveness*' within which participants became more aware of what self-compassion is, a finding which is consistent with the literature that reflects the value of self-compassion as a buffer to deal with the effects of life stressors (Terry, Leary, & Mehta, 2012; Wong & Mak, 2013; Korner et al., 2015). There was also general agreement between participants that they had become more aware of the value of self-compassion as a life-skill and that self-compassion was more openly discussed within social media. Within this theme participants identified changes in some of the cultural myths that often act as external barriers to self-compassion such as "*self-indulgence is not self-compassion*" (Neff, 2009; Neff & Costigan, 2014).

Whilst the researcher is unaware of any CFT group studies that have examined links between self-compassion and self-forgiveness, these responses reflect the findings of previous CFT group research (e.g., Gilbert & Procter, 2006; Lucre & Corten, 2013) where participants expressed a fear of self-compassion, and felt that being empathic of one's distress was a self-indulgence or weakness and should not to be cultivated.

Importantly, participants in this study also reported the sub-theme '*everyone struggles*', that reflected a reduced their sense of personal difference between the group

members that was helpful in reducing their sense of isolation. These findings are reflective of the results of Lucre and Corten's (2013) CFT group study and Neff's (2003b) conceptualisation of self-compassion. Lucre and Corten (2013) reported on a 16-week CFT group with participants who had been diagnosed with a personality disorder that was evaluated using quantitative and qualitative methodologies, where participants identified the theme '*the comfort of shared group experience*' and expressed the sentiment "*I am not alone*" (p.9). From a conceptual point of view, these findings reflect Neff's (2003a; 2003b) two related factors of common humanity and isolation. These factors are situated on the same bi-polar continuum where, common humanity makes it more possible to enable individuals to recognise that suffering is a shared human experience that promotes feelings of connectedness rather than feelings of isolation that sets one apart from others.

The thematic analysis revealed a second theme '*benefits of becoming self-compassionate and self-forgiving*' that revealed that participants became more aware of the potential benefits of becoming more self-compassionate and self-forgiving in spite of the internal barriers to do so. For example, participants reported that they found it much easier to be compassionate and forgiving towards others than themselves, and that they had learnt that it was useful and beneficial to be self-compassionate and self-forgiving for their own psychological health. Whilst others reported that their increased capacity for self-compassion had led to positive changes in their self-beliefs which had made it possible to overcome their positive beliefs about the value of self-criticism and made it more possible and acceptable to be kind to themselves.

These findings indicated a shift in self-to-self relating and suggest that participants found new strategies for dealing with self-criticism and self-condemnation that are reflective of the findings of Lucre and Corten (2013). Lucre and Corten's quantitative analyses revealed reductions in self-hate, shame, social comparisons, submissive behaviour and improvements in self-reassurance after attending their CFT group, whilst their qualitative analyses revealed the theme of '*awareness of self-criticism and addressing it with assertive action.*' Lucre and Corten concluded that these findings indicated a shift away from self-loathing to self-reassurance that reflected a greater capacity to assert themselves with their internal critic as well as with others. It is noted that as in Lucre and Corten's study, participants within this current study

identified an increased capacity for assertiveness with others and their critical self as a result of participating in the CFT group.

The findings of this current study and previous CFT group studies (Gilbert & Procter, 2006; Lucre & Corten, 2013) suggest that developing greater self-awareness appears key in facilitating therapeutic change. For example, Gilbert and Irons (2005) propose that in order for one to experience self-kindness, one has to develop self-awareness of the detrimental effect of self-judgment. As part of this process, the third theme '*reduced self-condemnation*' emerged from the analysis, where participants became more aware their common capacity for self-criticism and personal suffering that reflects what it is to be human. As a result participants reported a reduction in self-condemnation, partly because they began to report that their capacity for self-criticism was 'not their fault'.

This shift away self-condemnation to common humanity reflects Neff's (2003b) model of self-compassion. Neff asserts that self-compassion emphasises tendencies towards understanding rather than self-judgment, and an awareness that one's experiences reflect those of others that reduces the tendency to over-identify with one's negative thoughts and feelings. It would appear that such realisations made it more possible for participants in the current study to be less self-critical, more open and self-accepting when they made mistakes (Neff, et al., 2005). In this way participants became more aware of the process of self-forgiveness and reported reductions in their negative beliefs about making mistakes, instead regarding mistakes or errors as opportunities for learning.

In addition, participants identified self-compassion as facilitating the process of self-forgiveness, especially with regard to easing the complicating and negative influence of self-condemnation upon self-forgiveness. Participants explained how self-compassion, understanding, empathy and self-kindness had helped them to become more open and accepting of their imperfections, and this was eased by their awareness that all human beings have a capacity for self-condemnation and that all are fallible. These findings are consistent within the empirical literature that has examined transgressions between couples (Pelucchi, Palari, Regalia & Fincham, 2015). Pelucchi et al., suggest that the capacity of transgressor's to become self-forgiving is related to their ability to recognise their human fallibility (Bauer et al., 1992) and their capacity

for self-compassion. It is asserted by Gilbert and Woodyatt (2017) that such realisations allow individuals to transcend and tolerate their own weaknesses and failings in a way that mitigates the impact of self-condemnation through separating their own sense of self from their transgression.

In this regard, participants felt that self-compassion helped them to develop more positive and balanced perspectives when making meaning from problems and mistakes that reduced their capacities for negative thinking and self-blame (Gilbert & Proctor, 2006). This was especially with regard to participants' capacities for feeling over-responsible and how negative and biased thinking complicates self-forgiveness and psychological health. These themes are reflected within the empirical trauma literature (Janoff-Bulman, 1979), where individuals have been found to blame themselves for traumatic events through their need for over-control, a response that leaves them on the 'hook' of responsibility leading to increased psychological and physical symptoms (Exline et al., 2011; Davis et al., 2015).

The CFT group was beneficial

In addition to participants feeling that the CFT group had enabled them to become more self-compassionate and self-forgiving, the analysis revealed a second major theme, 'the CFT group was beneficial', where participants reported a wide range of other benefits that will now be further discussed.

Gilbert (2010) stresses that psychoeducation plays a vital part in the process of change within CFT, and the thematic analysis in the current study supported this, with participants reporting that they valued the insights and understandings that they had gained as a result of participating in the CFT group. In this regard, the first theme that emerged from this major theme was '*the group facilitated personal change*' whereby participants felt that their individual motivations or their willingness to change was a key part of the process of personal change. In relation to this theme, participants also felt that their readiness to take personal ownership and responsibility for their problems and issues was an ongoing and hopeful process. These sub-themes also emerged within Lucre and Corten's (2013) qualitative analysis that they termed 'taking responsibility for one's thoughts and actions' that are at the heart of CFT. For example, Gilbert (2014) describes compassion as a motivational force for personal change, defining compassion

as “*the feeling to suffering in self and others, with a commitment to try and alleviate and prevent it*” (p. 19). Gilbert and Woodyatt (2017) extended this definition in relation to self-forgiveness, stressing that “*change first begins with a willingness to move towards or into difficulty, the capacity to recognize a need for self-forgiveness, and then the desire to address this and relieve it*” (p. 36).

In their review, Gilbert and Woodyatt assert two basic sets of psychological competencies are required for self-forgiveness to occur. The first competency is the ability to move towards distress and suffering rather than take steps to avoid such contact, either through the use of denial, dissociation, or justification. The second competency is linked to taking wise action through the use of the six key CFT skills-competencies (attention sensitivity, sympathy, distress tolerance, empathy, nonjudgmental and care for well-being) that inform individuals to undertake wise, and courageous ongoing action in relation to their responsibilities. Within the realm of couple therapy, Pelucchi, Palari, Regalia and Fincham (2017) suggest that responsibility acts as an ‘ignition key’ for the process of self-forgiveness as it provides the transgressor with the impetus to focus on the suffering of the person who they have offended and deal with the self-condemnation, shame and guilt associated with the offence. It is noted that within this current study, participants felt that gaining group support and acceptance were helpful in developing new skills to manage their issues and problems, including at times of relapse.

The second theme, ‘*CFT skills facilitated change*’ that emerged from this major theme highlighted the importance of particular CFT competencies and skills in facilitating change. For example, participants described the importance of developing understanding, awareness and a greater sense of perspective as a precursor to becoming more able to manage and calm their distress and emotionally connect to a point where emotional regulation, compassionate thinking and forgiveness became more possible. As part of the process of self-forgiveness, participants indicated that they combined grounding skills (e.g., breathing exercises) and compassionate attributes and skills (e.g. sensitivity, empathy), with focal skills such as using the responsibility pie chart to calmly deal with feelings of over-responsibility and regulate the associated affect (e.g., guilt, anger) that enabled self-forgiveness to occur.

Gilbert and Woodyatt (2017) draw upon the available empirical literature and provide some support for these findings. They provide a detailed explanation about how the six CFT competences and their related specific skills operate within the process of self-forgiveness. They suggest that self-compassion motivates the decision to move towards self-forgiveness through the use of *Attention Sensitivity* and the attention focused training skills (e.g. mindful attention and observation) that enables individuals to focus on their suffering through the use of *Sympathy*. This makes it possible to be emotionally moved in spite of the distress that this may cause. Through the use of skills designed to develop the compassionate self, it is possible to ask oneself to consider the kind of help and support needed to become self-forgiving. This may include the use of *Distress tolerance* and the associated skills (e.g., soothing rhythm breathing, compassionate and safe-place imagery) that are helpful in reducing the distress, remorse and self-condemnation that is necessary to develop the necessary empathy and insight needed for self-forgiveness (Gilbert & Irons, 2005).

With regard to participants use of compassionate attributes and skills (e.g. sensitivity, empathy), Gilbert and Woodyatt (2017) highlight that *Empathy* enables us to connect with our common humanity through becoming more emotionally attuned and anticipate the emotional impact of our behaviours on others (Decty & Cowell, 2014). They point out that self-empathy and the associated skills of compassionate thinking and letter writing helps us to have reasonable expectations for ourselves in terms of standards and responsibilities that temper our capacity for making judgments about ourselves and others.

Gilbert and Woodyatt (2017) point out that the final CFT competency, *non-judgment*, utilises a range of skills (e.g. mindfulness, compassionate imagery) that relates to the ability to be open to our experiences including our mistakes, without the use of self-criticism and self-condemnation that then opens the door to self-forgiveness (Gilbert & Irons, 2005). Participants in the current study reported an increased awareness of costs of self-condemnation and judgment and benefits of self-compassion, themes that are reflected in the empirical literature (Gilbert & Procter, 2006; Lucre & Corten, 2013) and the earlier themes of '*reduced self-condemnation*' and '*self-compassion can change perspective*' whereby participants became more aware that they are part of an inherently flawed species who will continue to make mistakes. Participants' insights into their 'common humanity' made it more possible to extend

their understanding, empathy and self-kindness and in so become more accepting of their personal mistakes. Gilbert and Woodyatt (2017) state that all of these CFT competencies in addition to wisdom and courage are necessary if we are to work through the process of self-forgiveness and meet their psychological needs (Woodyatt, Wenzel & de Vel Palumbo, 2017c).

In the third and final theme of this major theme, participants reported that they had noticed improvements in a range of '*personal outcomes*,' as a result of attending the CFT group. For example, participants reported greater capacities in their ability to manage their minds and emotions through the use of body focused skills. Participants reported a greater openness to understanding their emotions, that together with the distress tolerance skills they learnt, had enabled participant's to calm their emotions and reduce their level of suffering. Furthermore, through the use of compassionate imagery, compassionate thinking skills, their compassionate self and the responsibility pie, participants reported reduced tendencies for over-responsibility, cognitive bias, and self-blame that aided their capacity to better manage their minds and free themselves from the burden of being self-unforgiving.

Whilst there are no comparative qualitative studies available, reviews of CFT group outcome studies report that participants experience reductions in self-criticism and negative affects (e.g. guilt, shame, anxiety, depression), and increased capacities for self-compassion, self-reassurance and feelings of warmth (Gilbert & Procter, 2006; Lucre & Corten, 2013). Furthermore, reviews of self-compassion studies and self-forgiveness outcome studies (Kirby et al., 2015; Wilson et al., 2018; Worthington, et al., 2017) indicate that self-compassion and self-forgiveness skills can be learnt, the outcomes of which may appear increase self-forgiveness and improved psychological health (Cornish & Wade, 2015b). Findings that appear supportive of the results of this current study.

Having individually discussed the findings of each of the three studies, the next section provides an overview of the current research and discusses the major findings of each of the three studies and presents a more in-depth discussion of the research results. The next chapter will also include sections about the limitations and clinical implications of this research before ending with recommendations for future research.

CHAPTER 7.

GENERAL DISCUSSION

7.1 Overview

This penultimate chapter begins by briefly summarising the background literature that will set the scene to discuss the researcher's stress and coping model of self-forgiveness, self-compassion, affect and psychological health, and the subsequent main findings of the three studies that comprised this PhD research. The limitations of the research will be discussed, as will the theoretical and clinical implications of the research findings. Finally, recommendations will be made for future research to address any empirical, theoretical and clinical issues that emerge.

This thesis began by reflecting on what it is to be a human being, with human history often reflecting the capacity of humans to be less than what we aspire to be. Genocide, war, slavery, abuse, the purposeful deprivation of others, the desire for power, money, status, and greed are but some of the actions that appear on our television screens, in our newspapers, on-line media, or for some of us our actual experience (Gilbert, 2017; van Prooijen, 2018). When we are faced with the extremes of these realities, we shake our heads and question how human beings are capable of these actions and we defensively seek to separate ourselves from the actions of others that preserves our ideals about what it is to be a 'good' human.

Whilst we may feel that our values and ideals would protect us from the very worst of these human actions, when we and our families, friends, comrades, and countries are threatened, history tells us that ordinary people can organise themselves to do extraordinarily awful things to each other. Given how easy it is for us to feel threatened is perhaps surprising that we as a species we have survived and evolved over the past 350,000 years (Callaway, 2017). One reason why we have lies in our hard-wired capacity to form, repair and maintain social bonds as a matter of survival and our wish to grow and achieve as individuals and as a species (Gilbert, 2000). In fact, it is when we join and achieve together that we perhaps at our best, whether this be in our personal, social, work, political, environmental, extra-terrestrial spheres. This capacity to repair our bonds after transgressing each other's values and ideals involves the

processes of self-compassion, forgiveness and self-forgiveness, and it is within these contexts that this research was set (Gilbert & Woodyatt, 2017).

Within the literature review in Chapter 2, self-forgiveness was found to usually involve acts of transgression in relation to others or in relation to our own socio-moral identities (Shnabel & Nadler, 2008; 2015). It was identified that provided we can empathise and understand the impact of our transgressions on ourselves and others, and identify feelings of responsibility, remorse and guilt, we can take action to repair our relationships with others and ourselves (Graham, Morse, O'Donnell & Steger, 2017; Massengale, Choe & David, 2017; Pelucchi et al., 2017; Woodyatt et al., 2017b). Woodyatt et al., (2017b) explain that there appears to be general agreement amongst self-forgiveness researchers that the process of self-forgiveness involves the use of self-compassion. Specifically, if we can (1) compassionately understand how the transgression occurred; (2) assume responsibility for the part that we played; (3) acknowledge and empathise with ourselves about our poor decision-making and our common imperfections, and (4) express a wish to learn from our transgressions, then it becomes more possible to repair the damage caused to our social and moral identities (Graham et al., 2017; Shnabel & Nadler, 2015).

Necessarily the process of self-forgiveness does not always go smoothly because human beings struggle with the first stage of self-forgiveness, namely responsibility (Woodyatt, et al., 2017). Woodyatt et al's (2017) review of the empirical literature suggests that this appears to be because human beings tend to be motivated by hedonistic aspirations that involve the reduction of unpleasurable feelings and emotions associated with the transgression (e.g. guilt, shame), and the maximising of pleasurable feelings and positive emotions as a source of emotional avoidance (Bryan, et al., 1992). Becoming responsible requires us to go against these motivations and pursue unhedonistic aims with the aim of making amends through pursuing higher-order eudemonic goals such as making new meaning, living according to our values, or personal growth that are part of the phases of restoration and renewal (Graham et al., 2017). Given our hedonic preferences and the rapidity with which we can feel threatened, judge, self-condemn through over-responsibility, or blame others through irresponsibility, it is perhaps no wonder that the pathway to genuine self-forgiveness is so difficult (Holmgren, 1998; Woodyatt & Wenzel, 2013b).

Within the stress and coping literature, responses to transgressions can be viewed as adaptive and maladaptive (Strelan & Covic, 2006, Toussaint et al., 2017; Worthington, 2006). Self-compassion is generally regarded as an adaptive response and facilitates the process of genuine self-forgiveness through transforming negative feelings into positive feelings in a way that reduces the level of felt threat enabling us to examine the contextual bigger picture (Gilbert & Woodyatt, 2017; Van Oyen et al., 2014). Becoming more self-compassionate may afford a greater capacity for reflecting upon the impact of childhood trauma upon adult interpersonal functioning, the context in which the past and current transgressions occurred, the motivations of others who were involved in the transgression, and the recognition of our common imperfections. This process of historical reflection may allow us to regulate our emotions, let go of negative feelings and grow personally. We may then be more able to develop more prosocial feelings such as self-empathy, self-kindness, and self-validation in our efforts to effect a repair to the self, as well as develop and maintain behaviours that are more in keeping with our values and self-beliefs. In contrast, self-condemnation is regarded as a maladaptive response. Specifically, if we continue to hold negative beliefs about ourselves, others, and our futures, then our capacity for threat remains and we are more likely to condemn and invalidate ourselves, and likely to complicate the process of self-forgiveness and the attainment of our eudemonic goals.

A recent review of models of self-forgiveness by Cornish et al., (2017) highlights that several clinical models have been developed to account for the process of self-forgiveness (Cornish & Wade, 2015a; Enright et al., 1996; Jacinto & Edwards, 2011; Worthington, 2001). However, there is disagreement amongst self-forgiveness researchers about how to define self-forgiveness, how many phases there are, and when the process of self-forgiveness is complete. In response, Worthington (2006; 2013) proposed a stress and coping theoretical model as a unifying model to guide future research, but this model does not reflect the important role that self-compassion is generally believed to play in the process of self-forgiveness. It is within these contexts and gaps in the research that the researcher proposed and evaluated a new stress and coping model of self-forgiveness, self-compassion, affect and psychological health.

What follows is a summary and discussion of the major findings of the three studies that evaluated the researcher's proposed model. This summary will then be followed by a discussion of the study's limitations, and the theoretical and clinical

implications of the findings of these studies. Given that Study 3 was intended to provide more detailed understandings of participants' experiences of change within the CFT group, the findings of Study 3 will be used to interpret the findings of Study 1 and especially Study 2.

7.2 Discussion of main findings

7.2.1 Study 1

Study 1 aimed to test key aspects of the researcher's proposed stress and coping model of self-forgiveness, self-compassion, affect and psychological health through examining the predicted relationship between increased trait self-forgiveness and the reduction of a range of psychological health variables (psychological distress, guilt and shame). Having established these relationships, it was then proposed to examine the mediating effects of the positive and negative components of Neff's (2003b) bifactor model (compassionate self-responding and uncompassionate self-responding) and Gilbert's (2010) model of affect regulation (positive affect, safe / content affect and negative affect) upon the predicted positive relationship between trait self-forgiveness and improved psychological health (reduced psychological distress, shame and guilt). The effects of a range of socio-demographic and personality variables upon these analyses were also to be studied.

Study 1 attempted to address the gaps in the self-forgiveness literature in several ways. Firstly, having proposed a new stress and coping model of self-forgiveness, self-compassion, affect and psychological health, it would be important provide some empirical evidence about its validity. This would be especially important given that the model proposed to draw upon Worthington's (2006) models of forgiveness and self-forgiveness, Neff's (2003b) model of self-compassion, and Gilbert's (2010) model of affect regulation.

Secondly, given the contention within some members of the self-compassion research community (Neff et al., 2017; Neff et al., 2018; Arimitsu et al., 2018), about the use of the single-factor model of self-compassion (represented by the Self-Compassion Scale total score), or the bifactor model (represented by the compassionate self-responding and uncompassionate self-responding scores), Study 1 provided an

opportunity to examine the potential influences of the bifactor and single-factor models of self-compassion upon the study variables.

The results of Study 1 indicated that the negative factors of Neff's bifactor model (uncompassionate self-responding) in addition to negative affect appeared to have the greatest mediating effects upon the relationships between trait self-forgiveness and the psychological health variables. This was especially the case with psychological distress where there was a mediating effect, whereas with shame and guilt there were partial mediating effects. In contrast, the indirect effects of the single-factor model (Self-Compassion Scale total score) and negative affect yielded the only significant effect upon the trait self-forgiveness and shame, leaving the relationship between trait self-forgiveness and psychological distress and shame being mediated by negative affect alone. In explaining these results, it is important to note that in the case of the partially mediated models, the direct effect confidence intervals were just below zero. This suggests that a larger sample size may have resulted in these direct effects becoming non-significant indicating that mediation would have probably occurred with all of psychological health variables, irrespective of whether the bifactor or single-factor model was used.

With regard to the recent controversy into the use of the bifactor model highlighted in the literature review in Chapter 2, the results of Study 1 yielded similar results between the bifactor and single-factor models, where negative affect and the negative components of Neff's (2003b) model (USR) dominated. These results are inconsistent with the findings of Neff, et al., (2018) who recommend against the use of the bifactor model, yet are consistent with those researchers whose research supports the use of the bifactor model (Costa et al., 2015; Lopez et al., 2015; Montero-Martin et al., 2016). It is noted that Neff, et al., (2017) also found evidence supporting the use of the bifactor scores with non-clinical samples but not clinical samples. Whilst research into the psychometric properties of the Self-Compassion Scale (SCS) is ongoing, one possible explanation for the findings of Study 1 is that the study sample was obtained from both clinical and non-clinical populations suggesting that it may be appropriate to continue to utilise the bifactor model with mixed clinical and non-clinical populations, but further research is need to test this. Alternatively, it may be that the activity of the positive and negative components of the SCS may be associated with individual or environmental differences that research has yet to identify.

Together, these findings suggest that the combined effects of the Uncompassionate Self-Responding (USR) sub-scales (self-judgment, isolation, and over-identification) and negative affect had a greater mediating effect upon the relationship between trait self-forgiveness and the psychological health variables than the Compassionate Self-Responding (CSR) sub-scales (self-kindness, common humanity, and mindfulness) and positive and safe/content affect. Reviews of the empirical literature (Tangney & Dearing, 2002; Kannan & Levitt, 2013; Leach, 2017; Gilbert & Woodyatt, 2017) over the course of the last 15 years appear to reflect these findings and highlight the tendency for human beings to become self-punitive when confronted with their errors that lead to an increase in negative affect and especially shame and guilt. The emergence of negative affect as a key mediator within this current study appears to confirm the importance of negative affect as having a powerful mediating effect between self-forgiveness and psychological health that is reflected within the literature (Barnard & Curry, 2011; Orth, et al., 2007; Strelan, 2017; Walker et al., 2007) and provides partial support for the inclusion of Gilbert's (2005; 2009) tripartite model of affect within the researcher's proposed model.

Whilst the researcher is unaware of any comparative studies, the mediating effect of USR and negative affect, upon the relationship between trait self-forgiveness and psychological health in Study 1, reflects the positive associations that have been found between the USR sub-scales and symptoms of depression in clinical samples (Krieger et al., 2013; van Dam et al., 2011), student samples (Akin, 2010; Mills et al., 2007;), and non-clinical samples (Hupfeld & Ruffieux, 2011; Ying, 2009). With studies by Krieger et al., (2013); Hupfeld and Ruffieux, (2011); Mills et al., (2007); Van Dam et al., (2011), reporting stronger associations between the negative SCS sub-scales and depression than the positive SCS sub-scales and depression. Two recent meta-analyses by Muris and Petrocchi (2017) and Wilson et al., (2018) have confirmed these results. Muris and Petrocchi (2017) examined the link between the sub-scales of the SCS and symptoms of psychopathology across 18 studies and found that the sub-scales of the USR had a stronger association with measures of psychopathology than the CSR sub-scales. Wilson et al., (2018) undertook a random effects analysis on the pre and post-scores of SCS sub-scales with self-compassion linked interventions against controls, and found that the USR subscales demonstrated slightly stronger relationships than the positive sub-scales. These empirical findings appear to support the results of Study 1, where the positive factors of the SCS (compassionate self-responding) did not have a

mediating effect upon the relationship between trait self-forgiveness and any of the psychological health variables.

It was hypothesised that positive (activating) affect and safe / content affect would have a mediating effect upon the relationship between trait self-forgiveness and any of the psychological health variables, however, this hypothesis was not supported. Findings that do not fully support the inclusion of the Gilbert's (2005; 2009) tripartite model of affect within the researcher's proposed model. The absence of a mediation effect with positive affect and safe affect upon the relationship between trait self-forgiveness and any of the psychological health variables is surprising, especially when self-compassion researchers (e.g. Leary et al., 2007; Neff, Rude & Kirkpatrick, 2007; Neff & Costigan, 2014; Yarnell & Neff, 2013), have asserted the benefits of developing self-compassion and positive and safe and warm affect as a solution to excessive self-criticism. For example, a number of empirical studies have found that increases in self-compassion yields reductions in self-criticism, negative affect, and a range of psychological health variables including guilt and shame, and an increase in positive safe and warm emotions and feelings including empathy and self-compassion (Block-Lerner, Adair, Plumb, Rhatigan, & Orsillo, 2007; Chang, 2008; Gilbert & Irons, 2005; Gilbert & Procter, 2006; Kelly et al., 2008; Leary et al., 2007; Neff, 2003b; Neff & Germer, 2013). Furthermore, positive affect has been found to motivate many prosocial relational benefits such as relationship commitment (Komura, 2014), increased helping behaviours towards others (Gorzaga, Keltner, Londahl & Smith, 2001), including self-forgiveness and forgiveness of others (Akin & Akin, 2015; Romero et al., 2006; Thompson et al., 2005; Yao et al., 2016). Other studies have also found safe / content affect to be associated with reductions in depression (Gilbert et al., 2008), psychological vulnerability and maladjustment (Gilbert et al., 2009), and forgiveness and life satisfaction (Akin & Akin, 2016).

At present there are no comparative studies that have examined self-forgiveness, self-compassion and safe / content affect, making the findings of Study 1 unique. Whilst positive affect and safe / content affect were not found to have a mediating effect on the relationship between trait self-forgiveness and the psychological health variables, Study 1 did find that in comparison with positive and negative affect, safe / content was the most strongly associated with trait self-forgiveness, USR, CSR, the SCS Total scale score, and as strongly associated with negative affect. These findings suggest that more

cross-sectional and intervention research is needed into the effects of safe / content affect within the study of self-compassion and self-forgiveness with larger clinical and non-clinical samples.

One possible explanation for these inconsistent findings is the evidence linking positive emotion, empathy, self-compassion, and self-forgiveness as demotivators of change (Wohl & McLaughlin, 2014). For example, positive emotions have been linked to increased selfishness, anti-social behaviour, immorality, narcissism, and pseudo self-forgiveness (Tan & Forgas, 2010; Vincent, Emich, & Goncalo, 2013; Wohl & McLaughlin, 2014). Furthermore, a recent review of the pseudo self-forgiveness literature by Wohl, Salman, Hollingshead, and Lidstone, (2017) highlights that under certain circumstances such as giving up smoking, positive affect can increase pseudo self-forgiveness through reducing the severity of the transgression by reducing the guilt associated with having a cigarette. This appears important as it was the uncomfortable presence of remorse and negative affect (e.g. guilt), that motivated the reduction of smoking behaviour (Wohl & Thompson, 2011). Whilst the impact of genuine self-forgiveness and pseudo self-forgiveness was not measured within the researcher's studies, narcissism was measured, the results of which yielded a negative relationship between narcissism and state self-forgiving self-beliefs ($r = -.21, p. <.05$), but no association was found between state-self-forgiving feelings and actions, trait self-forgiveness or any of the psychological health variables. These inconsistent results suggests that further research is necessary in order to establish the potential confounding effects of narcissism or pseudo self-forgiveness upon the mediating relationship positive affect between self-forgiveness and psychological health. This may involve using more sensitive measures of overt narcissism such as the Narcissistic Personality Inventory (Raskin & Terry, 1988) rather than the single-item of measure of narcissism that used in this study, and measures of self-forgiveness that distinguish between genuine self-forgiveness and pseudo self-forgiveness such as Woodyatt and Wenzel's (2013) Differentiated Process Scale of Self-Forgiveness (DPSSF).

A second explanation for the absence of mediating effect of positive and safe / warm affect upon self-forgiveness upon psychological health, may be associated with the fear of compassion literature (Gilbert, 2005; 2010). Gilbert draws upon the work of Bowlby (1969, 1973, 1980), and suggests that some people develop a fear of compassion-linked affiliative emotions such as positive and safe affect as a defence

against reconnecting with traumatic memories associated with insecure early attachment experiences (Gillath, et al., 2005). For example, insecurely attached people report unpredictable experiences of being parented, experiences that create a relational template for predicting future attachment experiences that lead to increased perceptions of threat, especially when they receive compassion from others or more especially themselves (Neff & McGehee, 2010; Raque-Bogdan, Ericson, Jackson, Martin, & Bryan, 2011). Therefore, it may be useful for future researchers to examine the potential confounding influence of attachment and fears of self-compassion in relation to the researcher's proposed model.

Neuroticism emerged as the variable to have the greatest influence upon the mediators and their relationships between self-forgiveness and the psychological health variables. A finding that appears reflective of a range of previously reviewed self-forgiveness studies (e.g. Leach & Lark, 2004; Macaskill, 2012; Maltby et al., 2001; Mauger et al., 1992; Strelan, 2017; Walker & Gorsuch, 2002) and self-compassion studies (Barnard & Curry, 2011; Neff, Rude & Kirkpatrick, 2007). By way of explaining these findings, Costa and McCrae (1992) noted that it is useful to conceptualise personality traits as filters that shape one's perceptions of the transgressor, such as their ability to self-care, and their worthiness and value. Within the Five Factor Model of neuroticism (Costa & McCrae, 1992), neuroticism comprises a range of underlying traits that include some of the following: anger-hostility, anxiety, depression and a vulnerability to stress (Martin & Kirkcaldy, 1998; Zonderman, Herbst, Schmidt, Costa & McCrae, 1993). Costa and McCrae (1992) assert that people who are high in neuroticism tend to misperceive external threats in their environment, become fearful (or angry) and then ruminate about what the perceived threat means for their future (Nolen-Hoeksema & Jackson, 2001). This rumination tends to fuel the initial reaction of fear (or anger) and cause those negative feelings to stay around longer in the body.

The strong negative correlations that were found in Study 1 between neuroticism and safe affect (-.70), trait and state self-forgiveness (ave. -.60), self-compassion (-.76), safe / warm affect (-.70), positive affect (-.58) and the strong positive associations with self-judgment (.61), isolation (.63) and over-identification (.65), negative affect (.60), and the psychological health variables, psychological distress (.85), shame (.60) and guilt (.54), appear to support Costa and McCrae's (1992) formulation of neuroticism,

and provides some explanations for why transgressions would feel more severe and painful for people high in this trait. For example, upon committing a transgression, people high in neuroticism tend to self-condemn, have a preference of self-punishment and struggle to calm and reassure themselves because of increased negative affect, and painful affects (e.g. guilt, shame, anxiety, stress, depression). This level of threat is seems to complicate their ability to feel safe and cope with their situation through the use of self-compassion, especially if self-compassion is linked with a fear of condoning their transgressions (McCullough & Hoyt, 2002) yielding a fear of self-compassion (Gilbert, 2009).

As was highlighted earlier in the literature review, fear of giving and receiving self-compassion has emerged as a key barrier to becoming self-compassionate that has been shown to complicate the process of warm self-care that maintains psychological health (Gilbert et al., 2011; Hermanto, et al., 2016). Whilst the researcher is unaware of any empirical research that has examined the influence that fear of self-compassion may have upon the process of self-forgiveness, the strong positive correlation between self-compassion and trait self-forgiveness (.76) found in Study 1 and previously reviewed studies suggests fear of self-compassion would compromise individual's abilities to self-forgive resulting in poorer psychological health.

Study 1 summary

In summary, Study 1 aimed to test key aspects of the researcher's proposed stress and coping model of self-forgiveness, self-compassion, affect and psychological health through examining the mediating effects of self-compassion, in addition to the effects of negative, positive and safe / content affect upon these relationships. The findings of Study 1 indicated the importance of USR and negative affect upon the relationship between increasing trait self-forgiveness and improved psychological health. This was especially the case with regard to trait self-forgiveness and psychological distress (anxiety, depression and stress) where USR and negative affect were found to mediate this relationship. With regard to the relationship between trait self-forgiveness with shame and guilt, USR and negative affect were found to partially mediate these relationships. When the confounding effects of a range of socio-demographic and personality variables were included in these analyses, neuroticism emerged as having a significant effect upon these analyses. Together, these results suggest that the combined

effects of self-judgment, isolation, over-involved thinking and negative affect work together with the influence of neuroticism and complicate the positive relationship between trait self-forgiveness and psychological health, especially with regard to psychological distress (anxiety, depression and stress). These findings indicate that of all the study variables, the negative components of Neff's (2003a; 2003b) model (USR), negative affect and neuroticism are key variables that have the greatest influence upon the relationship between trait self-forgiveness and psychological health. Findings that will be further explored and discussed in relation to the findings of Study 2, where the interactions between these key variables will be explored over time.

7.2.2 Study 2

Study 2 proposed to further evaluate the researcher's stress and coping model of self-forgiveness, self-compassion, affect and psychological health and identify causal relationships between the study variable scores over the course of the 12 week CFT group. This was undertaken using a group analysis and a mediation analysis. The group analysis involved the use of a repeated-measures within subjects design that examined changes in self-forgiveness, self-compassion, affects and psychological health variables across four time points; at assessment, and at weeks 1, 6, and 12 of the CFT group. The potential confounding effects of the identified socio-demographic and personality variables upon the group analysis were also examined. After testing the predicted relationship between increased trait and state self-forgiveness and the reduction of a range of psychological health variables (psychological distress, guilt and shame), it was then proposed to examine the mediating effects of; a) Neff's (2003a; 2003b) bifactor and single factor models, and b), Gilbert's (2010) model of affect regulation upon the predicted positive relationship between trait and state self-forgiveness and improved psychological health.

Study 2 thus tested and extended the hypothesised associations from Study 1 using a design that permitted a level of causality to be made between the variables. Study 2 attempted to address the gaps in the self-forgiveness literature through examining the longitudinal relationship between self-forgiveness and psychological health and the mediating effects of self-compassion and affect in relation to a self-compassion intervention. It is noted that this was the first study to evaluate a CFT group intervention within New Zealand.

CFT group results

The quantitative results of the CFT group study found that participants' reported significantly increased levels of self-compassion, self-forgiveness, positive and safe / content affect and significantly reduced levels of negative affect and a range of psychological health variables, including shame, guilt and psychological distress. It is noted that using the DASS-21 (Lovibond & Lovibond, 1995) severity criteria, participants' levels of psychological distress reduced from the 'severe' to the 'moderate' range over the course of the 12-week CFT group. These positive outcome findings are consistent with the results of previous meta-analyses of CFT studies (Kirby et al., 2015) and self-forgiveness studies (Davis et al., 2015).

Furthermore, a recent review by Worthington Griffin and Wade (2017) indicates that self-forgiveness is a skill set that can be learnt, and which can impact positively upon a range of mental health outcomes. The significant improvements in self-forgiveness and psychological health over the course of the 12-week CFT group appear consistent with these findings. Worthington et al's., (2017) review, found six empirical studies of self-forgiveness interventions, of which only one study (Cornish & Wade, 2015b), utilised a measures of self-forgiveness and self-compassion, and this study was grounded in Emotion Focused Therapy (Greenberg, 2002) rather than CFT. Cornish and Wade (2015b) found that participants in the treatment condition reported higher levels of self-forgiveness and self-compassion, less self-condemnation and reduced psychological symptoms. These findings are consistent with the results of Study 2, where for the first time it was found that participating in a CFT group yielded an increase in participants' self-compassion, self-forgiveness, and positive and safe / content affect, and reduced levels of negative affect, psychological distress and shame and guilt.

In summary, the quantitative findings of the CFT group intervention suggest that participants benefitted significantly from taking part in the CFT group, and make a unique contribution to the CFT and self-forgiveness literature in several ways. This was the first CFT outcome study to take place in New Zealand, the results of which indicated that after controlling for neuroticism, participants developed greater levels of trait and state self-forgiveness, self-compassion, positive and safe / content affect, and reduced levels of negative affect, psychological distress, shame and guilt during the

course of participating in a brief 12-week CFT group. It is noted that this was also the first study to demonstrate significant improvements in self-compassion and self-forgiveness as a result taking part in a CFT group study, results that support the anecdotal and empirical findings that were highlighted in the literature review in Chapter 2.

Mediation results

Mediation analyses were undertaken upon the study variable change scores to examine how the researcher's stress and coping model of self-forgiveness performed over time. The findings of these analyses found that participating in the CFT group, increased changes in participants' trait and state self-forgiveness and predicted reductions in shame and guilt, but not psychological distress. Changes in negative affect alone were found to have a significant mediating effect upon changes in trait self-forgiveness with shame and guilt, the exception being reductions in uncompassionate self-responding that also had a significant mediating effect upon increasing state self-forgiving self-beliefs with reductions in shame. It is noted that the single-factor model (represented by the use of the SCS total score), did not have a significant mediating effect upon changes in any of the associations between self-forgiveness and psychological health variables. Finally, the small sample size meant that it was not possible to control for the effects of any of the possible confounding socio-demographic and personality variables as had been the case of Study 1 and the Study 2 group analyses.

By way of explaining these findings, a review by Gilbert (2014) points out that CFT was originally designed for and appears effective in treating people who present with high levels of self-criticism, shame and guilt which may account for the reductions in the shame and guilt change scores, but not psychological distress. However, the absence of any significant correlation between reductions of the self-forgiveness and psychological distress change scores is still a surprising result given the CFT group outcomes that yielded significant reductions of psychological distress in this study. A finding that is reflected in CFT outcome reviews (Kirby et al., 2015; Leaviss & Uttley, 2014). In contrast to these outcome reviews, the absence of any change in psychological distress scores in Study 2, may be linked to factors within the clinical population from which the study sample was drawn. For example, the reviews of Leaviss and Uttley

(2014) and Kirby et al., (2015) drew upon CFT studies that tended to utilised non-clinical samples that suggested CFT is more helpful at the mild to moderate level of symptom severity, rather than the more ‘severe’ symptom profile that is reflective of the secondary mental health population from which the study sample was drawn and who may have experienced greater resistance to psychotherapeutic change.

Alternatively, it is suggested that the reduction of guilt and shame found over the course of the CFT group may represent an initial first phase of therapeutic change, and that a longer group may have facilitated a second phase of therapeutic change involving the eventual reduction in psychological distress. Specifically, the lack of change in participants psychological distress found in these mediation analyses may indicate that for the majority of participants the process of self-forgiveness was incomplete. This proposition is supported by the fact that the first two phases of self-forgiveness (responsibility and remorse) are closely linked with guilt and shame (Bauer et al., 1992; Hall & Fincham, 2005; 2008), whilst reductions in psychological distress (anxiety, depression, and stress) are linked with completing the self-forgiveness process involving restoration and renewal of the self (Cornish & Wade, 2015b; Thompson et al., 2015). If future studies find this to be correct, CFT groups of a longer duration may be required to facilitate changes of self-forgiveness and improved psychological distress (stress, anxiety, depression). Alternatively, the findings of Study 2 could suggest that whilst internal change may be possible within the therapeutic setting of the CFT group, there may have been powerful environmental issues or other confounding issues that were maintaining participants’ psychological distress that the primary researcher was unaware of. Future research may need to examine these propositions in relation to increasing the duration of CFT groups over further time points such as 16 and 20 weeks.

The results of the Study 2 parallel mediations found that developing self-compassion skills led to a reduction in negative affect and USR that mediated the relationship between increased trait self-forgiveness and reduced guilt, increased state self-forgiving self-beliefs with reduced shame, and increased state self-forgiving feelings and actions with reduced shame and guilt. These findings appear reflective of reviews by Arimitsu and Hofman (2015) and Inwood and Ferrari, (2018) who identified a growing number of studies providing evidence in support of the positive effects of self-compassion on self-critical thinking and reduced negative affects. These studies include short-term interventions (Gilbert & Irons, 2005; Johnson & O’Brien, 2013;

Kelly, Zuroff, 2009; Neff, Kirkpatrick & Rude, 2007), and longer-term interventions (Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008; Gilbert, 2010; Jazaieri et al., 2013; Neff & Germer, 2013). Arimitsu and Hofman (2015) went on to undertake a study comparing the effect of compassionate thinking and a range of other CBT skills (cognitive-reappraisal, responsibility-reattribution, and self-deflection) in a undergraduate sample and found that those participants who used compassionate thinking and cognitive reappraisal reported lower levels of negative affect than those who used responsibility reattribution and self-deflection. Further research is needed to explore the relationships between these CBT methods, self-compassion and self-forgiveness where it would be expected that over-responsibility attributions would have a greater role to play in complicating the process of self-forgiveness.

Consistent with Study 1, the findings of the Study 2 parallel mediations found that CSR and positive and safe / content affect did not have a significant mediating effect upon the relationship between trait and state self-forgiveness and guilt and shame. Once more, this finding may reflect the evidence of a recent review of the pseudo self-forgiveness literature by Wohl, et al., (2017) that highlighted that under certain conditions positive affect can demotivate self-forgiveness as it is the uncomfortable presence of remorse, negative affect (e.g. guilt), and responsibility that appears to motivate change. Further research is needed to test the influence of pseudo self-forgiveness on studies linking self-compassion, self-forgiveness and psychological health. Alternatively, the absence of any mediating effect of CSR and positive and safe / content affect may reflect the aforementioned literature on fears of positive and affiliative emotions. Specifically, the process of becoming self-compassionate may have proved too challenging for the more severely distressed participants leading to them deactivating their attachment systems and reducing their need for self-compassion and associated positive and affiliative affects. Such responses would complicate the process of self-forgiveness leading to no change in their levels of psychological distress (Gilbert et al., 2011; Giliath et al., 2005).

Study 2 summary

In summary, the results of the Study 2 CFT intervention group outcomes analysis found that participants benefitted greatly from taking part in the CFT group, and became significantly more self-forgiving, self-compassionate, experienced higher levels

of positive and safe affect and improved psychological health, and reported significant reductions of negative affect, psychological distress, shame and guilt. In order to provide a more in-depth understanding into the relationships between the constructs under study and the expected processes of change, parallel mediations were undertaken, the results of which demonstrated that negative affect had a medium sized mediating effect upon the relationships between trait self-forgiveness with guilt, state self-forgiving self-beliefs with shame and state self-forgiving feelings and actions.

Together the findings of Study 1 and 2 appear reasonably consistent, with negative affect and the negative components of Neff's (2003a; 2003b) model (USR) emerging as having the greatest mediating effects upon the relationship between self-forgiveness and psychological distress, and negative affect and USR partially mediating the relationship between trait self-forgiveness with shame and guilt. When the effects of the researcher's model were examined over the course of the CFT group, using parallel mediations, negative affect yielded a consistent mediating effect upon the relationship between state self-forgiveness with shame and trait self-forgiveness and state self-forgiving feelings and actions with guilt. With negative affect and USR individually mediating the relationship between state self-forgiveness with shame, and trait self-forgiveness and state self-forgiving feelings and actions with guilt. These quantitative findings will now be discussed and explored in relation to the qualitative findings of Study 3 and their contribution to the literature.

7.2.3 Study 3 (integration).

Study 3 was a qualitative study that used the methodology of the focus group data to help contextualise the interpretations derived from the quantitative data and to provide more detailed understanding of participant's experience of the CFT group and the expected process of change. Woodyatt et al., (2017b) are critical of the lack of qualitative studies into self-forgiveness, and this study was the first qualitative study to examine the effects of a CFT intervention upon self-forgiveness, self-compassion, affect and psychological health.

Two major themes emerged from Study 3's thematic analyses that were intricately woven together within participants' narratives. The first theme, "*becoming self-compassionate and self-forgiving*", broadly reflected the strong associations between

self-compassion and self-forgiveness (Gilbert & Woodyatt, 2017) that were found in Study 1 and Study 2 and the reviewed literature. For example, participants felt that as a result of participating in the CFT group, they had become more aware and less fearful of becoming self-compassionate. This finding is consistent with the findings of Neff, (2009), the previously discussed fear of compassion literature (Gilbert et al., 2011), and existing CFT group research, where becoming self-compassionate is often viewed as indulgent, inefficient and condoning errors and mistakes (Gilbert & Proctor, 2006; Lucre & Corten, 2013).

Study 3 participants indicated that as the CFT group participants became more self-compassionate they became aware that their own struggles were reflective of other members of the group, realisations that reduced their sense of isolation and difference that unhooked them from their common tendency to self-condemn in favour of a growing sense of common humanity (Neff, 2003a; Neff 2003b). These findings are consistent with the work of Gilbert and Irons (2005) who propose that in order to experience self-kindness, one has to develop the self-awareness of the damaging impact of self-condemnation. Whilst these specific findings were not directly tested in this research, examination of the results of Study 1 and Study 2 found some evidence to support these qualitative findings. For example, in Study 1, the negative aspects of self-compassion such as uncompassionate self-responding were found to have a mediating effect on the relationship between self-forgiveness and psychological distress and a partial mediating effect on shame and guilt. In Study 2, uncompassionate self-responding was also found to mediate between changes in state self-forgiving self-beliefs with shame, suggesting that becoming more self-compassionate helped the group participants to become less uncompassionate towards themselves and that enabled them to become more self-forgiving at a schematic level promoting a reduction in shame.

The findings of the Study 3 theme, “*becoming self-compassionate and self-forgiving*” also indicated that, as participants progressed through the CFT group, they also became aware of the potential for self-compassion to change their personal perspectives through developing a greater capacity for balanced thinking. This was especially the case with regard to ideas of over-responsibility and self-blame the reductions of which led to improvements in their psychological health. For example, as their awareness grew, participants reported that their thinking became more balanced, their negative beliefs about self-forgiveness declined, and their positive beliefs about

self-forgiveness grew. This enabled participants to become more open, positive and less self-condemning about making mistakes, viewing their errors, mistakes and failures as part of being human and as an opportunities to learn and grow personally. These results are reflective of the work of Pelucchi et al., (2015) who examined how couples recover from transgressions. Pelucchi et al suggest that the capacity of a transgressor's ability to become self-forgiving is linked to their capacity to experience self-compassion and recognise their own fallibility (Bauer et al., 1992).

The findings of Study 2 also provide some indirect support for the findings of the Study 3 theme "*becoming self-compassionate and self-forgiving*", suggesting that, as participants became more self-compassionate, they experienced reductions in negative affect that mediated the relationship between trait self-forgiveness and guilt, state self-forgiving self-beliefs with shame, and state self-forgiving feelings and actions with shame and guilt. The themes of self-judgment, isolation and overidentified thinking that comprise Neff's (2003a; 2003b) concept of uncompassionate self-responding are reflected in the trauma literature, where individuals can feel over-responsible for their abuse through self-blame that maintains the isolation, powerlessness, guilt and shame that mirrors their abusive experiences (Exline et al., 2011; Janoff-Bulman, 1979; Matos, Duarte, & Pinto-Gouveia, 2017). Whilst it was unclear how many clients within the study samples had experienced trauma, the findings of Study 2 and Study 3 indicate that developing CFT skills and becoming self-compassionate facilitated reductions in negative affect and uncompassionate self-responding that promoted the self-forgiveness process yielding reductions in shame and guilt.

The second major theme identified in the thematic analysis of the focus group data, '*the CFT group was beneficial*' reflected changes in participants' attributions beliefs that required a willingness to change and take responsibility for their difficulties. These themes also emerged within Lucre and Corten's (2013) qualitative analysis of their CFT group that they termed 'taking responsibility for one's thoughts and actions' and their mistakes, motivations that are at the heart of CFT and the process of self-forgiveness (Gilbert & Woodyatt, 2017; Pelucchi et al., 2015). In their review, Gilbert and Woodyatt (2017) assert that two basic sets of psychological competencies are required for self-forgiveness to occur. The first competency is the ability to move towards distress and suffering rather than take steps to avoid such contact, through the use of denial, dissociation, or justification. The second competency is linked to taking

wise action through the use of the six key CFT skills-competencies (attention sensitivity, sympathy, distress tolerance, empathy, nonjudgment and care for well-being) that inform individuals to undertake wise, and courageous ongoing action in relation to their responsibilities. Within Study 3, participants acknowledged that taking ownership of their feelings and difficulties was hard, but that the prospect of change offered hope for the future. In this regard, participants felt that group support was helpful in establishing new skills to effect ongoing change, especially at times of relapse.

As part of the second theme, “the CFT group was beneficial”, participants in Study 3 reported a range of personal benefits that they had gained during the course of the CFT group that included increased capacities for self-forgiveness, self-compassion, assertiveness, more self-confidence and self-acceptance, and an increased capacity for managing their emotions, thoughts and reducing their suffering. The positive CFT group results obtained in Study 2 appears consistent with these thematic findings, where participants also reported significant improvements in self-forgiveness, self-compassion, positive and safe affect, and psychological health, and significant reductions in negative affect. These findings are reflective of those of the CFT and self-forgiveness outcome literature (Cornish & Wade, 2015b; Davis et al., 2015; Kirby et al., 2015; 2016; Worthington et al 2017).

With regard to becoming self-forgiving, the results of Study 3 provided evidence about the benefits of specific CFT skills in promoting the process of change, evidence that is lacking within the research literature (Arimitsu & Hofmann, 2015; Sommer-Spjikerman et al., 2018). For example, participants felt that the CFT grounding skills (e.g. breathing, mindfulness) were particularly helpful in developing a sense of calmness to a point where the compassionate attributes of self-kindness, sensitivity, and empathy became more accessible. The use of more focal CFT skills such as cognitive restructuring (compassionate thinking) and responsibility reattribution (the responsibility pie chart exercise) were able to be utilised and developed, changes that helped participants to deal with feelings of over-responsibility and self-condemnation and become more self-compassionate and self-forgiving. Whilst there are no directly comparable studies, studies by Lucre and Corten (2013) and Feliu-Soler et al., (2016), with clients diagnosed with Borderline Personality Disorder (BPD), indicate that developing loving-kindness, compassion mediation, and compassionate breathing skills

are helpful in promoting self-kindness and acceptance. Furthermore, previously reviewed research by Arimistu and Hofmann (2015) found that compassionate thinking and cognitive reappraisal to be effective in reducing negative emotions. Further qualitative and quantitative research is needed into these constructs and their impact on the process of self-forgiveness.

Integrative summary

In summary, Study 3 was the first study to undertake a thematic analysis of a CFT group with a specific focus on the development of self-forgiveness, affect and psychological health. This third study identified two major themes: ‘Becoming self-compassionate and self-forgiving’, and ‘the CFT group was beneficial’ as a result of participating in the CFT group. The first major theme reflected participants growing familiarity, awareness and insight into the links between self-compassion and the process of self-forgiveness. Making these links helped participants reduce their negative beliefs about becoming self-compassionate and self-forgiving. Participants became more aware of the benefits of becoming self-compassionate and self-forgiving with the outcome that participants experienced reductions in self-condemnation that yielded benefits for their psychological health such as reduced suffering.

The second major theme reflected participants’ impressions that taking part participating in the CFT group had facilitated personal change, through assuming a personal commitment to change. This involved taking ownership and personal responsibility for their thoughts and feelings about their mistakes, rather than condemning themselves and others. This was a personal process that required commitment to an on-going process of change utilising CFT skills to assist with emotional regulation and the development of more balanced thinking that yielded greater self-confidence, self-acceptance and increased assertiveness. Together, these qualitative results provided more detailed and personal explanations of the processes of change highlighted in Study 1 and Study 2, where it was found that reductions in negative affect and uncompassionate self-responding were implicated in mediating the relationship between increased self-forgiveness and reduced shame and guilt.

The literature review in Chapter 2 highlighted that self-compassion researchers are just beginning to undertake empirical research to understand the processes of change

in CFT (Sommers-Spijkerman et al., (2018a). For example, a recent review by Sommers-Spijkerman et al., (2018b) found that the empirical evidence to support Gilbert's (2014) assertions about the mechanisms of change within the CFT was still lacking. Furthermore, it emerged that the processes of change between self-forgiveness, self-compassion, affect and psychological health had not been studied, a gap in the literature that this PhD study attempted to address. In response, the researcher proposed a new stress and coping model of self-forgiveness, self-compassion, affect and psychological health that was examined and tested quantitatively using a cross-sectional design (Study 1), a repeated measures longitudinal design (Study 2), and qualitatively using focus groups. Together, these three studies were the first empirical studies to provide evidence about how self-compassion and affect, and in particular how changes in uncompassionate self-responding and negative affect, influence the process of self-forgiveness and psychological health.

Having identified the core findings of this PhD research, in this next section these findings will be discussed in relation to the threats to validity that were imposed by the design of the study, the types of analyses that were used, and the sample sizes that were obtained to undertake this research.

7.3 Limitations of the current research

In considering validity issues with study design and causal inference, the work of Cook and Campbell (1976) appears salient. Cook and Campbell highlight four types of validity that require consideration in evaluating study design, namely: *Internal validity*, *external validity*, *construct validity* and *statistical conclusion validity*. Briefly, internal validity refers to the extent to which causality can be inferred from a study. External validity refers to the extent that study findings can be generalised over time. Construct validity refers to the extent to which the findings of a study can be generalised because of accurately measuring a study concept, and statistical conclusion validity involves the degree to which the study conclusions are correct or reasonable. The thrust of Cook and Campbell's argument is that all quantitative research designs are flawed and susceptible to a range of threats to their internal validity, assertions which will be discussed in relation to limitations of Study 1 and Study 2. In relation to the limitations of Study 3, the researcher will draw upon the work of Shadish, Cook and Campbell (2002) who extended the work of Cook and Campbell (1976) into the field of qualitative research.

7.3.1 Studies 1 and 2

Study 1 utilised a cross-sectional design that allowed for the relationship between trait self-forgiveness and a range of psychological health variables to be studied, whilst examining the effects of a range of mediators and potential confounding variables upon these relationships. The major disadvantages of this design are in terms of its internal and external validity as it is not possible to establish cause-and-effect relationships between the variables under study over time. In order to try and establish such associations it was necessary to design a second study (Study 2), however concerns within the organisation about introducing delays in patients treatment meant that it was not possible to utilise a true waiting list control group, so a repeated-measures design was utilised. Cook and Campbell (1976) point out that repeated-measures designs are potentially vulnerable to *reactivity of measurement* or practice effects, as well as *endogenous* or *maturational changes*. These threats involve changes within participants that occur spontaneously without reference to any particular intervention, and it is noted that changes in participants' environments (e.g., bereavements, improved relational support) could not be excluded. Whilst such changes would have been possible, this was considered unlikely as the clients who are referred to community mental health teams tend to have enduring and chronic mental health needs that are resistant to change without the introduction of a clinical intervention.

Within clinical studies, Cook and Campbell (1976) highlight the importance of being aware of the phenomena of *regression to the mean*, that involves the tendency for both clinical researchers to select participants on the basis of high levels of the construct under study, or equally, for some severely distressed participants to put themselves forward for clinical interventions. As a result, what tends to occur is that participants who score highly on a scale of interest are more likely to experience greater reduced scores than participants who scored lower on the same scale, because the scores at pretest will not be as high at post-test. Whilst the effects of this phenomena cannot be excluded in Study 2, it is noted that no participants scored a maximum score of psychological distress at week 1 of the CFT group, and the participants' average psychological distress scores at the beginning of the CFT group were in the 'severe' rather than the 'extremely severe' range of the DASS-21 (Lovibond & Lovibond, 1995). Whilst this suggests that whilst the effects of regression to the mean cannot be excluded, it may not have been a feature of the majority of participants' change scores.

Threats to external validity include whether the samples were representative of the population from which they were obtained and treatment fidelity. Taking the issue of whether the sample was representative first. The Study 1 sample was drawn from a mixed clinical and non-clinical (student) population, and whilst this sample mix was more likely to be representative of the Auckland population than either alone, it is noted that both the Study 1 and Study 2 samples were over-represented in terms of gender (more females to males), being single, being of NZ/European descent, and over-represented in the lower age bracket. However, it is noted that age, gender, and culture (collectivist vs. non-collectivistic culture) were controlled for within the Study 1 analyses, which should have reduced their threats to both the internal and external validity of the study.

Within the contexts of this research, treatment fidelity involves the extent to which a treatment protocol's core components are implemented as intended both in terms of face validity and reliability (Bellg, et al., 2004; Borrelli, 2011; Poltawski, Norris & Dean, 2014). In order to try and ensure that the treatment intervention was representative of a CFT group intervention, the CFT programme used in Study 2 was based upon a manualised approach (Kolts, 2011; 2014) that was well respected within the CFT community as having high face validity (Gilbert, 2011). It was expected that this would help ensure that the CFT intervention was delivered reliably across the four planned CFT groups. Furthermore, it is noted that reliability was aided through the CFT group intervention being delivered by the primary researcher and the same experienced CBT nurse therapist. The primary researcher was a Consultant Clinical Psychologist and who had previously undertaken CFT training and had been running CFT groups for two years prior to commencing this research, whilst the nurse therapist had undertaken CBT training and also had considerable experience running groups. Whilst this consistent approach aimed to reduce possible different therapist effects, it could not be guaranteed that the same programme was delivered in an identical way, or indeed that the facilitators had become more effective at delivering the same material over time. Future research could consider the possibility of incorporating fidelity checks such as undertaking random audio-recordings of the group and asking experienced CFT therapists to rate how well the facilitators adhere to the treatment manual or expected CFT competencies (Liddell, Allan & Goss, 2016).

As has already been acknowledged, a further threat to internal validity involved the difficulties of including a waitlist control group into the study design. It is acknowledged that this makes it difficult to definitively conclude that any changes in the study variables over the course of the CFT group would likely be the result of participating in the CFT group, although causality can be inferred.

Further concerns about the internal validity of the study involved issues of selection and created other possible construct validity issues. Specifically, those participants self-selected to participate in the studies and that some participants may have differed from other participants because of a particular construct that was not measured. Randomisation is often suggested as the solution to manage these issues, however, it was not possible to undertake this approach because of practical and ethical issues. Firstly, it took 2-3 months to assess and recruit enough participants to take part in the study to offset drop-out rate. Secondly, it was not possible to run more than one group at a time; and thirdly, there were ethical concerns about having to ask clients to wait for therapy beyond the normal waiting time for the CFT group. Instead, exclusion criteria were developed to control for possible extraneous variables including clients diagnosed with severe mental health problems (e.g. severe depression, psychosis, personality disorders) and developmental difficulties (e.g. autism). In addition, the effects of a number of known socio-demographic and personality variables were controlled for in both Study 1 and the Study 2 group study.

Cook and Campbell (1976) also draw researchers' attention to the importance of considering the role of expectancy and Hawthorne Effects. Given that the researcher was also the main facilitator of the CFT group, it was possible that some participants may have felt that need to inflate how well they done, partly because of the need to 'reward' the researcher for the help given or to falsely validate themselves because of the shame that they felt about not progressing as they had hoped. In order to control for this possibility, participants completed a measure of social desirability in Study 1 and again in Study 2 that was not found to have a confounding effect suggesting that in general, participants had not sought to present themselves in socially desirable ways.

7.3.2 Study 3

Although validity issues are perhaps most often thought to be part of the quantitative research paradigm, validity has also been written about extensively from within the qualitative tradition both in terms of methodology (e.g. Kvale, 1989; Maxwell, 1992), method (focus groups), and the method of analysis (thematic analysis) that was used in Study 3 (Braun & Clarke, 2013). Shadish, Cook and Campbell (2002) take a similar approach to that used by Cook and Campbell (1976), and describe a range of threats to validity within qualitative research. These include *errors of commission* (describing something that did not occur), *errors of omission* (failing to describe something that did occur), *errors of frequency* (inaccuracies about how often something occurred), and *inter-rater disagreements* about what occurred (Maxwell, 1990). These validity threats can emerge at any point within the process of undertaking qualitative research, involving the method that is utilised to obtain and analyse the data.

Taking the issue of method and validity first, Wilkinson, (2004) and Kruger and Casey, (2009) point out that focus groups have been criticised on several grounds. Firstly, they suggest that focus groups are susceptible to facilitator bias that may have affected the validity of the information obtained through *errors of omission* and *commission*. Drawing upon the guidance of Kruger and Casey (2009) the researcher was aware of the possibility of facilitator bias and errors of commission and endeavoured to maintain a low level of involvement through the use of open ended questions whilst monitoring the narrative of the focus members, and curtailing conversations that did not fit with the topic of research interest.

Secondly, it has been suggested that focus group discussions may be shallower than those obtained in individual interviews and may not provide a proper understanding of participants' experiences (Kruger & Casey, 2009) creating errors of omission. Hollander (2004) suggests that some participants may not feel able to take part within group discussions because of the personal nature of what is being discussed, or there may be dominant members within the group who express their opinions more than others. It may be that the more passive members have opposing views and do not want to cause conflict or feel disapproved of by other group members. Kruger and Casey (2009) point out that the extent to which this will happen will depend upon the dynamics of the group, the skills of the moderator in ensuring that all have a voice, and

how safe members feel with other participants. Kruger and Casey (2009) point out that good facilitators need to possess certain skills and characteristics in order to minimise errors of commission and omission. Facilitators need to be able to lead discussions to ensure that the objectives of the focus group are met but also exercise unobtrusive control, keeping their involvement to a minimum to reduce the possibility of biasing the discussion through commission errors. It was expected that the primary researcher's experience in facilitating groups would reduce the risks of errors of commission and omission but this was not formally assessed through independent evaluation.

Thirdly, Kruger and Casey (2009) also state that facilitators should have no positional power or control over the participants (e.g., hiring, firing), be unknown to participants, and be uninvolved with the group outcomes of the focus group. In response to these criticisms, whilst it was anticipated that the first criteria could probably be satisfied (the facilitator's experience would reduce the risks of omission and commission), the second and third criteria could not be satisfied as participants; a) had just taken part in a CFT group that the primary investigator had facilitated, and b), the principal investigator was also moderating the focus group.

Whilst these appear to be flaws in Study 3, it is suggested the primary investigator's familiarity with the participants may have provided the security, safety and confidence that participants may have needed to have open discussions about emotionally sensitive matters (Kitzinger, 1994; Morgan, 1988). It has already been noted in Study 2 that prior to commencing the focus group, participants had completed a social desirability scale that would provide an indication and test of the participants' tendency to need social approval and acceptance. Although not formally tested, given that changes in social desirability were uncorrelated to changes in shame and guilt, it was felt that the probability of researcher biasing the focus group discussions was low. This is not to say that a larger study sample may not have yielded such an effect.

Braun and Clarke (2006; 2013) have been critical of the historical lack of a systematic approach within qualitative research that they assert has weakened the generalisability of qualitative research. In response, Braun and Clarke (2013) suggest the use of certain quality criteria and techniques that are suitable for qualitative research; including member checking, triangulation, and the development of a six-phase approach that is suitable for use in undertaking thematic analysis. Briefly, member

checking involves checking the findings with the study participants to ensure that they are valid and appropriate, whereas triangulation involves looking for links within the data through the use of at least two methods of data collection (Lincoln & Guba, 1985). Member checking was used informally as part of the interview process that involved the researcher checking and verifying understandings with the participants, and triangulation was used as part of the mixed methods approach used in this PhD study.

Furthermore, the six-phase approach recommended by Braun and Clarke (2006; 2013) that was developed to improve the validity of qualitative research was also utilised to improve the validity of the findings of Study 3. Braun and Clarke (2013) are critical of those qualitative researchers who use of statistical terms such as inter-rater reliability and Cohen's Kappa (Yardley, 2008). Braun and Clarke (2013) assert that such objective attempts at obtaining reliability are inappropriate as qualitative research can never be truly objective. Whilst the researcher has some agreement with this position, it was felt that a compromise position could be found, and the reliability and validity of Study 3 could be improved through adopting a non-statistical approach termed 'dialogical intersubjectivity' that involved utilising the help of two of my supervisors (KvK and JF), to identify the codes and themes to a point where there was general agreement about their validity and reliability (Brinkmann & Kvale, 2015; Sandelowski & Barroso, 2007).

In summary, it is acknowledged that it was inevitable that the study design and the analytical processes that the researcher took influenced the validity and reliability of the study to some degree. However, with regard to the qualitative findings it was also the researcher's active involvement with the participants and the research material that may have increased the validity of the research findings as discussed by McLeod (2001). The final issue that is important to discuss in this section is that of sample size.

7.3.3 Sample size.

Cohen (1988; 1992) points out that the power of any statistical test is based upon the probability that the test will reject the null hypothesis when the null hypothesis is false. More specifically, power reflects the probability of not committing a type II error. Cohen goes on to explain that the two major factors that affect the power of a study are the sample size and the effect size. Hayes (2018a) points out that when considering

undertaking mediation analyses there is no agreed way to determine the sample size needed to detect an effect (Fritz & Mackinnon, 2007; Ma & Zeng, 2014). Given it was uncertain what sample size would be required to detect an effect the proposed studies, and the effects of the numbers of mediating and confounding variables involved in testing the model, it was decided to interpret any results conservatively in relation to the effect sizes and confidence intervals that were obtained.

Whilst a number of significant mediations were found in Study 1 and 2 with good effect sizes despite the relatively small sample sizes, the results suggest that in some instances the sample size of the studies may have affected the obtained results. For example, in Study 1 in relation to the bifactor model, trait self-forgiveness and psychological distress were mediated by USR and negative affect, and trait self-forgiveness and shame and guilt were only partially mediated by USR and negative affect resulting in a just significant result ($p = .03$). This suggests that a larger sample size could have yielded larger effect sizes resulting in non-significant mediating effects for all of the hypotheses, thus affecting some of the bootstrapping results. In Study 1, the mediating effects of the single-factor model with safe / content affect, positive affect and negative affect upon trait self-forgiveness with shame just yielded a non-significant indirect effect. In the case of safe / content affect, the confidence intervals just crossed zero, ($b = -.07$, 95% CI $[-.14, .00]$), whereas negative affect yielded a significant effect of $b = -.10$, 95% CI $[-.18, -.04]$. Similarly, in Study 2, there were a number of relatively high but non-significant correlations, which meant that they could not be included in the mediation analyses or their hypotheses tested. For example, trait self-forgiveness yielded a non-significant correlations with psychological distress ($\rho = -.18$, $p = .28$), shame, ($\rho = -.27$, $p = .10$), and safe / content affect was not significantly correlated with any of the self-forgiveness variables despite of an average positive correlation of $\rho = .24$. This suggests that a larger sample size could have allowed other results to emerge from within the Study 2 analyses, and this would be a recommendation for future research.

Braun and Clarke (2013) highlight that within the qualitative tradition statistical terms such as power and effect are inappropriate, and that the sizes of samples are generally much smaller than those used in quantitative research. This is because qualitative research is more concerned with understanding experience and meaning rather than developing generalised statements, as is the case in quantitative research.

However, Braun and Clarke do assert that when undertaking qualitative research it is important to have a sample that is large enough to identify relevant influencing factors, but not so large as to be saturated by data. Given that Study 3 was the first qualitative study into the links between self-forgiveness, self-compassion, affect and psychological health, guidance about sample size was taken from other CFT studies that used qualitative approaches (e.g. Gilbert & Procter, 2006; Lucre & Corten, 2013). It is also noted that the data from Study 3 was rich enough to yield consistent themes that informed this research.

Having discussed the findings of the PhD research in full, in this next section it remains to consider what the theoretical and clinical implications are for the self-forgiveness and self-compassion research communities.

7.4 Theoretical implications

Given the long anecdotal, theoretical and more recent emerging empirical evidence linking self-compassion and self-forgiveness, it is perhaps surprising how little had been written about self-compassion and self-forgiveness from within the CFT and wider compassion and forgiveness-focused communities. For example, whilst an edited text by Gilbert (2005) contained a chapter on compassion, forgiveness and their implications for psychotherapy (Worthington et al., 2005), subsequent core texts by Germer (2009), Gilbert (2009), and Neff (2011), made little mention of self-forgiveness and self-compassion, and it was not until 2017 that the first edited text on self-forgiveness that drew extensively on previous self-compassion research was published (Woodyatt et al., 2017).

The results of the literature review in Chapter 2 highlight that, whilst research into self-compassion and self-forgiveness has grown over the past decade, no theoretical models have been developed to unify these key constructs (Woodyatt et al., 2017b). Drawing upon the stress and coping literature, the researcher's own stress and coping model of self-forgiveness, self-compassion, affect and psychological health was proposed to build greater understandings between these constructs. The need to test the validity of this model is reflected in the aims of the three studies that comprise this PhD research.

The results of these three exploratory studies in the current theses suggest that the researcher's model has theoretical validity, but further research needs to be undertaken to thoroughly test whether the model has what Paul Thagard (1992) terms *explanatory coherence*. Briefly, Thagard (1978) explains that determining the explanatory coherence of any theory emerges from satisfying three criteria, namely: *explanatory breadth* (whether a theory explains a greater range of facts than its rivals), *simplicity* (the extent to which a theory needs to be adjusted to account for discrepancies that challenge the validity of the theory), and *analogy* (the extent to which the theory is supported by other evidence).

Taking each criteria in turn, it is suggested that the researcher's stress and coping model of self-forgiveness, self-compassion, affect and psychological health has good explanatory breadth, as for the first time it draws together a great deal of research with a range of supporting theories and models associated with forgiveness (Cornish & Wade, 2015a; Hall & Fincham, 2005; Lazarus & Folkman, 1984; McConnell, 2015; Worthington, 2006; Strelan & Covic, 2006; Toussaint et al., 2017); self-compassion (Gilbert 2009, 2010, 2014; Neff, 2003b, 2014), and affect regulation (Gilbert, 2009; 2010) to create a bold but unifying model.

The results of Study 1 indicated that all of the constructs of the researcher's stress model were strongly correlated in the expected directions with self-forgiveness, self-compassion, and positive and safe / content affect found to be positively correlated, and negative affect and the psychological health variables negatively correlated. Parallel mediation analyses indicated that the model accounted for an average of 51.7% of the variance between increasing trait self-forgiveness and reductions in levels of the psychological health variables (psychological distress, shame and guilt), after controlling for age, SES, neuroticism and agreeableness. With reductions in negative affect, and uncompassionate self-responding, emerging as key mediators between trait self-forgiveness and psychological health variables, after controlling for the effect of neuroticism.

As the model has yet to be published and has only been subjected to exploratory testing, it remains unclear whether the model fulfills Thagard's (1992) second criteria of simplicity and analogy. However, the results of Study 1 are certainly encouraging and are consistent with previously reviewed empirical research that found stronger links

between Neff's (2003) uncompassionate self-responding subscales (self-judgment, isolation and over-identified thinking) and psychopathology than the compassionate self-responding sub-scales (Hupfield & Ruffieux, 2011; Krieger et al., 2013; Mills et al., 2007; Van Dam et al., 2011). The Study 1 results also appear to support the evidence linking neuroticism with Neff's conceptualisation (Neff, Rude & Kirkpatrick, 2007), with the effects of USR creating negative rejecting responses and affects that would create a disposition against self-forgiveness, leading to an increased overidentification of thinking and isolation that are the cognitive and behavioural hallmarks of shame, guilt and increased psychological distress (Leach, 2017, Toussaint et al., 2017).

Similar but weaker results were obtained in Study 2, with the parallel mediation analyses indicating that the model accounted for an average of 18% of the variance of change between increasing trait and state self-forgiveness and reduced shame and guilt. Participants who took part in the CFT group developed increased capacities for self-compassion that led to reductions in negative affect, and to a lesser extent uncompassionate self-responding that mediated the relationship between self-forgiveness and reduced shame and guilt. Findings that reflect the published clinical models of self-forgiveness (Cornish & Wade, 2015; Enright et al., 1996; Jacinto & Edwards, 2011; Worthington, 2001) and theoretical models of self-forgiveness, (Hall & Fincham, 2005; McConnell, 2015; Toussaint et al., 2017; Worthington, 2006). It is noted that the small sample size used in Study 2 did not allow for the confounding effects of neuroticism or other variables including those that were not controlled for (e.g. depression, shame) to be assessed that could have accounted for an increased percentage of the variance.

Together the findings of the three studies that comprise this thesis provide some evidence of *analogy*, linking self-forgiveness research (Woodyatt et al., 2007; Gilbert & Woodyatt, 2017; Toussaint et al., 2017), with Neff's (2003) model of self-compassion and the negative affect component of Gilbert's (2010) model of affect regulation. Whilst the positive and safe / content affect components of Gilbert's affect regulation model did not emerge strongly from these studies, and represent a challenge in terms of Thagard's (1992) construct of *simplicity* (the extent to which a theory needs to be adjusted to account for discrepancies that challenge the validity of the theory). It is noted that the three current studies were exploratory with relatively small samples,

using a 12-week CFT group that may not have provided an adequate test of the complete influence of this model upon Neff's model of self-compassion and Gilbert's model of affect regulation.

7.5 Clinical implications

The findings from the current study have important clinical implications. The results of Study 2 and Study 3 indicate that the skills of self-compassion and self-forgiveness can be taught in a brief 12-week group format that is effective in increasing self-compassion, self-forgiveness, positive and safe affect and reducing negative affect, psychological distress, shame and guilt. Findings that are supported by reviews of previous self-forgiveness and self-compassion outcome studies (Griffin, Worthington, et al., 2017; Griffin, et al., 2014; Griffin, 2013; Kirby et al., 2015; Kirby, 2016; Neff & Germer, 2013). While the research was carried out in New Zealand, the results are likely to be applicable to clinical populations elsewhere, especially given the ubiquitous nature of humanity and the challenges of living in modern western civilisation (Gilbert, 2017; Huang & Bargh, 2014).

It is suggested that the addition of a CFT group within a psychological service would be a valuable addition to other psychological interventions and groups that may be on offer. For example, the clients who completed the CFT group in Study 2 indicated that in comparison with the time that they spent on the waiting list, that they became more aware of a pathway towards self-forgiveness and improved psychological health, and that this pathway appeared to make sense in relation to their personal histories and presenting difficulties. Furthermore, the results of Study 2 found that attending the group facilitated increased self-forgiveness at a behavioural level (clients became more self-forgiving and self-compassionate), at cognitive level (clients became more balanced in their thinking, less self-critical, isolated, and identified less with what they thought), and at a schematic level (clients experienced a reductions in negative self-schema). Given that the main focus of this research was more upon the process of self-compassion and self-forgiveness rather than outcome and follow up, it was unclear whether these benefits were sustained over time. Given that sustained benefits have been reported in reviews of CFT outcome studies (Kirby et al., 2015; Kirby, 2016; Leaviss & Uttley, 2014), future studies may wish to repeat the measures used in this study at 6 and 12 month follow up.

This PhD research indicated that becoming more self-compassionate helped clients to become more self-forgiving and experience reductions in shame and guilt. The findings of Study 2 indicated that becoming more self-compassionate yielded reductions in negative affect and USR that mediated improvements in self-forgiveness and reductions of shame and guilt. Therefore, from a clinical perspective it would appear especially important for CFT therapists to focus upon reducing negative affect and USR in order to maximise self-forgiveness and reduce shame and guilt. In order to facilitate this it would be particularly important to weaken the positive beliefs associated with USR that are implicated in influencing negative affect and complicating the process of self-forgiveness. This process would involve helping clients to make cognitive shifts that are either as a result of; a) fears of becoming inefficient through making further mistakes, or b) out of anger or self-hate through a wish to self-punish either because of not acting in accordance with their personal values, or c) because of enduring shame-linked negative self-beliefs in relation to severe personal transgressions by themselves or others (Castilho, Pinto-Gouveia & Duarte, 2013). Together these findings and suggestions also have clinical implications for how clinician's undertake CFT assessments and necessarily the process of CFT therapy, and will now be discussed in the remainder of this section.

7.5.1 Clinical implications for assessment

In relation to Neff's (2003a; 2003b) model and the process of becoming more self-forgiving, the findings of Study 2 suggest that it would be helpful for CFT clinicians to assess and identify clients' positive beliefs about the concepts of USR, how they foster negative affect, and how together they complicate the process of self-forgiveness. The findings of Study 2 and 3 also indicate that the negative components of Neff's (2003a; 2003b) model (self-judgment, isolation, over identified thinking) in addition to negative affect were implicated in complicating the process of self-forgiveness leading to increased shame and guilt.

As part of the process of assessment it therefore appears especially important for clinicians to identify and formulate client's barriers to becoming self-compassionate and self-forgiving and how they complicate their psychological well-being (Gilbert, 2010). It is noted that researchers have yet to develop a scale measuring fears of self-forgiveness, but such fears could be identified as part of the assessment process. In

addition, the Self-compassion Scale (Neff, 2003a), as well as other CFT scales such as the Fears of Compassion Scales (Gilbert et al., 2011), and the Forms of Self-Criticising/Attacking and Self-reassuring Scale (Gilbert, et al., 2004) could be useful within the processes of assessment and outcome. In Study 1, neuroticism emerged as the key confounding factor that affected the relationship between self-forgiveness and the psychological health variables, and whilst it was not possible to examine whether neuroticism played the same role in Study 2 mediation analyses, it would seem important to also consider screening for this variable given the confounding effect upon the Study 2 group results.

7.5.2 Clinical implications for therapy

Having identified that USR constructs and negative affect are the key targets in facilitating self-forgiveness and reducing shame and guilt, how would the process of CFT facilitates these changes? The results of Study 2 and 3 suggest that a key part of this process would involve helping clients to identify negative beliefs about USR and the costs and benefits of adhering to such beliefs and attributes. By way of illustration, possible examples of these positive and negative cognitions are laid out in table 7.1.

Table 7.1. Highlighting potential shifts of uncompassionate self-responding beliefs and cognitions to facilitate compassionate self-responding and self-forgiveness.

USR construct (Neff 2003a; 2003b).	Positive beliefs about USR attributions	Negative beliefs about USR attributions
Self-judgment	“Being self-critical helps me to not make mistakes”	“Being self-critical makes me less effective by reducing my creativity”
	“I deserve to be punished for the mistakes that I have made.”	“Punishing myself won’t help me to repair the damage that I have done to myself and others”
	“I deserve to be punished because of the person that I am.”	“What happened was not all my fault.”
Isolation	“I make more mistakes than other people.”	“Everyone makes mistakes”
Over-identified thinking	“When things go wrong it’s all my fault”.	“Everything is not my fault.”

Gilbert (2014) asserts that the main goal of CFT is to address fears of giving and receiving compassion whether this is from the self to the self, from others to the self, or from self to others. In this regard, the findings of Study 2 and 3 suggest that it is the fear of committing further transgressions in the absence of self-judgment and self condemnation that appears key, perhaps because it is feared that failure to do so would lead to further transgressions, reduced self-forgiveness and increased shame and guilt.

Saulsman, Campbell and Sng (2017) developed a seven-session self-help CFT course that draws upon these CFT processes, the second module of which focuses on 'Barriers to Self-Compassion' and can be downloaded from the Centre for Clinical Interventions website (<https://www.cci.health.wa.gov.au/Resources/Looking-After-Yourself/Self-Compassion>). This module provides some guidance for clinicians who want to help their clients to change their positive beliefs about self-criticism and illustrates some of the change techniques that are used in CFT.

Saulsman et al., (2017) encourage clients to engage in a process of enquiry about the functions of such beliefs (self-improvement and self-punishment) before encouraging them to challenge their positive beliefs about self-criticism (evidence for and against). Saulsmann et al. suggest that clients to complete an exercise that asks them to consider an issue that they often criticise themselves about and then reconsider how different their responses and voice tones would be if a friend or a child had similar problems. They also ask clients to consider their negative beliefs about self-compassion, in particular what they fear might happen if they reduce their self-criticism (e.g. becoming lazy, indulgent, undisciplined, out of control). Finally, clients are asked to undertake a behavioural experiment involving keeping a diary that enables them to observe the effects of deliberately switching between kind and self-critical days with the aims of reducing positive beliefs about self-criticism and negative beliefs about self-compassion. Given that self-compassion and self-criticism has been associated with a range of clinical presentations such as depression, social anxiety, PTSD (Kannan & Levitt, 2013), it appears likely that focusing upon clients' positive beliefs about self-criticism and USR may increase the effectiveness of psychotherapeutic work with these and other clinical presentations.

Finally, the results of Study 2 and the feedback from clients in Study 3, suggests that outcomes may have improved if the group had been extended from 12 to 16 weeks

with the suggestion to using these additional sessions to specifically focus upon the self-forgiveness process. This may be especially important given the confounding effects of neuroticism found in Study 1 and Study 2. Clients who attend secondary mental health services are more likely to present with high levels of neuroticism, co-morbid personality issues, and high levels of self-criticism that would likely increase their barriers to self-compassion and self-forgiveness (Lucre & Corten, 2013).

Having reviewed and discussed the findings of this research together with their theoretical and clinical implications, what follows are the recommendations for future research that will set the scene for the final concluding chapter.

7.6 Recommendations for future research

Given the complexity of the researcher's proposed stress and coping model of self-forgiveness, self-compassion, affect and psychological health, it was planned to examine only the salient features of the model. This included examining links between the secondary (challenge) appraisals (trait and state self-forgiveness) and psychological health variables (psychological distress, shame and guilt) that were proposed to be mediated by a blend of restorative coping (compassionate self-responding and positive affects) and retributive coping (uncompassionate self-responding and negative affect). The effects of a range of potentially confounding socio-demographic and personality factors upon these relationships were also evaluated.

The aspects of the model that were not examined included the links between the stressors, the primary threat and loss appraisals and the secondary challenge appraisals (trait and state self-forgiveness). In terms of the stressors, it was therefore left undetermined what the transgression was, whether the transgression was interpersonal or intrapersonal, what personal, value, rule or standard had been violated, and what meanings were being construed such as the levels of seriousness and felt responsibility for the transgression. The level of justifiable forgiveness or punishment that was felt appropriate from themselves, others or their god and how these linked to participant's capacities for trait and state self-forgiveness were also left unstudied. Future research is needed to examine these variables and how they relate to the broader model.

Toussaint et al., (2017) point out that the relationship between self-forgiveness and health could also be influenced by a range of mediators and moderators other than self-condemnation including psychosocial variables that were not part of this research analysis. These include the mediating influences of depression, social support, self-forgiveness, or the existence of other coping behaviours such as denial and emotional detachment (Toussaint et al., 2008; Webb, Hirsch, Visser, & Brewer, 2013; Webb, Phillips, Bumgarner & Conway-Williams, 2012). Woodyatt et al., (2017b) assert that self-forgiveness research is complex, and suggest that it may be entirely possible for some of these variables to simultaneously mediate and moderate the effect of self-forgiveness upon psychological health (Hayes, 2018a).

Aside from the complexity of the model, another weakness of the current study was the small sample size, which meant that any findings needed to be interpreted conservatively. Whilst the current studies have produced some very interesting findings, it is important that future research re-test the model with larger clinical and non-clinical populations to establish how the model performs. For example, how long does a CFT course need to be in order to yield the best self-forgiveness outcomes? Does the required optimal length of treatment vary according to the target of change (e.g. shame, depression, suicidality, life satisfaction, quality of life)? Can the model be used with different populations (adolescents, adults, older adults) or those who are healthy or suffer ill-health (chronic illnesses)? What are the influences of gender, sexuality (straight, LGBT), general culture (collectivistic, non-collectivistic), or specific local cultural comparisons (e.g. Pākehā, Māori, Pacific Islander) upon the study variables?

More specifically, it is necessary to develop a greater understanding of how the positive and negative aspects of Neff's (2003a; 2003b) model facilitate and complicate the process of self-forgiveness and psychological health. For example, in becoming self-compassionate and more self-forgiving, it may be important to first increase feelings of safety through reducing the threats associated with reductions in specific negative affects (e.g. guilt), before focusing on the positive components of self-compassion (self-kindness, common humanity, mindfulness).

As was highlighted in the literature review in Chapter 2, empirical studies are just beginning to identify how the various CFT skills effect change, and whilst there appear to be encouraging early results (Sommer-Spijkerman et al., 2018a), it remains to be seen

whether these CFT skills foster changes in self-forgiveness in the same way as they do in fostering self-compassion. For example, Arimistu and Hofmann (2015) compared the effect of compassionate thinking with other traditional cognitive behavioural therapy methods (cognitive reappraisal, responsibility attribution, and self-deflection) and found that participants who used compassionate thinking and reappraisal reported significantly lower levels of negative affect compared with the responsibility attribution and the control group. Given the established links between increased self-forgiveness, reduced guilt and over-responsibility, it would be expected that utilising responsibility attribution skills would enhance the process of self-forgiveness. Indeed, participants in Study 3 highlighted that the use of the responsibility pie chart (Padesky & Greenberger, 1995) was a key skill in establishing more appropriate responsibility attributions. Further empirical research is needed to establish this.

Whilst it is unclear which self-compassion skills promote self-forgiveness and psychological health more effectively than others, it is also unclear whether this process is better facilitated through reducing positive beliefs about uncompassionate self-responding and self-forgiveness (e.g. ‘self-criticism is helps me to be effective’, ‘I deserve to be punished for what I have done’), or increasing negative beliefs about uncompassionate self-responding (e.g. ‘self-criticism is ineffective’, ‘everyone makes mistakes’). Alternatively, therapeutic change could occur through increasing positive beliefs about compassionate self-responding and self-forgiveness (e.g. ‘being kind to myself helps me to forgive myself’) and reducing negative beliefs about compassionate self-responding and self-forgiveness (e.g. ‘self-kindness condones my mistakes’), or a mixture of these beliefs. Further research is needed to identify these influences, especially in relation to developing a measure of fears of self-forgiveness in the same way as has successfully been done with fear of self-compassion, where fear of compassion has been associated with impeding experiences of warmth, reassurance and anxio-depressive symptoms (e.g. Gilbert et al., 2011; Hermanto et al., 2016).

Another area of future research could focus on repeating Study 1 with a larger non-clinical sample that would allow future researchers to use the PROCESS macro (Hayes, 2018b) to explore the proposed model in more detail. This would increase the validity of the current study findings. Furthermore, a larger sample would also make it possible to undertake more for sophisticated statistical analyses such as Structural Equation Modeling (SEM), and allow for greater control over aspects of the analysis

such as the measure of fit of the model with the data, and the influence or observed and latent variables (Darlington & Hayes, 2017; Lau & Chung, 2012). With regard to Study 2, obtaining large enough clinical sample to be able to utilise SEM would be a considerable challenge, however, the use of PROCESS with a larger clinical sample would allow researchers to examine differences in therapeutic outcome. Such as why some participants experienced better or worse outcomes than others, or the mediating effects of the individual SCS sub-scales and affect upon the relationship between self-forgiveness and psychological outcomes.

Finally, further qualitative research is necessary to identify the subtle detail of these change processes to supplement quantitative studies that use statistical averages or correlations that result in aggregating data effects. Furthermore, in addition to the ‘top down’ approach used in Study 1, it may be more preferable to undertake qualitative studies first to build a psychological model of stress and coping, self-compassion, affect, self-forgiveness and psychological health, and then validate the model using quantitative methodologies. If focus groups are used then it is recommended to separate the roles of focus group facilitator and researcher to reduce the risk of introducing expectancy bias into the results. Alternatively, it may be useful to utilise single-case methodologies to examine therapeutic change over the course of a CFT therapy intervention.

Having discussed the findings and limitations of the three studies, together with their theoretical and clinical implications and the recommendations for future research, what follows are the conclusions that can be drawn from these studies in relation to the original aims of this PhD research.

8.0 CONCLUSIONS

Historically many authors have written about the restorative influence that self-compassion and affect can have upon the process of self-forgiveness in promoting psychological health (e.g. Dalai Lama, & Chan, 2004; 2012; Tutu, 2000; 2015), but little empirical research exists into these relationships (Cornish & Wade, 2015b; Gilbert & Woodyatt, 2017). Worthington (2006) proposed a model of self-forgiveness from within a stress and coping paradigm (Lazarus & Folkman, 1984) to unify and guide future research, but this model does not account for the restorative influence of self-compassion.

Drawing upon the work of Worthington (2006), Gilbert (2005; 2009; 2014) and Neff (2003a; 2003b; 2012), the researcher proposed a new model stress and coping model of self-forgiveness, self-compassion, affect and psychological health. The model proposed that how one copes with the stress associated with our transgressions is reflective of; a) our capacities for self-forgiveness, b) self-compassion (compassionate self-responding and uncompassionate self-responding), and c), the affects (positive, negative, safe / content affect) that we experience, the combined effects of which influence our psychological health. It was hypothesised that the relationship between self-forgiveness and psychological health would be mediated by the level of compassionate self-responding, and positive and safe / content affect and the level of uncompassionate self-responding and negative affect that we experience is felt at the time. It was also hypothesised that these mediating relationships would be influenced by personality variables (neuroticism, agreeableness, narcissism, and social desirability) and socio-economic variables (age, gender, ethnicity, and religiosity / spirituality).

The researcher's model was evaluated through undertaking three studies using a mixed methods approach. Study 1 was a cross-sectional study that examined the relationships between these variables. Study 2 aimed to establish cause-and-effect relationships between the variables that comprise the researcher's model as a result of participants undertaking a 12-week CFT intervention. Whilst Study 3 was a qualitative study that aimed to contextualise the interpretations derived from the quantitative data obtained from Study 1 and Study 2, and aimed to provide more detailed understandings of participant's experience of the group and the expected processes of change.

8.1 Summary of the main points.

Together the findings of Study 1 and 2 appear reasonably consistent, with negative affect and the negative components of Neff's (2003a) model (USR) emerging as having the greatest mediating effects upon the relationship between self-forgiveness and psychological distress, and negative affect and USR partially mediating the relationship between trait self-forgiveness with shame and guilt. Neuroticism emerged as the significant confounding variable in Study 1 and in the Study 2 group results, where it was found that participating in the CFT group intervention led to increases in self-forgiveness, compassionate self-responding, positive affect, safe / content affect, and reductions in uncompassionate self-responding, negative affect, shame, guilt and psychological distress. Comparisons between Neff's (2003b) single-factor and bifactor models were broadly similar, but the bifactor model yielded more detailed results that provided more insight into the relationship between self-compassion and self-forgiveness. These findings do not support the recommendations of Neff et al., (2018) and who advise against using the bifactor model in preference of the single factor model.

When the effects of the researcher's model were examined over the course of the CFT group, using parallel mediations, negative affect yielded a consistent mediating effect upon the relationship between state self-forgiveness with shame and trait self-forgiveness and state self-forgiving feelings and actions with guilt. With negative affect and USR individually mediating the relationship between state self-forgiveness with shame, and trait self-forgiveness and state self-forgiving feelings and actions with guilt.

The findings of Study 2 indicated that becoming more self-compassionate yielded reductions in negative affect and USR that mediated improvements in self-forgiveness and reductions of shame and guilt. Therefore, from a clinical perspective it would appear especially important for CFT therapists to focus upon reducing negative affect and USR in order to maximise self-forgiveness and reduce shame and guilt. In order to facilitate this it would be particularly important to weaken the positive beliefs associated with uncompassionate self-responding that are causing negative affect and complicating the process of self-forgiveness.

The third qualitative study identified two major themes: ‘Becoming self-compassionate and self-forgiving’, and ‘the CFT group was beneficial’ as a result of participating in the CFT group. The first major theme reflected participants growing familiarity, awareness and insight into the links between self-compassion and the process of self-forgiveness. Making these links helped participants to reduce their negative beliefs about becoming self-compassionate and self-forgiving, and become more aware of the benefits of self-compassionate and self-forgiving. With the outcome that participants experienced reductions in self-condemnation that yielded benefits for their psychological health.

The second major theme reflected participants’ impressions that participating in the CFT group had facilitated personal change, through assuming a personal commitment to change. This involved taking ownership and personal responsibility for their thoughts and feelings about their mistakes, rather than condemning themselves and others. This was a personal process that required commitment to an on-going process of change involving utilising of CFT skills to assist with emotional regulation and the development of more balanced thinking about their transgressions that yielded greater self-confidence, self-acceptance and increased assertiveness and reduced shame and guilt. Together, these qualitative findings provided more detailed explanations of the processes of change in CFT highlighted in Study 1 and Study 2, where it was found that reductions in negative affect and uncompassionate self-responding were implicated in mediating the relationship between increased self-forgiveness and improved shame and guilt. The results of this empirical research provide much needed insights into how self-compassion facilitates self-forgiveness and psychological health that is absent within the self-compassion and self-forgiveness literature (Gilbert & Woodyatt, 2017).

8.2. Contribution to research

This PhD research has made several unique contributions to the self-compassion and self-forgiveness research literature. This research was the first attempt to establish theoretical and empirical links between the stress and coping model of forgiveness, self-forgiveness (Worthington, 2006), CFT (Gilbert, 2010; 2014), Gilbert’s (2009) model of affect regulation, and Neff’s (2003a; 2012) model of self-compassion.

In order to facilitate this, the researcher proposed the first stress and coping model

to examine the relationship between self-forgiveness, self-compassion, affect and psychological health. The model proposed that the positive components of Neff's (2003b) model (compassionate self-responding) combined with positive and safe / content affect were adaptive coping responses that would promote self-forgiveness and psychological health. In contrast, it was also proposed that the negative components of Neff's (2003b) model (uncompassionate self-responding) combined with negative affect were maladaptive coping responses would complicate self-forgiveness and psychological health. Three studies were undertaken test the model the results of which advanced the research literature.

Study 1 found that after controlling for neuroticism, negative affect and uncompassionate self-responding had the greatest mediating effects upon promoting trait self-forgiveness and psychological health. In order to test any causal relationships between the model constructs, the researcher undertook Study 2, that was the first study to demonstrate the effectiveness of a 12-week CFT group in promoting self-forgiveness, self-compassion, and positive and safe / content affect, and reduce negative affect, shame, guilt and psychological distress (depression, anxiety and stress). The results of Study 2 also provided the first empirical evidence into how self-compassion facilitates self-forgiveness and improved psychological health. Specifically, that becoming more self-compassionate promoted self-forgiveness and reductions in shame and guilt through facilitating reductions in negative affect and to a lesser extent uncompassionate self-responding.

Given the recent controversy that emerged during the course of completing this PhD about which factors of the self-compassion scale are most valid to use (Neff et al., 2018a; 2019), the researcher was keen to examining the effects of Neff's bifactor and single factor models upon the study variables. The results of which found to be valid and broadly similar. However, the bifactor model yielded more detailed results that provided more insight into the relationships between self-compassion, affect, self-forgiveness and psychological health.

Following Woodyatt et al's (2017b) call for the need to undertake more of a mixed-methods approach into the study of self-forgiveness, Study 3 was the first qualitative study to undertake a thematic analysis of the relationship between self-compassion and self-forgiveness. Study 3 identified two major themes: 'Becoming self-

compassionate and self-forgiving’, and ‘the CFT group was beneficial’ that together with the findings of Study 1 and 2 provided a very rich data set for analysis the results of which supported Gilbert and Woodyatt’s (2017) assertions that two sets of CFT competencies are necessary for self-forgiveness to occur. The first competency involves the ability to move towards suffering rather than avoiding it. The second competency involved undertaking wise action through utilising CFT skills competencies that enable individuals to undertake courageous and determined action in relation to their personal responsibilities, including the process of self-forgiveness.

In summary, the combined results of the three studies indicated the importance of assuming personal responsibility for thoughts and feelings around personal transgressions rather than adopting a position of self-condemnation or condemnation of others. Generally, the process of self-forgiveness was facilitated by learning CFT skills that assisted with the regulation of negative affect through the reduction in uncompassionate self-responding (self-judgment, isolation, overidentified thinking) that promoted psychological health. These findings provide much needed empirical evidence in relation to Gilbert and Woodyatt’s (2017) propositions about how the development of CFT skills facilitates the process of self-forgiveness and psychological health. Together, these three studies are the first empirical studies to provide evidence about how self-compassion and affect, and changes in uncompassionate self-responding and negative affect, influence the process of self-forgiveness and psychological health.

In this final section the researcher will provide some concluding comments that will draw upon the findings of this research that will provide some answers to the questions that the researcher posed and which inspired this PhD research.

8.3 Concluding comments

At the beginning of this PhD research I posed a number of questions that guided my choice of psychology as a career and which I have been trying to answer during my professional life. They included questions like: Who are we? How does the self develop? What can be done to offset some of the detrimental impacts of our personal upbringings? How can we better support the people we love and ourselves? How can we better cope with life stresses? How can we live life in a happier and healthy way and contribute to and preserve the world we live in? How can we be better human beings?

Of these seven questions, I felt that I had reasonable answers to the first two questions the answers which appeared linked within an attachment paradigm bonds (Bowlby, 1988; Fonagy, Gergely, Jurist & Target, 2005; Granquist, et al., 2017; Sroufe & Siegel, 2011). The remaining six questions were more linked to dealing and coping with the consequences of our upbringings in relation to the stresses and challenges of everyday living, whilst maximising our support system in order to gain happiness, develop personal meaning and create personal growth. The impetus created by these unanswered six questions led to a desire to undertake this PhD. It was from my interest in self-compassion (Gilbert, 2005; 2010; Neff; 2003; 2008) and self-forgiveness (Hall & Fincham, 2005; Worthington, 2006), that I became more convinced that there was a need for a theoretical model to unify these bodies of knowledge as a basis for psychological support. This enquiry led to the development of the researcher's original stress and coping model of self-forgiveness, self-compassion, affect and psychological health that was subsequently evaluated through the three studies that comprised this PhD research.

In relation to the third question, what can be done to offset some of the detrimental impacts of our personal upbringings? The answer seems to be that much can be done, but that this requires much enquiry, understanding, insight and empathy into the circumstances that we found ourselves that were not of our choosing and not 'our fault'. The problem is that we are burdened with a highly reactive threat system that has a negative bias and as sense of over-responsibility that leads us to become quickly overwhelmed (Gilbert, 2009; 2014). Instead of offering ourselves kindness and support we tend to judge and blame ourselves, responses that only increases our sense of isolation and suffering that when linked with our thoughts and feelings become hard to refute.

In relation to the fourth question; 'how can we better support the people we love and ourselves?' It seems that compassion and forgiveness have much to offer as they provide a way to helps us to deal with the part that we play in coping with the inevitable disappointments in life, whether we are talking about our behaviours or the behaviours of others.

In relation to the fifth question; 'how can we better cope with life stresses?' The results of the current studies indicate that it is essential to work on reducing the negative

affect that we experience about our mistakes through reducing the barriers to self-compassion, focusing on changing our positive beliefs about the value of self-criticism, our sense of negative personal difference, and gaining a greater sense of perspective on our negative beliefs and thoughts.

In response to the sixth question; ‘how can we live life in a happier and healthy way and contribute to and preserve the world we live in?’ It seems that important that in the face of our mistakes, that we offer ourselves the understanding, empathy and self-kindness that we need to be able to see our failings as part of what it is to be a flawed human being. Taking personal responsibility for our mistakes and failings is essential if we are to restore the damage that we have done to our socio-moral identities, our relationships and our environments.

In response to the seventh and final question, ‘how can we be better human beings?’ it appears that we need to support ourselves with kindness, empathy, curiosity and self-compassion in relation to our hard-wired capacities to threaten ourselves with personal judgments, and social comparisons that drive us forward to achieve. We need to view the process of living as a curious voyage of constant personal enquiry that takes us away from the allure of excessive hedonistic comforts into deeper waters where we feel more challenged by the unknown and unfamiliar, the mastery of which is where eudemonic growth occurs. It is the tension that exists between these two positions in relation to the challenges of living and our need for love and connection where we can understand what it means to be truly human.

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Table A.1. Gender differences across self-forgiveness, self-compassion, affect, personality variables and psychological health variables (Study 1).

Variables	<i>U</i>	<i>p</i>	Males <i>n</i> = 38	Females <i>n</i> = 101
			Mean (SD)	Mean (SD)
HFS - Trait Self-forgiveness	1504.00	.03	21.68 (7.52)	25.09 (8.56)
SSFS - Self-Forgiving Feelings Actions ^a	1104.50	.11	17.41 (5.70)	19.82 (6.89)
SSFS - Self-Forgiving Beliefs ^d	1001.50	.03	24.07 (6.55)	27.04 (7.44)
SCS - Self-compassion _{Total}	1623.00	.12	32.74 (9.36)	35.88 (11.21)
SCS - Self-kindness	1491.50	.03	10.89 (3.75)	12.93 (4.93)
SCS - Common humanity	1643.50	.14	10.50 (3.75)	11.62 (4.03)
SCS - Mindfulness	1954.00	.99	11.34 (3.04)	11.41 (3.63)
SCS - Self-uncompassion _{Total}	1624.50	.12	48.66 (9.41)	45.12 (12.07)
SCS - Self-judgment	1463.00	.02	19.53 (3.94)	17.26 (5.18)
SCS - Isolation	1525.50	.04	15.00 (3.51)	13.50 (4.08)
SCS - Overinvolved thinking	1853.50	.63	14.11 (3.31)	14.30 (4.14)
SCS – Total score	1596.50	.09	54.39 (12.75)	82.73 (16.59)
PANAS - Negative affect	1793.00	.45	28.71 (9.86)	27.43 (9.49)
PANAS - Positive affect	1648.00	.15	26.45 (7.62)	28.68 (9.24)
TTPAS - Safe/content affect	1356.50	.28	9.87 (4.11)	12.33 (4.56)
BFI - Agreeableness	1820.00	.52	34.38 (5.29)	34.82 (5.98)
BFI - Neuroticism	1945.00	.95	27.79 (6.48)	27.64 (6.88)
SINS - Narcissism	1942.00	.94	2.03 (1.12)	2.15 (1.39)
SDS - Social desirability	1727.50	.28	5.84 (2.10)	5.41 (2.02)
SSGS - Shame	1556.50	.06	15.45 (5.45)	13.36 (6.11)
SSGS - Guilt	1803.50	.49	16.26 (5.03)	15.53 (5.73)
DASS 21 _{total}	1604.00	.16	30.31 (14.44)	26.12 (15.45)

Note. M, Mean; SD, Standard Deviation; HFS-S, Heartland Forgiveness Scale-Self-forgiveness sub-scale; SSFS-FA, State Self-Forgiveness Scale – Feelings and Actions; SSFS-SFB, State Self-Forgiveness Scale – Self-Forgiving Beliefs; SSFS-Total, State Self-Forgiveness Scale – Total Score; SCS-CSR, Self-Compassion Scale – Compassionate Self-Responding; SCS-USR, Self-Compassion Scale – Uncompassionate Self-Responding; SCS-Total, Self-Compassion Scale – Total Scale Score; PANAS-PA, Positive And Negative Affect Scale – Positive Affect; PANAS-NA, Positive And Negative Affect Scale – Negative Affect; TTPAS-SCA, Two-Types of Positive Affect Scale; SSGS-S, State Shame and Guilt Scale - Shame; SSGS-G, State Shame and Guilt Scale – Guilt; DASS21total, Depression, Anxiety, Stress Scale (21-item) total score; SINS, Single Item Narcissism Scale; SDS, Social Desirability Scale; BFI-A, Big Five Inventory - Agreeableness; BFI-N, Big Five Inventory – Neuroticism; DUREL-IR, Duke University Intrinsic Religion Index;

NB: * = the skewness and kurtosis statistic was ± 2.00 . ** = the skewness and kurtosis statistic was ± 3.00 .

Table A.2. Collectivist and non-collectivist group differences in terms of self-forgiveness, self-compassion, affect, personality variables and psychological health variables (Study 1).

			Collectivist Culture <i>n</i> = 23	Non-collectivist culture <i>n</i> = 101
Variables	<i>U</i>	<i>p</i>	Mean (<i>SD</i>)	Mean (<i>SD</i>)
Age	712.50	<.001	24.42 (6.72)	35.08 (12.97)
Religiosity / spirituality	1305.00	.31	8.46 (4.16)	6.74 (3.97)
HFS - Trait Self-forgiveness	1160.00	.07	26.85 (7.01)	23.57 (8.61)
SSFS - Self-Forgiving Feelings Actions ^a	882.00	.07	21.43 (5.19)	18.76 (6.91)
SSFS - Self-Forgiving Beliefs ^d	872.00	.06	29.17 (5.40)	25.70 (7.58)
SCS - Self-compassion _{Total}	1295.50	.29	36.65 (8.83)	34.67 (11.20)
SCS - Self-kindness	1249.00	.19	13.38 (4.42)	12.16 (4.77)
SCS - Common humanity	1398.00	.65	11.46 (3.42)	11.29 (4.10)
SCS - Mindfulness	1368.00	.50	11.81 (3.06)	11.30 (3.56)
SCS - Self-uncompassion _{Total}	1224.50	.15	42.81 (12.58)	46.81 (11.17)
SCS - Self-judgment	1143.50	.06	16.19 (5.05)	18.25 (4.89)
SCS - Isolation	1411.50	.66	13.42 (4.49)	14.02 (3.86)
SCS - Overinvolved thinking	1218.50	.14	13.19 (4.37)	14.49 (3.80)
SCS – Total score	1202.50	.12	71.92 (18.83)	65.95 (20.52)
PANAS - Negative affect	887.50	<.001	22.23 (8.54)	29.03 (9.40)
PANAS - Positive affect	1254.50	.20	30.00 (7.90)	27.64 (9.04)
TTPAS - Safe/content affect	856.50	<.001	14.42 (3.71)	11.04 (4.52)
BFI - Agreeableness	1267.00	.23	36.38 (3.77)	34.32 (6.13)
BFI - Neuroticism	1187.50	.24	25.96 (6.45)	28.07 (6.79)
SINS - Narcissism	1296.00	.26	2.38 (1.38)	2.06 (1.31)
SDS - Social desirability	1237.00	.16	6.00 (1.88)	5.42 (2.08)
SSGS - Shame	1115.50	.05	11.81 (5.09)	14.40 (6.11)
SSGS - Guilt	1262.50	.25	14.73 (5.98)	15.96 (5.45)
DASS 21 _{total}	1046.00	.02	20.62 (24.24)	36.71 (30.90)

Note. M, Mean; SD, Standard Deviation; HFS-S, Heartland Forgiveness Scale-Self-forgiveness sub-scale; SSFS-FA, State Self-Forgiveness Scale – Feelings and Actions; SSFS-SFB, State Self-Forgiveness Scale – Self-Forgiving Beliefs; SSFS-Total, State Self-Forgiveness Scale – Total Score; SCS-CSR, Self-Compassion Scale – Compassionate Self-Responding; SCS-USR, Self-Compassion Scale – Uncompassionate Self-Responding; SCS-Total, Self-Compassion Scale – Total Scale Score; PANAS-PA, Positive And Negative Affect Scale – Positive Affect; PANAS-NA, Positive And Negative Affect Scale – Negative Affect; TTPAS-SCA, Two-Types of Positive Affect Scale; SSGS-S, State Shame and Guilt Scale - Shame; SSGS-G, State Shame and Guilt Scale – Guilt; DASS21total, Depression, Anxiety, Stress Scale (21-item) total score; SINS, Single Item Narcissism Scale; SDS, Social Desirability Scale; BFI-A, Big Five Inventory - Agreeableness; BFI-N, Big Five Inventory – Neuroticism; DUREL-IR, Duke University Intrinsic Religion Index;

Table A.3. Illustrating the means, standard deviations, ranges, skewness and kurtosis figures of the HFS, SSFS, SCS, PANAS, TTPAS, SSGS, SINS, SDS, BFI, DUREL-IR and the DASS-21 scales at assessment for the CFT group ($n = 39$).

Scale	<i>M (SD)</i>	<i>Range (Stat)</i>	<i>Skewness (SE)</i>	<i>Kurtosis (SE)</i>
HFS-S	19.77 (6.52)	6-36 (30.0)	.24 (.38)	.01 (.74)
SSFS-FA ¹	15.00 (5.38)	8-28 (20.0)	.98 (.43)*	.50 (.83)
SSFS-SFB ¹	21.30 (6.23)	9-33 (24.0)	.10 (.43)	-.42 (.83)
SSFS-Total	34.44 (10.24)	19-59 (40.0)	.50 (.41)	-.07 (.81)
SCS-CSR	29.62 (8.48)	14-49 (35.0)	.29 (.38)	-.31 (.74)
SCS-USR	52.41 (7.33)	34-65 (31.0)	-.39 (.38)	-.15 (.74)
SCS-Total	55.21 (13.34)	30-87 (57.0)	-.06 (.38)	-.38 (.74)
PANAS-PA	23.26 (6.85)	12-42 (30.0)	.76 (.38)*	.96 (.74)
PANAS-NA	34.26 (7.68)	18-47 (29.0)	-.32 (.38)	-.49 (.74)
TTPAS-SCA	8.23 (3.24)	4-15 (11.0)	.41 (.38)	-.77 (.74)
SSGS-S	17.77 (4.25)	10-25 (15.0)	-.15 (.38)	-.99 (.74)
SSGS-G	18.95 (4.01)	10-25 (15.0)	-.19 (.38)	-.45 (.74)
DASS21 _{total}	36.39 (11.75)	2-56 (54.0)	-.05 (.38)	-.71 (.74)
SINS	2.28 (1.75)	1-7 (6.0)	1.21 (.40)**	.26 (.74)
SDS	5.79 (2.33)	0-10 (10.0)	-.20 (.38)	.28 (.74)
BFI-A	32.44 (6.42)	19-44 (25.0)	-.36 (.38)	-.45 (.74)
BFI-N	31.41 (5.12)	19-39 (20.0)	-.33 (.38)	-.89 (.74)
DUREL-IR	8.64 (3.73)	3-15 (12.0)	.04 (.38)	-1.14 (.74)

Note. M, Mean; SD, Standard Deviation; HFS-S, Heartland Forgiveness Scale-Self-forgiveness sub-scale; SSFS-FA, State Self-Forgiveness Scale – Feelings and Actions; SSFS-SFB, State Self-Forgiveness Scale – Self-Forgiving Beliefs; SSFS-Total, State Self-Forgiveness Scale – Total Score; SCS-CSR, Self-Compassion Scale – Compassionate Self-Responding; SCS-USR, Self-Compassion Scale – Uncompassionate Self-Responding; SCS-Total, Self-Compassion Scale – Total Scale Score; PANAS-PA, Positive And Negative Affect Scale – Positive Affect; PANAS-NA, Positive And Negative Affect Scale – Negative Affect; TTPAS-SCA, Two-Types of Positive Affect Scale; SSGS-S, State Shame and Guilt Scale - Shame; SSGS-G, State Shame and Guilt Scale – Guilt; DASS21_{total}, Depression, Anxiety, Stress Scale (21-item) total score; SINS, Single Item Narcissism Scale; SDS, Social Desirability Scale; BFI-A, Big Five Inventory - Agreeableness; BFI-N, Big Five Inventory – Neuroticism; DUREL-IR, Duke University Intrinsic Religion Index;

NB: * = the skewness and kurtosis statistic was ± 2.00 . ** = the skewness and kurtosis statistic was ± 3.00 .

Table A.4. Illustrating the means, standard deviations, ranges, skewness and kurtosis figures of the HFS, SSFS, SCS, PANAS, TTPAS, SSGS, SINS, SDS, BFI, DUREL-IR and the DASS-21 scales at week 1 of the CFT group ($n = 39$).

Scale	<i>M (SD)</i>	<i>Range</i>	<i>Skewness (SE)</i>	<i>Kurtosis (SE)</i>
HFS-S	19.18 (6.25)	8-36	.43 (.38)	.22 (.74)
SSFS-FA ¹	14.13 (4.49)	8-26	.76 (.41)	.22 (.81)
SSFS-SFB ¹	20.31 (6.56)	9-33	.07 (.41)	-.67 (.81)
SSFS-Total	34.44 (10.24)	19-59	.50 (.41)	-.07 (.81)
SCS-CSR	29.41 (8.36)	14-50	.11 (.38)	-.26 (.74)
SCS-USR	51.46 (9.23)	17-63	-1.86 (.38)**	5.07 (.74)**
SCS-Total	55.95 (14.69)	30-100	-.44 (.38)	.85 (.74)
PANAS-PA	23.28 (6.70)	12-42	1.01 (.38)**	1.57 (.74)*
PANAS-NA	33.97 (8.19)	13-47	-.62 (.38)	.12 (.74)
TTPAS-SCA	8.37 (3.50)	4-20	1.17 (.38)**	1.90 (.75)**
SSGS-S	17.54 (4.88)	5-25	-.34 (.38)	-.27 (.74)
SSGS-G	18.67 (4.86)	10-25	-1.07 (.38)**	1.52 (.74)*
DASS21 _{total}	37.15 (12.48)	8-56	-.57 (.38)	-.27 (.74)
SINS	2.31 (1.79)	1-6	.98 (.40)*	-.57 (.78)
SDS	5.82 (2.27)	0-10	-.25 (.38)	.47 (.74)
BFI-A	31.51 (7.35)	14-43	-.48 (.38)	-.11 (.74)
BFI-N	31.33 (5.13)	19-39	-.46 (.38)	-.66 (.74)
DUREL-IR	8.64 (3.73)	3-15	.04 (.38)	-1.14 (.74)

Note. M, Mean; SD, Standard Deviation; HFS-S, Heartland Forgiveness Scale-Self-forgiveness sub-scale; SSFS-FA; State Self-Forgiveness Scale – Feelings and Actions; SSFS-SFB, State Self-Forgiveness Scale – Self-Forgiving Beliefs; SSFS-Total, State Self-Forgiveness Scale – Total Score; SCS-CSR, Self-Compassion Scale – Compassionate Self-Responding; SCS-USR, Self-Compassion Scale – Uncompassionate Self-Responding; SCS-Total, Self-Compassion Scale – Total Scale Score; PANAS-PA, Positive And Negative Affect Scale – Positive Affect; PANAS-NA, Positive And Negative Affect Scale – Negative Affect; TTPAS-SCA, Two-Types of Positive Affect Scale; SSGS-S, State Shame and Guilt Scale - Shame; SSGS-G, State Shame and Guilt Scale – Guilt; DASS21_{total}, Depression, Anxiety, Stress Scale (21-item) total score; SINS, Single Item Narcissism Scale; SDS, Social Desirability Scale; BFI-A, Big Five Inventory - Agreeableness; BFI-N, Big Five Inventory – Neuroticism; DUREL-IR, Duke University Intrinsic Religion Index;

NB: * = the skewness and kurtosis statistic was ± 2.00 . ** = the skewness and kurtosis statistic was ± 3.00 .

Table A.5. Illustrating the means, standard deviations, ranges, skewness and kurtosis figures of the HFS, SSFS, SCS, PANAS, TTPAS, SSGS, SINS, SDS, BFI, DUREL-IR and DASS-21 scales at Week 6 of the CFT group ($n = 39$).

Scale	<i>M (SD)</i>	<i>Range</i>	<i>Skewness (SE)</i>	<i>Kurtosis (SE)</i>
HFS-S	23.23 (5.74)	6-36	-.27 (.38)	1.06 (.74)
SSFS-FA ¹	17.06 (4.57)	8-26	-.01 (.41)	-.48 (.81)
SSFS-SFB ¹	23.28 (6.31)	8-33	-.29 (.41)	-.35 (.81)
SSFS-Total	41.00 (16.00)	16-57	-.35 (.41)	-.10 (.81)
SCS-CSR	34.69 (8.18)	18-50	-.19 (.38)	-.75 (.74)
SCS-USR	47.95 (8.07)	26-62	-.46 (.38)	.50 (.74)
SCS-Total	64.82 (14.23)	39-102	.12 (.38)	.02 (.74)
PANAS-PA	26.00 (8.82)	11-50	.69 (.38)	.42 (.74)
PANAS-NA	30.54 (9.05)	10-50	-.17 (.38)	.09 (.74)
TTPAS-SCA	9.26 (2.87)	4-16	.39 (.38)	-.25 (.74)
SSGS-S	14.38 (4.93)	5-25	-.06 (.38)	-.11 (.74)
SSGS-G	16.54 (4.97)	5-25	-.35 (.38)	-.55 (.74)
DASS21 _{total}	31.03 (14.26)	4-58	-.13 (.38)	-.58 (.74)
SINS	2.16 (1.46)	1-6	1.36 (.38)**	-1.07 (.75)
SDS	5.49 (2.26)	1-9	-.10 (.38)	-.60 (.74)
BFI-A	31.38 (7.09)	14-44	-.23 (.38)	-.34 (.74)
BFI-N	30.38 (4.80)	19-39	.01 (.38)	1.07 (.74)
DUREL-IR	8.74 (3.77)	3-15	-.21 (.38)	-1.12 (.75)

Note. M, Mean; SD, Standard Deviation; HFS-S, Heartland Forgiveness Scale-Self-forgiveness sub-scale; SSFS-FA, State Self-Forgiveness Scale – Feelings and Actions; SSFS-SFB, State Self-Forgiveness Scale – Self-Forgiving Beliefs; SSFS-Total, State Self-Forgiveness Scale – Total Score; SCS-CSR, Self-Compassion Scale – Compassionate Self-Responding; SCS-USR, Self-Compassion Scale – Uncompassionate Self-Responding; SCS-Total, Self-Compassion Scale – Total Scale Score; PANAS-PA, Positive And Negative Affect Scale – Positive Affect; PANAS-NA, Positive And Negative Affect Scale – Negative Affect; TTPAS-SCA, Two-Types of Positive Affect Scale; SSGS-S, State Shame and Guilt Scale - Shame; SSGS-G, State Shame and Guilt Scale – Guilt; DASS21_{total}, Depression, Anxiety, Stress Scale (21-item) total score; SINS, Single Item Narcissism Scale; SDS, Social Desirability Scale; BFI-A, Big Five Inventory - Agreeableness; BFI-N, Big Five Inventory – Neuroticism; DUREL-IR, Duke University Intrinsic Religion Index;

NB: * = the skewness and kurtosis statistic was ± 2.00 . ** = the skewness and kurtosis statistic was ± 3.00 .

Table A.6. Illustrating the means, standard deviations, ranges, skewness and kurtosis figures of the HFS, SSFS, SCS, PANAS, TTPAS, SSGS, SINS, SDS, BFI, DUREL-IR and DASS-21 scales at Week 12 of the CFT group ($n = 39$).

Scale	<i>M (SD)</i>	<i>Range (Stat)</i>	<i>Skewness (SE)</i>	<i>Kurtosis (SE)</i>
HFS-S	25.62 (7.70)	7-41	-.49 (.38)	.55 (.74)
SSFS-FA ¹	21.31 (5.31)	8-30	-.28 (.41)	-.26 (.81)
SSFS-SFB ¹	27.41 (5.81)	14-36	-.50 (.41)	-.42 (.81)
SSFS-Total	48.72 (10.64)	25-64	-.33 (.41)	-.56 (.81)
SCS-CSR	39.74 (8.48)	23-65	.30 (.38)	.98 (.74)
SCS-USR	41.38 (9.37)	17-61	-.29 (.38)	.09 (.74)
SCS-Total	76.41 (16.49)	41-117	.19 (.38)	.22 (.74)
PANAS-PA	28.46 (8.31)	14-44	.69 (.38)	.42 (.74)
PANAS-NA	26.92 (8.70)	10-48	.53 (.38)	-.07 (.74)
TTPAS-SCA	11.51 (3.51)	4-20	-.06 (.38)	-.45 (.74)
SSGS-S	12.44 (5.07)	5-25	.75 (.38)*	.22 (.74)
SSGS-G	14.46 (5.05)	5-25	.15 (.38)	-.36 (.74)
DASS21 _{total}	25.49 (13.48)	5-59	.58 (.38)	-.38 (.74)
SINS	2.24 (1.53)	1-7	1.29 (.38)**	1.18 (.75)
SDS	5.64 (2.03)	1-10	-.16 (.38)	.16 (.74)
BFI-A	32.10 (7.16)	18-45	.38 (.38)	-.72 (.74)
BFI-N	28.85 (4.80)	11-39	-.89 (.38)*	1.62 (.74)*
DUREL-IR	9.05 (3.80)	3-15	-.41 (.38)	-1.19 (.74)

Note. M, Mean; SD, Standard Deviation; HFS-S, Heartland Forgiveness Scale-Self-forgiveness sub-scale; SSFS-FA; State Self-Forgiveness Scale – Feelings and Actions; SSFS-SFB, State Self-Forgiveness Scale – Self-Forgiving Beliefs; SSFS-Total, State Self-Forgiveness Scale – Total Score; SCS-CSR, Self-Compassion Scale – Compassionate Self-Responding; SCS-USR, Self-Compassion Scale – Uncompassionate Self-Responding; SCS-Total, Self-Compassion Scale – Total Scale Score; PANAS-PA, Positive And Negative Affect Scale – Positive Affect; PANAS-NA, Positive And Negative Affect Scale – Negative Affect; TTPAS-SCA, Two-Types of Positive Affect Scale; SSGS-S, State Shame and Guilt Scale - Shame; SSGS-G, State Shame and Guilt Scale – Guilt; DASS21_{total}, Depression, Anxiety, Stress Scale (21-item) total score; SINS, Single Item Narcissism Scale; SDS, Social Desirability Scale; BFI-A, Big Five Inventory - Agreeableness; BFI-N, Big Five Inventory – Neuroticism; DUREL-IR, Duke University Intrinsic Religion Index;

NB: * = the skewness and kurtosis statistic was ± 2.00 . ** = the skewness and kurtosis statistic was ± 3.00 .

Table A.7. Spearman correlations for the Socio-Demographic Variables Age, Gender, SES, Culture, and Religiosity / Spirituality, with the change independent variables, mediating variables, moderating variables, and dependent variables. $n = 39$

	Age	Gender ^{1 a}	SES ^b	Culture ¹	Religiosity / Spirituality
HFS - Self-forgiveness	.05	-.15	.06	-.18	.22
SSFS - Self-Forgiving Feelings Actions ^d	-.36*	.00	.01	-.21	.06
SSFS - Self-Forgiving Beliefs ^d	-.39*	-.30	.20	.03	.38*
SCS – Compassionate Self-Responding	-.05	.13	.13	-.18	-.15
SCS - Self-kindness	-.13	.08	.19	-.24	.15
SCS - Common humanity	-.19	.17	.13	-.17	.17
SCS - Mindfulness	.10	.13	.04	-.04	.09
SCS – Uncompassionate Self-Responding	.19	.02	.09	.21	-.15
SCS - Self-judgment	.14	.11	-.02	.28	-.19
SCS - Isolation	.15	-.06	-.08	.14	-.04
SCS - Overinvolved thinking	.07	.04	-.09	.12	-.14
SCS – Total score	-.13	.07	.15	-.21	.10
PANAS - Negative affect	-.05	-.01	-.04	-.11	-.28
PANAS - Positive affect	.05	.16	.23	.11	-.02
TTPAS - Safe/content affect	-.07	.27	.09	-.10	.09
BFI - Agreeableness	.35*	.09	.31	.14	.16
BFI - Neuroticism	.22	-.19	-.07	-.26	-.06
SINS - Narcissism	.33	.01	.13	-.06	-.10
SDS - Social desirability	-.26	.03	-.01	.04	-.13
SSGS - Shame	.13	-.16	.15	-.00	-.11
SSGS - Guilt	.00	-.13	-.01	-.27	-.06
DASS 21 _{total}	.14	-.24	-.16	-.29	.02

¹ Ranked Biserial correlations

^a Gender = male (1) and female (2)

^b SES = 1-8 - managerial (1) - (8) labourer (6)

^c Culture = collectivist culture (1) and non-collectivist culture (2).

^d $n = 32$.

* $p. = < .05$.

Table A.8. Results of post-hoc tests with a Bonferroni correction, carried out on the variable Trait Self-Forgiveness across weeks 1, 6, and 12 of the CFT group ($n = 39$).

(I) HFS-SF	(J) HFS-SF	MD (I-J)	SE	Sig. ^b	95% CI ^b	
					Lower Bound	Upper Bound
T1	T2	-4.05*	.91	<.001	-6.33	-1.77
	T3	-6.44*	1.06	<.001	-9.10	-3.77
T2	T1	4.05*	.91	<.001	1.77	6.33
	T3	-2.38*	1.03	.08	-4.96	.19
T3	T1	6.44*	1.03	<.001	3.77	9.10
	T2	2.38*	1.03	.08	-.19	4.96

Based on estimated marginal means

* The mean difference is significant at the 0.05 level

^b Adjustment for multiple comparisons: Bonferroni.

Abbreviations: HFS-SF, trait self-forgiveness. MD, Mean Difference, SE, Standard Error

Table A.9. Results of post-hoc tests with a Bonferroni correction, carried out on the variable State Self-Forgiving Feelings and Actions across weeks 1, 6, and 12 of the CFT group ($n = 39$).

(I) SSFS-FA	(J) SSFS-FA	MD (I-J)	SE	Sig. ^b	95% CI ^b	
					Lower Bound	Upper Bound
T1	T2	-2.94*	.87	<.01	-5.17	-.71
	T3	-7.19*	.78	<.001	-9.18	-5.19
T2	T1	2.94*	.87	<.01	.71	5.17
	T3	-4.25*	.63	<.001	-5.85	-2.65
T3	T1	7.19*	.78	<.001	5.19	9.18
	T2	4.25*	.63	<.001	2.65	4.96

Based on estimated marginal means

* The mean difference is significant at the 0.05 level

^a Covariates appearing in the model are evaluated at the following values: Neuroticism = -4.16, Agreeableness = 2.34.

^b Adjustment for multiple comparisons: Bonferroni.

Abbreviations, SSFS-FA, State Self-Forgiveness (Feelings and Actions), MD, Mean Difference, SE, Standard Error

Table A.10. Results of post-hoc tests with a Bonferroni correction, carried out on the variable State Self-Forgiving Self-Beliefs across weeks 1, 6, and 12 of the CFT group ($n = 39$).

(I) SSFS-SFB	(J) SSFS-SFB	MD (I-J)	SE	Sig. ^b	95% CI ^b	
					Lower Bound	Upper Bound
T1	T2	-2.97*	.79	<.01	-4.97	-.97
	T3	-7.09*	.90	<.001	-9.38	-4.81
T2	T1	2.97*	.79	<.01	.97	4.97
	T3	-4.12*	.82	<.001	-5.21	-2.04
T3	T1	7.09*	.90	<.001	4.81	9.38
	T2	4.12*	.82	<.001	2.04	6.21

Based on estimated marginal means

* The mean difference is significant at the 0.05 level

^a Covariates appearing in the model are evaluated at the following values: Neuroticism = -4.16, Agreeableness = 2.34, Religiosity / Spirituality = .81.

^b Adjustment for multiple comparisons: Bonferroni.

Abbreviations: SSFS-SFB, State Self-Forgiveness Scale – Self-Forgiving Beliefs, MD, Mean Difference, SE, Standard Error

Table A.11. Results of post-hoc tests with a Bonferroni correction, carried out on the variable Uncompassionate Self-Responding weeks 1, 6, and 12 of the CFT group ($n = 39$).

(I) USR	(J) USR	MD (I-J)	SE	Sig. ^b	95% CI ^b	
					Lower Bound	Upper Bound
T1	T2	3.51*	1.30	.03	.26	6.77
	T3	-20.46*	2.92	<.001	6.31	13.84
T2	T1	-3.51*	2.30	.03	-6.77	-.26
	T3	6.56*	1.01	<.001	4.02	9.10
T3	T1	-10.08*	1.50	<.001	-13.85	-6.31
	T2	-6.57*	1.05	<.001	-9.10	-4.02

Based on estimated marginal means

* The mean difference is significant at the 0.05 level

^b Adjustment for multiple comparisons: Bonferroni.

Abbreviation: USR, Uncompassionate Self-Responding, MD, Mean Difference, SE, Standard Error

Table A.12. Results of post-hoc tests with a Bonferroni correction, carried out on the variable Compassionate Self-Responding (CSR) across weeks 1, 6, and 12 of the CFT group ($n = 39$).

(I) CSR	(J) CSR	MD (I-J)	SE	Sig. ^b	95% CI ^b	
					Lower Bound	Upper Bound
T1	T2	-5.28*	1.45	<.01	-8.92	-1.64
	T3	-10.33*	1.66	<.001	-14.47	-6.18
T2	T1	5.28*	1.45	<.01	1.64	8.92
	T3	-5.05*	1.20	<.001	-8.06	-2.04
T3	T1	10.33*	1.65	<.001	6.18	14.49
	T2	5.05*	1.20	<.001	2.04	8.06

Based on estimated marginal means

* The mean difference is significant at the 0.05 level

^b Adjustment for multiple comparisons: Bonferroni.

Abbreviation: CSR, Compassionate Self-Responding; MD, Mean Difference, SE, Standard Error

Table A.13. Results of post-hoc tests with a Bonferroni correction, carried out on the variable Shame across weeks 1, 6, and 12 of the CFT group ($n = 39$).

(I) Shame	(J) Shame	MD (I-J)	SE	Sig. ^b	95% CI ^b	
					Lower Bound	Upper Bound
T1	T2	3.15*	.74	<.001	1.30	5.00
	T3	5.10*	.88	<.001	2.90	7.31
T2	T1	-3.15*	.74	<.001	-5.00	-1.30
	T3	1.95*	.68	.02	0.25	3.64
T3	T1	-5.10*	.88	<.001	-7.31	-2.90
	T2	-1.95*	.68	.02	-3.64	-.25

Based on estimated marginal means

* The mean difference is significant at the 0.05 level

^b Adjustment for multiple comparisons: Bonferroni.

Abbreviations: MD, Mean Difference, SE, Standard Error

Table A.14. Results of post-hoc tests with a Bonferroni correction, carried out on the variable Guilt across weeks 1, 6, and 12 of the CFT group ($n = 39$).

(I) Guilt	(J) Guilt	MD (I-J)	SE	Sig. ^b	95% CI ^b	
					Lower Bound	Upper Bound
T1	T2	2.13*	.70	.01	0.36	3.89
	T3	4.20*	.82	<.001	2.16	6.26
T2	T1	-2.13*	.70	.01	-3.89	-0.36
	T3	2.08*	.83	<.05	0.01	4.15
T3	T1	-4.20*	.82	<.001	-6.26	-2.16
	T2	-2.08*	.83	<.05	-4.15	-0.01

Based on estimated marginal means

* The mean difference is significant at the 0.05 level

^b Adjustment for multiple comparisons: Bonferroni.

Abbreviations: MD, Mean Difference, SE, Standard Error

Table A.15. Results of post-hoc tests with a Bonferroni correction, carried out on the variable Self-Compassion Total (SCS-Total) across weeks 1, 6, and 12 of the CFT group ($n = 39$).

(I) SCS-Total	(J) SCS-Total	MD (I-J)	SE	Sig. ^b	95% CI ^b	
					Lower Bound	Upper Bound
T1	T2	-8.87*	2.31	<.001	-14.66	-3.08
	T3	-20.46*	2.92	<.001	-27.76	-13.15
T2	T1	8.87*	2.31	<.001	3.08	14.67
	T3	-11.60*	1.90	<.001	-16.34	-6.84
T3	T1	20.46*	2.92	<.001	13.15	27.77
	T2	11.59*	1.90	<.001	6.84	15.43

Based on estimated marginal means

* The mean difference is significant at the 0.05 level

^b Adjustment for multiple comparisons: Bonferroni.

Abbreviations: SCS-Total, Self-Compassion Scale – Total, MD, Mean Difference, SE, Standard Error

Table A.16. Results of post-hoc tests with a Bonferroni correction, carried out on the variable Psychological Distress (DASS-Total) across weeks 1, 6, and 12 of the CFT group ($n = 39$).

(I) DASS-Total	(J) DASS-Total	MD (I-J)	SE	Sig. ^b	95% CI ^b	
					Lower Bound	Upper Bound
T1	T2	6.13*	1.95	.01	1.25	11.01
	T3	11.68*	1.80	<.001	7.17	16.17
T2	T1	-6.13*	1.95	.01	-11.01	-1.25
	T3	5.54*	2.13	.04	-0.20	10.88
T3	T1	-11.68*	1.80	<.001	-16.17	-7.17
	T2	-5.54*	2.13	.04	-10.88	-0.20

Based on estimated marginal means

* The mean difference is significant at the 0.05 level

^b Adjustment for multiple comparisons: Bonferroni.

Abbreviations: DASS-Total, Depression, Anxiety and Stress Scale – Total score, MD, Mean Difference, SE, Standard Error

Table A.17. Results of post-hoc tests with a Bonferroni correction, carried out on the variable Positive Affect (PANAS-PA) across weeks 1, 6, and 12 of the CFT group ($n = 39$).

(I) PANAS-PA	(J) PANAS-PA	MD (I-J)	SE	Sig. ^b	95% CI ^b	
					Lower Bound	Upper Bound
T1	T2	-2.72*	1.13	.06	-5.55	0.11
	T3	-5.18*	1.29	<.01	-8.40	-1.96
T2	T1	2.72*	1.13	.06	-0.11	5.55
	T3	-2.46*	1.51	.33	-6.23	1.31
T3	T1	5.18*	1.28	<.01	1.96	8.40
	T2	2.46*	1.51	.33	-1.31	6.23

Based on estimated marginal means

* The mean difference is significant at the 0.05 level

^b Adjustment for multiple comparisons: Bonferroni.

Abbreviations: PANAS-PA, Positive And Negative Affect Scale – Positive Affect, MD, Mean Difference, SE, Standard Error

Table A.18. Results of post-hoc tests with a Bonferroni correction, carried out on the variable Negative Affect (PANAS-NA) across weeks 1, 6, and 12 of the CFT group ($n = 39$).

(I) PANAS-NA	(J) PANAS-NA	MD (I-J)	SE	Sig. ^b	95% CI ^b	
					Lower Bound	Upper Bound
T1	T2	3.44*	1.27	.03	0.25	0.11
	T3	7.18*	1.24	<.01	3.93	-1.96
T2	T1	-3.44*	1.27	.03	-6.62	5.55
	T3	3.61*	1.16	<.01	0.71	1.31
T3	T1	-7.05*	1.24	<.01	-10.17	8.40
	T2	-3.61*	1.16	.01	-6.52	6.23

Based on estimated marginal means

* The mean difference is significant at the 0.05 level

^b Adjustment for multiple comparisons: Bonferroni.

Abbreviations: PANAS-NA, Positive And Negative Affect Scale – Negative Affect, MD, Mean Difference, SE, Standard Error

Table A.19. Results of post-hoc tests with a Bonferroni correction, carried out on the variable Safe / Content Affect (TTPAS-SCA) across weeks 1, 6, and 12 of the CFT group ($n = 39$).

(I) TTPAS-SCA	(J) TTPAS-SCA	MD (I-J)	SE	Sig.	95% CI ^b	
					Lower Bound	Upper Bound
T1	T2	-0.92*	0.55	.300	-2.29	0.45
	T3	-3.10*	0.55	<.001	-4.49	-1.72
T2	T1	0.92*	0.55	.300	-0.45	2.29
	T3	-2.18*	0.46	<.001	-3.34	-1.03
T3	T1	3.10*	0.55	<.001	1.72	4.49
	T2	2.18*	0.46	<.001	1.03	3.34

Based on estimated marginal means

* The mean difference is significant at the 0.05 level

^b Adjustment for multiple comparisons: Bonferroni.

Abbreviations: TTPAS-SCA, Two Types of Positive Affect Scale, MD, Mean Difference, SE, Standard Error

Table A.20. Indicating the results of Mauchly's test of sphericity upon the Study 2 group results.

Variable	Mauchly's test results
Trait self-forgiveness	$\chi^2 (2) = 1.24, p = .54$
State Self-Forgiveness – Feelings and Actions ¹	$\chi^2 (2) = 4.07, p = .13$
State Self-Forgiveness – Self Forgiving Beliefs ¹	$\chi^2 (2) = .70, p = .71.$
Uncompassionate Self-Responding	$\chi^2 (2) = 7.57, p = .02*.$
Compassionate Self-Responding	$\chi^2 (2) = 5.05, p = .08$
Self-compassion total	$\chi^2 (2) = 10.37, p = .006**$
Psychological distress	$\chi^2 (2) = 1.48, p = .48.$
Shame	$\chi^2 (2) = 3.92, p = .14.$
Guilt	$\chi^2 (2) = 1.45, p = .48.$
Positive Affect	$\chi^2 (2) = 4.36, p = .11.$
Negative Affect	$\chi^2 (2) = 0.44, p = .80.$
Safe / Content affect	$\chi^2 (2) = 1.83, p = .40.$

¹ ANCOVA analyses were performed upon these variables

Table A.21. Path coefficients, indirect effects, and 95% bias-corrected confidence intervals predicting trait self-forgiveness upon guilt ($n = 39$).

Path	Effect	LLCI	ULCI	SE (HC3)	<i>t</i>	<i>p</i> -value
Total effect (<i>c</i>)	-.29	-.53	-.04	.12	-2.38	.02*
Direct effect (<i>c'</i>)	-.06	-.29	.17	.11	-0.57	.57
<i>a</i> ₁ (CSR)	.73	.20	1.27	.26	2.80	.01*
<i>a</i> ₂ (NA)	-.39	-.77	-.00	.19	-2.04	.04*
<i>a</i> ₃ (USR)	-.64	-1.09	-.18	.22	-2.85	.01*
<i>b</i> ₁ (CSR)	-.00	-.26	-.25	.25	-.00	.99
<i>b</i> ₂ (NA)	.26	-.04	.57	.15	1.76	.09
<i>b</i> ₃ (USR)	.18	-.13	.49	.15	1.21	.24
Completely standardised indirect effects						
Total	-.29	-.54	-.04	.13		
<i>a</i> ₁ <i>b</i> ₁ (CSR)	.00	-.19	.25	.11		
<i>a</i> ₂ <i>b</i> ₂ (NA)	-.13	-.37	-.00	.10		
<i>a</i> ₃ <i>b</i> ₃ (USR)	.15	-.37	.11	.12		

Notes: *c* = total effect, *c'* = direct effect. *a*₁, *a*₂, *a*₃ = regression coefficients of *X*₁, *X*₂, *X*₃ respectively. *b*₁, *b*₂, *b*₃ = regression coefficients of *M*₁, *M*₂, *M*₃ respectively. *a*₁ = state self-forgiveness feelings and actions - compassionate self-responding, *a*₂ = state self-forgiveness feelings and actions - uncompassionate self-responding, *b*₁ = compassionate self-responding – psychological distress, *b*₂ = compassionate self-responding – psychological distress. * = significant mediation. **p* < .05, ***p* < .01, ****p* < .001.

Abbreviations: LLCI, bootstrapping lower limit confidence interval, ULCI, bootstrapping upper limit confidence interval, SE (HC3), standard error with heteroscedasticity correction.

Table A.22. Path coefficients, indirect effects, and 95% bias-corrected confidence intervals predicting trait self-forgiveness and guilt ($n = 39$)

Path	Effect	LLCI	ULCI	SE (HC3)	t	p -value
Total effect (c)	-.28	-.53	.04	.12	-2.38	.02*
Direct effect (c')	-.06	-.28	.16	.11	-.56	.58
a_1 (SCS-T)	1.39	.50	2.29	.44	3.15	<.001***
a_2 (NA)	-.38	-.77	-.00	.19	-2.04	.04*
b_1 (SCS-T)	-.08	-.21	.04	.06	1.30	.20
b_2 (NA)	.28	-.02	.58	.15	1.89	.07
Completely standardised indirect effects						
Total	-.29	-.55	-.06	.13		
a_1b_1 (SCS-T)	.15	-.37	.09	.11		
$a_2b_2^*$ (NA)	-.14	-.39	-.00	.10		

Notes: c = total effect, c' = direct effect. $a_1a_1, a_2,$ = regression coefficients of X_1, X_2 , respectively. b_1, b_2 = regression coefficients of M_1, M_2 respectively. a_1 = trait self-forgiveness – SCS total scale, a_2 = trait self-forgiveness – negative affect, b_1 = SCS total scale – guilt, b_2 = negative affect – guilt.
^{*} = significant mediation. $*p < .05$, $**p < .01$, $***p < .001$.

Abbreviations: LLCI, lower limit confidence interval, ULCI, upper limit confidence interval, SE (HC3), standard error with heteroscedasticity correction.

Table A.23. Path coefficients, indirect effects, and 95% bias-corrected confidence intervals predicting state self-forgiving self-beliefs upon shame ($n = 32$).

Path	Effect	LLCI	ULCI	SE (HC3)	<i>t</i>	<i>p</i> -value
Total effect (<i>c</i>)	-.34	-.62	-.08	.13	-2.63	.01**
Direct effect (<i>c'</i>)	-.11	-.06	.28	.08	1.27	.22
<i>a</i> ₁ (CSR)	.78	.12	1.44	.32	2.43	.02*
<i>a</i> ₂ (PA)	.58	.12	1.04	.23	2.56	.02*
<i>a</i> ₃ (USR)	-.93	-1.34	-.53	.20	-4.75	<.001***
<i>a</i> ₄ (NA)	-.55	-.92	-.18	.18	-3.02	.01**
<i>b</i> ₁ (CSR)	.17	-.06	.40	.11	1.55	.13
<i>b</i> ₂ (PA)	-.20	-.42	.03	.11	-1.79	.09
<i>b</i> ₃ (USR)	.29	-.09	.48	.10	2.97	.01**
<i>b</i> ₄ (NA)	.39	.23	.54	.08	5.07	<.001***
Completely standardised indirect effects						
Total	-.55	-.82	-.31	.13		
<i>a</i> ₁ <i>b</i> ₁ (CSR)	.16	-.07	.45	.13		
<i>a</i> ₂ <i>b</i> ₂ (PA)	-.14	-.36	.01	.10		
<i>a</i> ₃ <i>b</i> ₃ [*] (USR)	-.32	-.57	-.06	.13		
<i>a</i> ₄ <i>b</i> ₄ [*] (NA)	-.26	-.45	-.11	.09		

Notes: *c* = total effect, *c'* = direct effect. *a*₁, *a*₂, *a*₃, *a*₄ = regression coefficients of *X*₁, *X*₂, *X*₃, *X*₄ respectively. *b*₁, *b*₂, *b*₃, *b*₄ = regression coefficients of *M*₁, *M*₂, *M*₃, *M*₄ respectively. *a*₁ = state self-forgiveness self-beliefs - compassionate self-responding, *a*₂ = state self-forgiveness self-beliefs - uncompassionate self-responding (USR), *a*₃ = state self-forgiveness self-beliefs - compassionate self-responding, *a*₄ = state self-forgiveness self-beliefs - uncompassionate self-responding, *b*₁ = compassionate self-responding – shame, *b*₂ = positive affect – shame, *b*₃ = uncompassionate self-responding – shame, *b*₄ = negative affect – shame.

^{*} = significant mediation. **p* < .05, ***p* < .01, ****p* < .001.

Abbreviations: LLCI, lower limit confidence interval, ULCI, bootstrapping upper limit confidence interval, SE (HC3), standard error with heteroscedasticity correction.

Table A.24. Path coefficients, indirect effects, and 95% bias-corrected confidence intervals predicting state self-forgiving self-beliefs upon shame ($n = 32$).

Path	Effect	LLCI	ULCI	SE (HC3)	<i>t</i>	<i>p</i> -value
Total effect (<i>c</i>)	-.35	-.62	-.08	.13	-2.63	.01*
Direct effect (<i>c'</i>)	-.01	-.06	-.32	.35	.09	.93
<i>a</i> ₁ (SCS-T)	1.73	.82	2.64	.45	3.89	< .001***
<i>a</i> ₂ (PA)	.58	.12	1.04	.23	2.56	.02*
<i>a</i> ₃ (NA)	-.55	-.92	-.18	.18	-3.02	.01*
<i>b</i> ₁ (SCS-T)	.03	-.18	.12	.07	-.40	.69
<i>b</i> ₂ (PA)	-.15	-.39	.09	.12	-1.30	.20
<i>b</i> ₃ (NA)	.41	.15	.67	.13	3.26	< .001***
Completely standardised indirect effects						
Total	-.44	-.74	-.22	.13		
<i>a</i> ₁ <i>b</i> ₁ (SCS-T)	-.06	-.37	.22	.15		
<i>a</i> ₂ <i>b</i> ₂ (PA)	-.11	-.38	.03	.10		
<i>a</i>₃<i>b</i>₃# (NA)	-.27	-.52	-.10	.11		

Notes: *c* = total effect, *c'* = direct effect. *a*₁, *a*₂, *a*₃ = regression coefficients of *X*₁, *X*₂, *X*₃, respectively. *b*₁, *b*₂, *b*₃, = regression coefficients of *M*₁, *M*₂, *M*₃, respectively. *a*₁ = state self-forgiveness self-beliefs – SCS total scale, *a*₂ = state self-forgiveness self-beliefs – positive affect, *a*₃ = state self-forgiveness self-beliefs – negative affect, *b*₁ = SCS total scale – shame, *b*₂ = negative affect – shame, *b*₃ = positive affect – shame. * = significant mediation. **p* < .05, ***p* < .01, ****p* < .001.

Abbreviations: LLCI, lower limit confidence interval, ULCI, upper limit confidence interval, SE (HC3), standard error with heteroscedasticity correction..

Table A.25. Path coefficients, indirect effects, and 95% bias-corrected confidence intervals predicting state self-forgiving forgiving feelings and actions upon guilt ($n = 32$).

Path	Effect	LLCI	ULCI	SE (HC3)	t	p -value
Total effect (c)	-.46	-.86	-.06	.19	-2.35	.03*
Direct effect (c')	-.12	-.49	.25	.18	-.67	.51
a_1 (CSR)	1.13	.52	1.73	.30	3.80	< .001***
a_2 (PA)	.53	.05	1.02	.24	2.25	.03*
a_3 (USR)	-1.17	-1.78	-.55	.30	-3.89	< .001***
a_4 (NA)	-.52	-1.06	.01	.26	-2.00	.05
b_1 (CSR)	-.03	-.30	.25	.13	-.21	.83
b_2 (PA)	.07	-.20	.34	.13	-.54	.59
b_3 (USR)	.18	-.19	.54	.18	.99	.33
b_4 (NA)	.27	-.10	.63	.18	1.48	.15
Completely standardised indirect effects						
Total	-.35	-.63	-.04	.15		
a_1b_1 (CSR)	-.03	-.27	.29	.14		
a_2b_2 (PA)	-.04	-.16	.17	.08		
a_3b_3 (USR)	-.21	-.48	.28	.19		
$a_4b_4^*$ (NA)	-.14	-.44	-.01	.11		

Notes: c = total effect, c' = direct effect. a_1, a_2, a_3, a_4 = regression coefficients of X_1, X_2, X_3, X_4 respectively. b_1, b_2, b_3, b_4 = regression coefficients of M_1, M_2, M_3, M_4 , respectively. a_1 = state self-forgiveness feelings and actions - compassionate self-responding, a_2 = state self-forgiveness feelings and actions – positive affect, a_3 = state self-forgiveness feelings and actions – positive affect, a_4 = state self-forgiveness feelings and actions - uncompassionate self-responding, b_1 = compassionate self-responding – guilt, b_2 = positive affect – guilt, b_3 = uncompassionate self-responding –guilt, b_4 = negative affect – guilt.

* = significant mediation. * $p < .05$, ** $p < .01$, *** $p < .001$.

Abbreviations: LLCI, lower limit confidence interval, ULCI, bootstrapping upper limit confidence interval, SE (HC3), standard error with heteroscedasticity correction.

Table A.26. Path coefficients, indirect effects, and 95% bias-corrected confidence intervals predicting state self-forgiving feelings and actions upon guilt ($n = 32$).

Path	Effect	LLCI	ULCI	SE (HC3)	<i>t</i>	<i>p</i> -value
Total effect (<i>c</i>)	-.46	-.86	-.06	.19	-2.35	.03*
Direct effect (<i>c'</i>)	-.15	-.51	.21	.17	-.86	.40
<i>a</i> ₁ (SCS-T)	.30	1.25	3.35	.51	4.48	< .001***
<i>a</i> ₂ (PA)	.53	.05	1.02	.24	2.25	.03*
<i>a</i> ₃ (NA)	-.52	-1.06	.01	.26	-2.00	.05
<i>b</i> ₁ (SCS-T)	-.09	-.29	.12	.10	-.88	.39
<i>b</i> ₂ (PA)	.08	-.21	.36	.14	-.55	.59
<i>b</i> ₃ (NA)	.28	-.08	.64	.18	1.59	.12
Completely standardised indirect effects						
Total	-.32	-.59	-.03	.14		
<i>a</i> ₁ <i>b</i> ₁ (SCS-T)	-.21	-.49	.34	.21		
<i>a</i> ₂ <i>b</i> ₂ (PA)	.04	-.16	.17	.08		
<i>a</i> ₃ <i>b</i> ₃ [#] (NA)	-.15	-.44	-.01	.11		

Notes: *c* = total effect, *c'* = direct effect. *a*₁, *a*₂, *a*₃ = regression coefficients of *X*₁, *X*₂, *X*₃, respectively. *b*₁, *b*₂, *b*₃, = regression coefficients of *M*₁, *M*₂, *M*₃, respectively. *a*₁ = state self-forgiveness feelings and actions – SCS total scale, *a*₂ = state self-forgiveness feelings and actions – positive affect, *a*₃ = state self-forgiveness feelings and actions – negative affect, *b*₁ = SCS total scale – guilt, *b*₂ = positive affect – guilt, *b*₃ = negative affect – guilt. * = significant mediation. **p* < .05, ***p* < .01, ****p* < .001.

Abbreviations: LLCI, lower limit confidence interval, ULCI, upper limit confidence interval, SE (HC3), standard error with heteroscedasticity correction.

Table A.27. Path coefficients, indirect effects, and 95% bias-corrected confidence intervals predicting state self-forgiving feelings and actions upon shame ($n = 32$).

Path	Effect	LLCI	ULCI	SE (HC3)	<i>t</i>	<i>p</i> -value
Total effect (<i>c</i>)	-.44	-.80	-.08	.18	-2.52	.02*
Direct effect (<i>c'</i>)	-.10	-.42	.21	.15	-0.66	.51
<i>a</i> ₁ (CSR)	1.13	.52	1.73	.30	3.80	< .001***
<i>a</i> ₂ (PA)	.53	-.05	1.02	.24	2.25	.03*
<i>a</i> ₃ (USR)	-1.17	-1.78	-.55	.30	-3.89	< .001***
<i>a</i> ₄ (NA)	-.52	-1.06	.01	.26	-2.00	.05
<i>b</i> ₁ (CSR)	-.19	-.04	.43	.25	-.00	.99
<i>b</i> ₂ (PA)	.26	-.04	.57	.15	1.76	.09
<i>b</i> ₃ (USR)	.22	-.00	.45	.11	2.03	.05
<i>b</i> ₄ (NA)	.36	.19	.54	.08	4.37	< .001***
Completely standardised indirect effects						
Total	-.33	-.60	-.03	.15		
<i>a</i> ₁ <i>b</i> ₁ (CSR)	.21	-.04	.54	.15		
<i>a</i> ₂ <i>b</i> ₂ (PA)	-.10	-.29	.02	.08		
<i>a</i> ₃ <i>b</i> ₃ (USR)	-.25	-.49	.05	.13		
<i>a</i> ₄ <i>b</i> ₄ [#] (NA)	-.18	-.37	-.03	.08		

Notes: *c* = total effect, *c'* = direct effect. *a*₁, *a*₂, *a*₃, *a*₄ = regression coefficients of *X*₁, *X*₂, *X*₃, *X*₄, respectively. *b*₁, *b*₂, *b*₃, *b*₄ = regression coefficients of *M*₁, *M*₂, *M*₃, *M*₄, respectively. *a*₁ = state self-forgiveness feelings and actions - compassionate self-responding, *a*₂ = state self-forgiveness feelings and actions – positive affect, *a*₃ = state self-forgiveness feelings and actions - uncompassionate self-responding, *a*₄ = state self-forgiveness feelings and actions – negative affect, *b*₁ = compassionate self-responding – shame, *b*₂ = positive affect – shame, *b*₃ = uncompassionate self-responding – shame, *b*₄ = negative affect – shame.

* = significant mediation. **p* < .05, ***p* < .01, ****p* < .001.

Abbreviations: BootLLCI, bootstrapping lower limit confidence interval, BootULCI, bootstrapping upper limit confidence interval, SE (HC3), standard error with heteroscedasticity correction.

Table A.28. Path coefficients, indirect effects, and 95% bias-corrected confidence intervals predicting trait self-forgiveness upon guilt ($n = 39$).

Path	Effect	LLCI	ULCI	SE (HC3)	t	p -value
Total effect (c)	-.44	-.80	.08	.18	-2.52	.02*
Direct effect (c')	-.16	-.53	.23	.19	-.84	.41
a_1 (CSR)	2.30	1.25	3.35	.51	4.48	.01**
a_2 (PA)	.53	.05	1.02	.24	2.25	.03*
a_3 (NA)	-.52	-1.06	.01	.26	-2.00	.05
b_1 (CSR)	.00	-.16	.17	.08	.07	.95
b_2 (PA)	-.16	-.41	.08	.12	-1.38	.18
b_3 (NA)	.40	.14	.67	.13	3.14	.01**

Completely standardised indirect effects

Total	-.27	-.55	.01	.14
a_1b_1 (CSR)	.01	-.29	.39	.11
a_2b_2 (PA)	-.08	-.37	.00	.10
a_3b_3 (NA)	-.20	-.44	-.03	.11

Notes: c = total effect, c' = direct effect., a_1, a_2, a_3 = regression coefficients of X_1, X_2, X_3 respectively. b_1, b_2, b_3 = regression coefficients of M_1, M_2, M_3 respectively. a_1 = state self-forgiveness feelings and actions - compassionate self-responding, a_2 = state self-forgiveness feelings and actions – positive affect, a_3 = state self-forgiveness feelings and actions – positive affect, b_1 = compassionate self-responding – shame, b_2 = positive affect – shame, b_3 = negative affect – shame. * = significant mediation. * $p < .05$, ** $p < .01$, *** $p < .001$.

Abbreviations: BootLLCI, bootstrapping lower limit confidence interval, BootULCI, bootstrapping upper limit confidence interval, SE (HC3), standard error with heteroscedasticity correction.

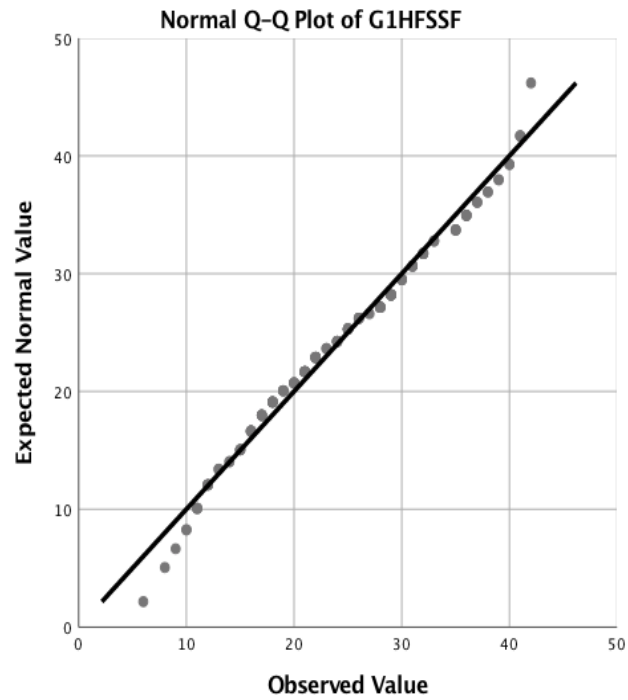


Figure A.1. A normal Q-Q plot of the variable trait self-forgiveness in Study 1 (G1HFSSF).

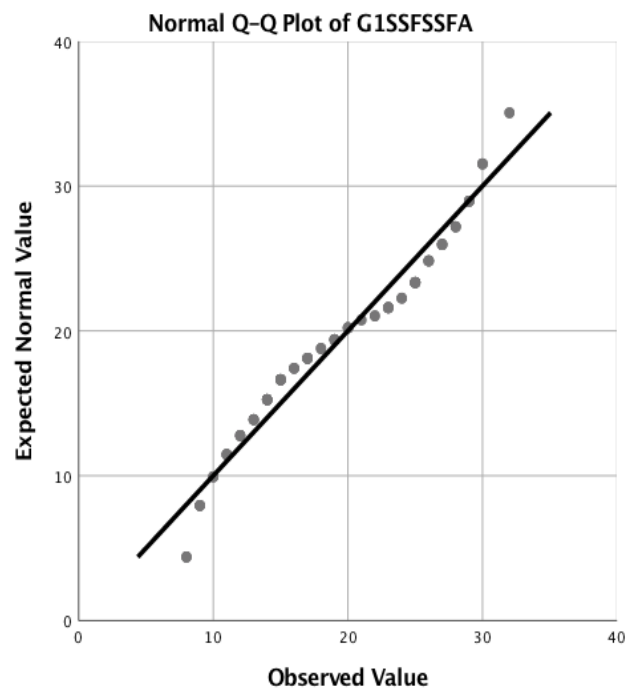


Figure A.2. A normal Q-Q plot of the variable state self-forgiving feelings and actions (G1SSFSSFA) in Study 1.

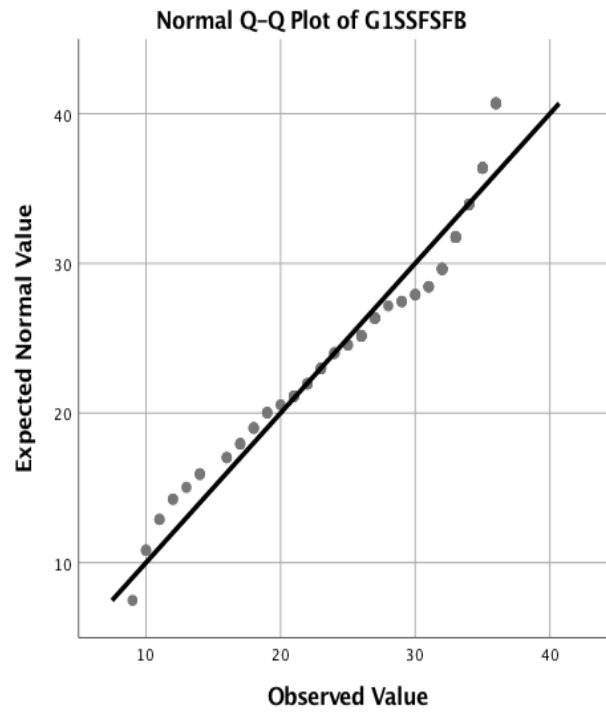


Figure A.3. A normal Q-Q plot of the variable state self-forgiving self-beliefs (G1SSF5FB) in Study 1.

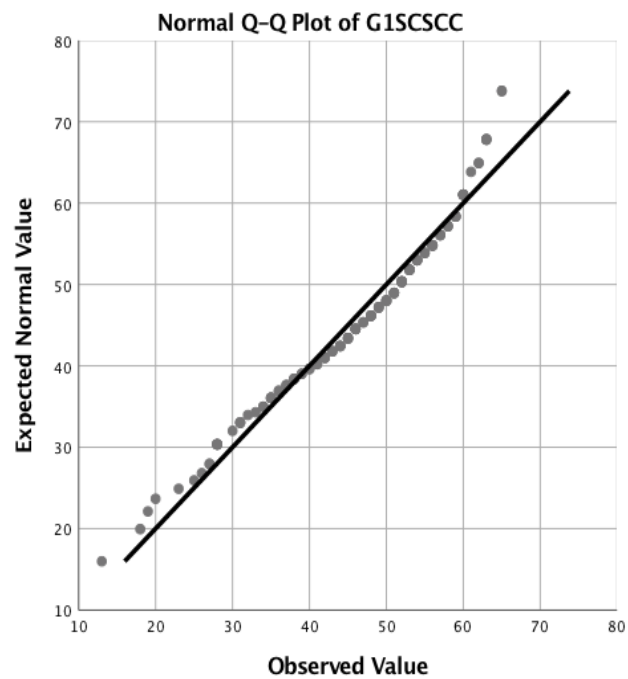


Figure A.4. A normal Q-Q plot of the variable uncompassionate self-responding (G1SCSCC) in Study 1.

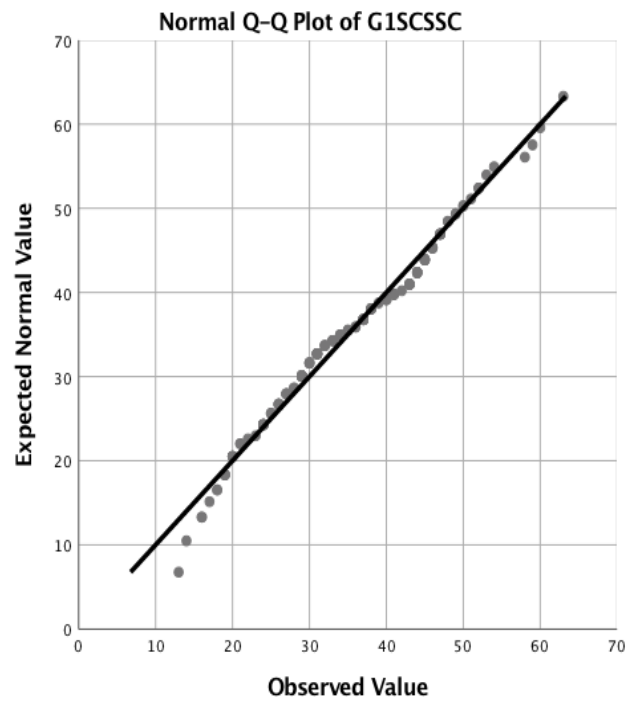


Figure A.5. A normal Q-Q plot of the variable compassionate self-responding (G1SCSSC) in Study 1.

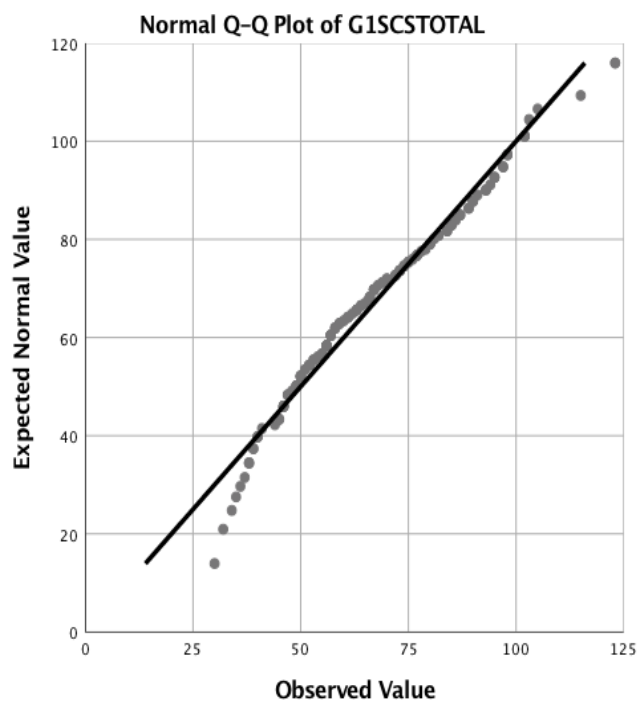


Figure A.6. A normal Q-Q plot of the variable self-compassion total (G1SCSTOTAL) in Study 1.

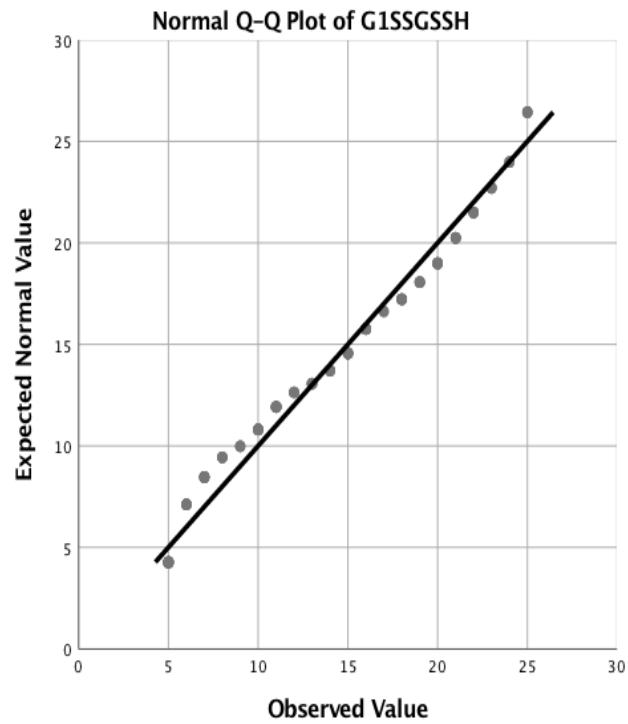


Figure A.7. A normal Q-Q plot of the variable shame (G1SSGSSH) in Study 1.

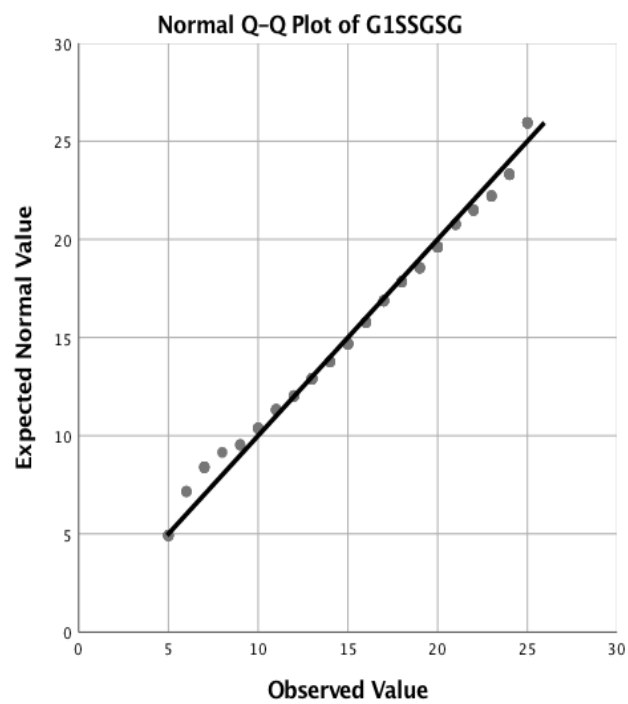


Figure A.8. A normal Q-Q plot of the variable guilt (G1SSGSG) in Study 1.

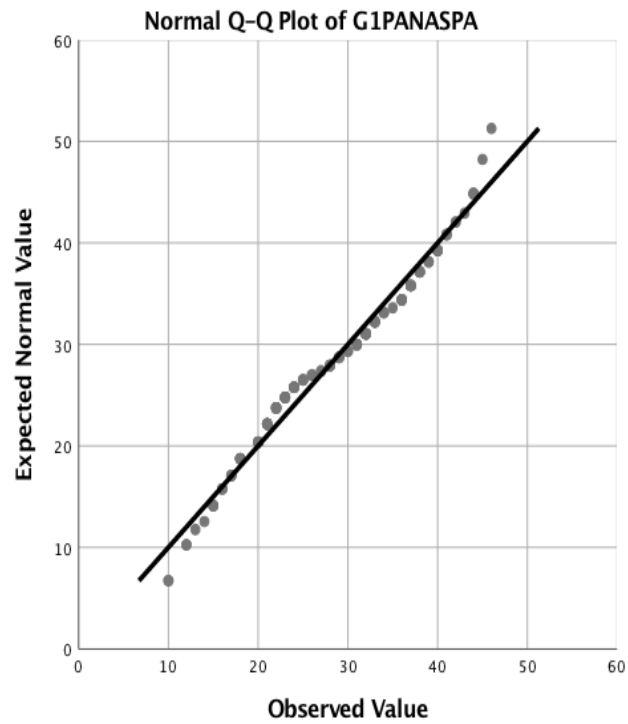


Figure A.9. A normal Q-Q plot of the variable positive affect (G1PANASPA) in Study 1.

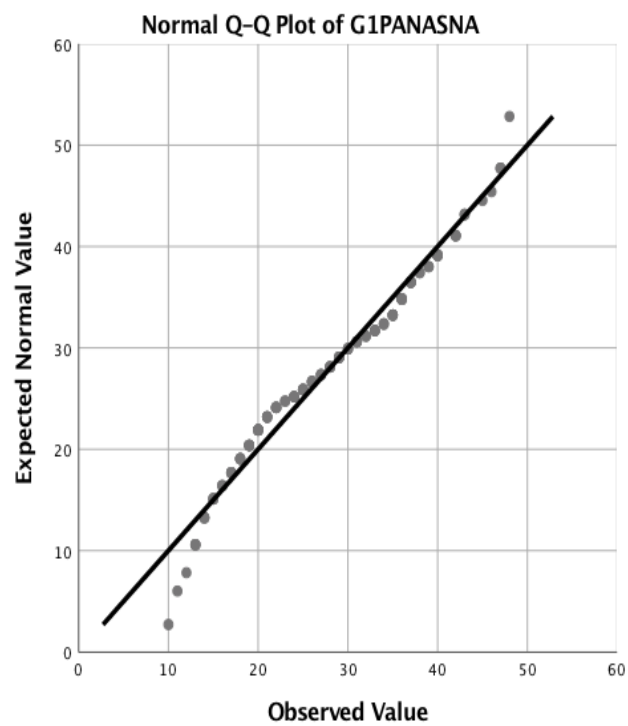


Figure A.10. A normal Q-Q plot of the variable negative affect (G1PANASNA) in Study 1.

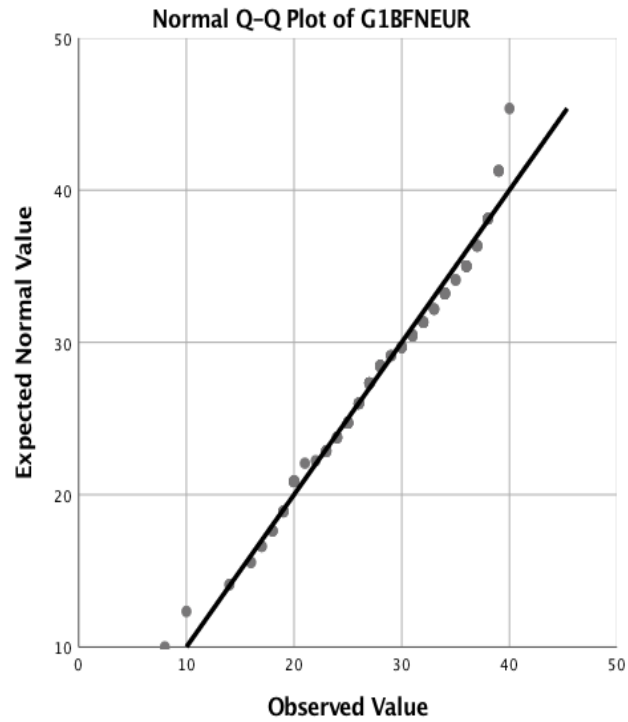


Figure A.11. A normal Q-Q plot of the variable neuroticism (G1BFNEUR) in Study 1.

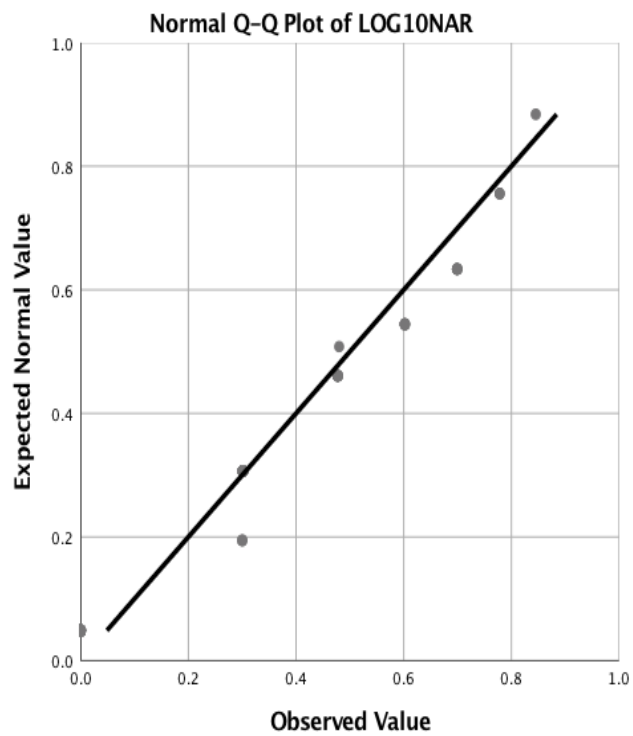


Figure A.12. A normal Q-Q plot of the variable narcissism (LOG10NAR) in Study 1.

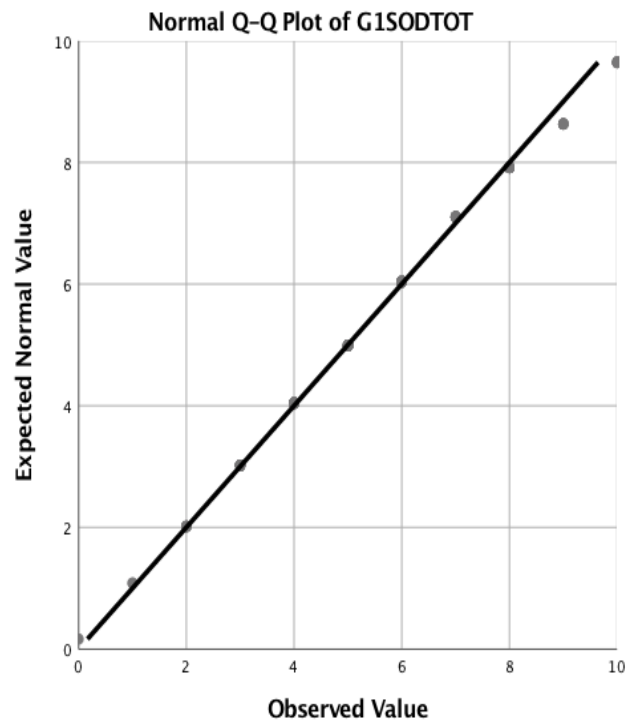


Figure A.13. A normal Q-Q plot of the variable social desirability (G!SODTOT) in Study 1

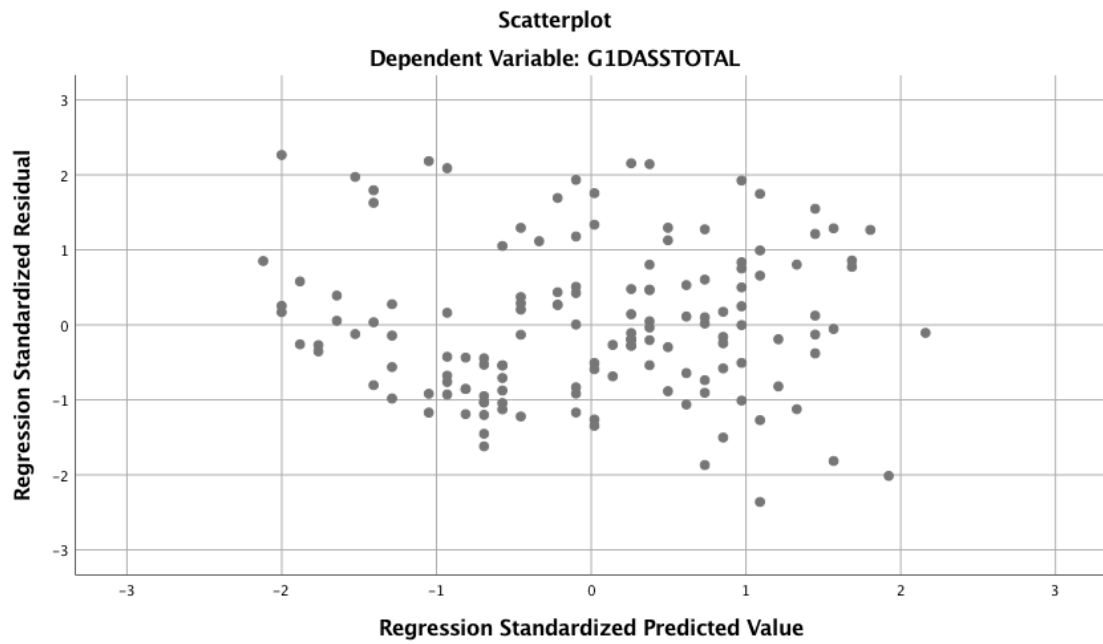


Figure A.14. A scatterplot of standardised residuals with trait self-forgiveness (X) against psychological distress (Y)

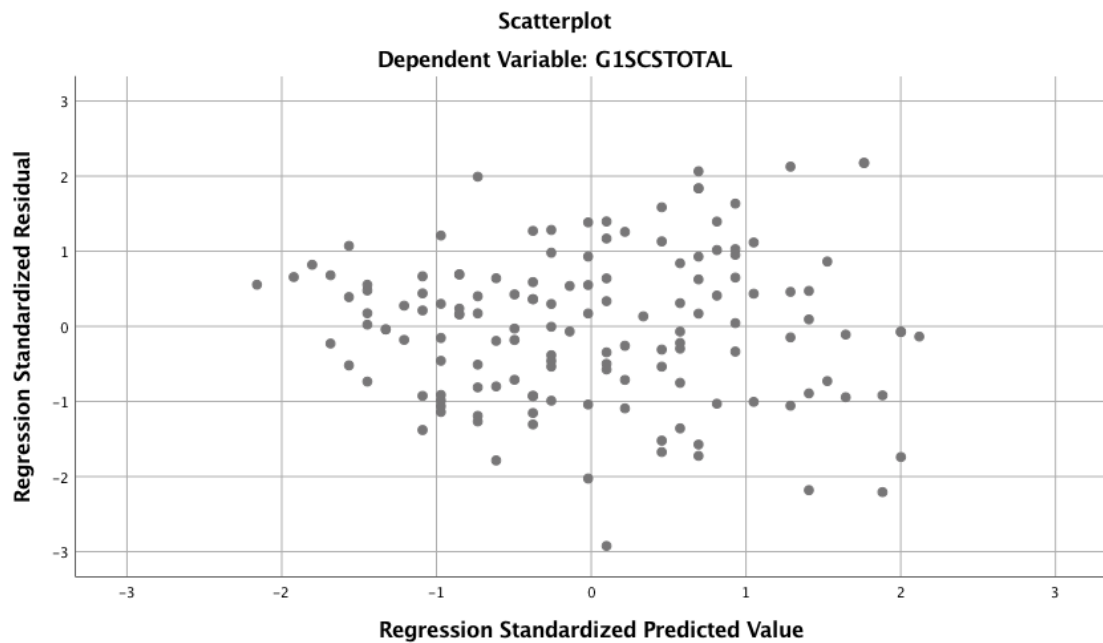


Figure A.15. A scatterplot of standardised residuals with trait self-forgiveness (X) predicting Self-compassion total (M)

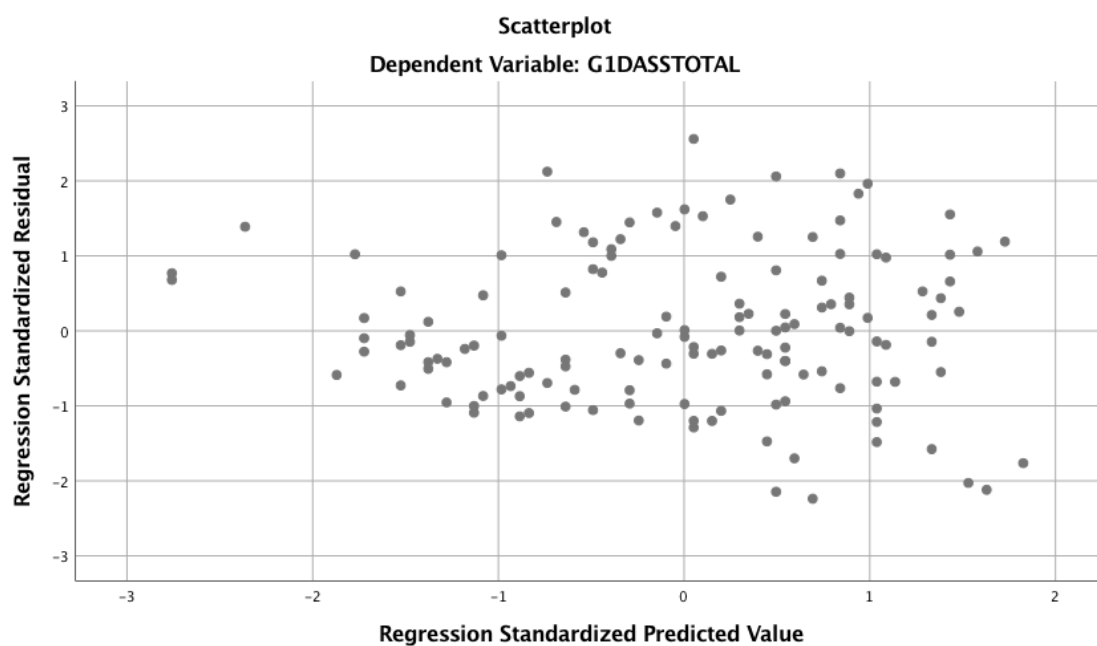


Figure A.16. A scatterplot of standardised residuals with Self-compassion total (M) predicting psychological distress (Y)

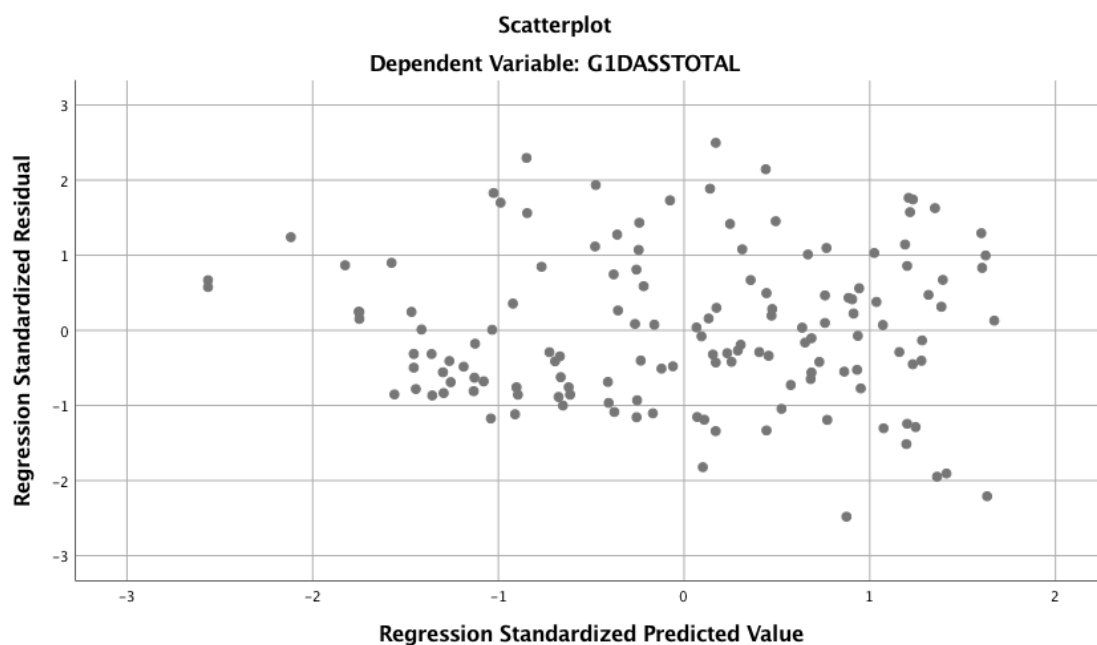


Figure A.17. A scatterplot of standardised residuals with trait self-forgiveness (X) and Self-compassion total (M) predicting psychological distress (Y)

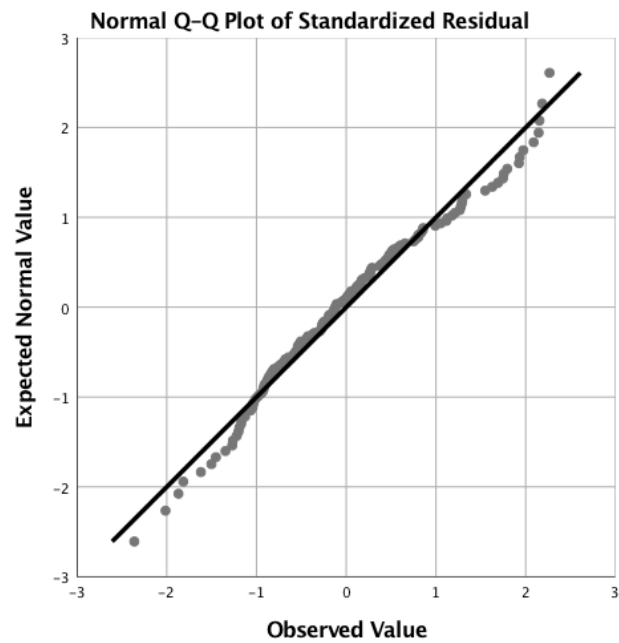


Figure A.18. A Q-Q plot from the standardised regression residuals from regressing trait self-forgiveness (X) against psychological distress (Y)

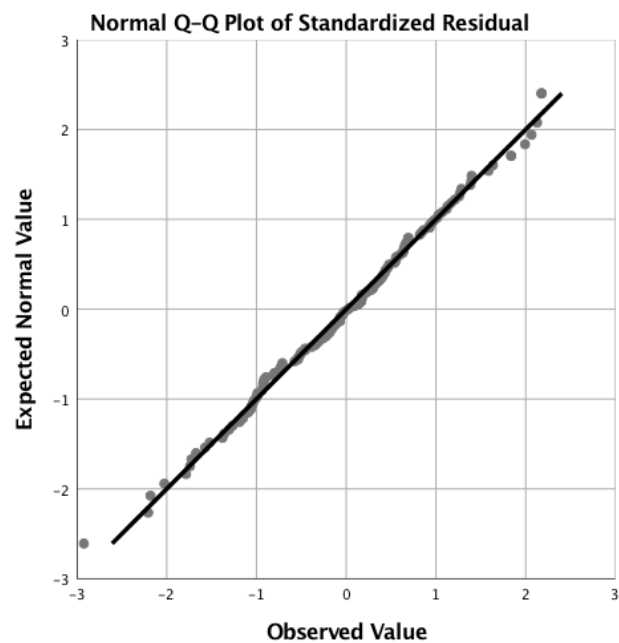


Figure A.19. A Q-Q plot from the standardised regression residuals from regressing (Y) trait self-forgiveness (X) predicting Self-compassion total (M)

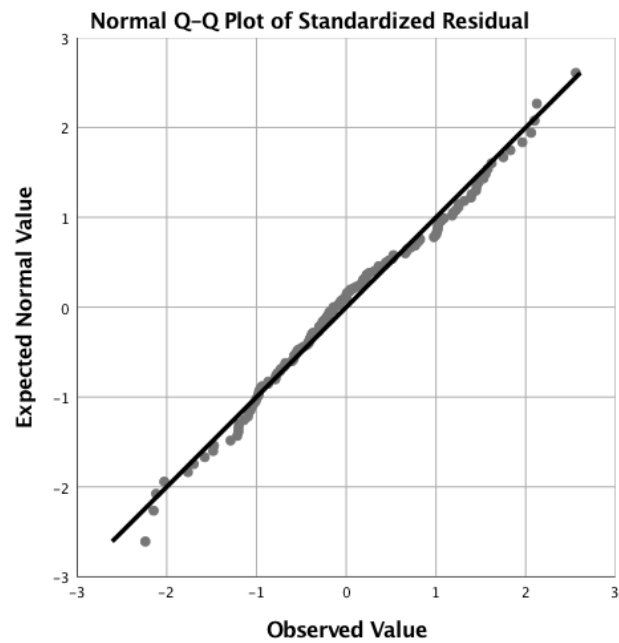


Figure A.20 A Q-Q plot from the standardised regression residuals from regressing Self-compassion total (M) predicting psychological distress (Y)

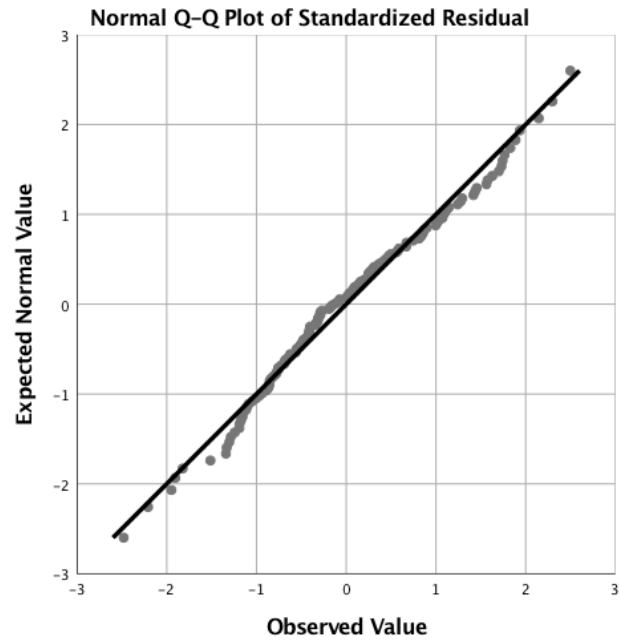


Figure A.21. A Q-Q plot from the regression residuals from regressing trait self-forgiveness (X) and Self-compassion total (M) predicting psychological distress (Y)

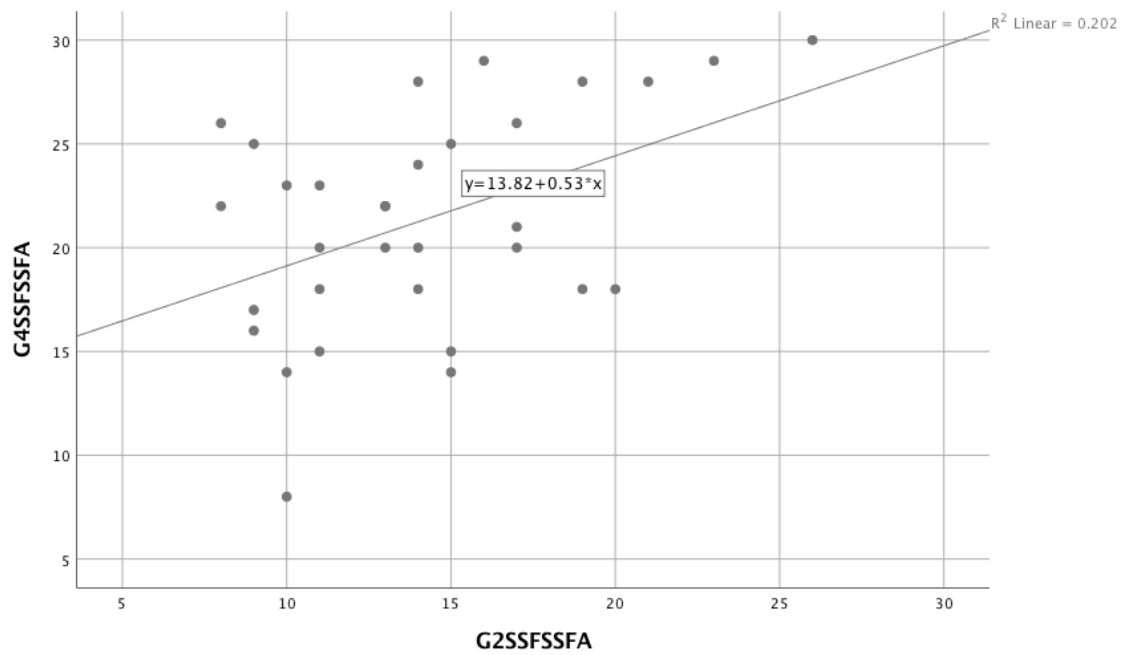


Figure A.22. Scatterplot with fit line demonstrating a linear relationship between State Self-forgiving Feelings and Actions at Time 2 (G2SSFSSFA) and at Time 4 (G4SSFSSFA)

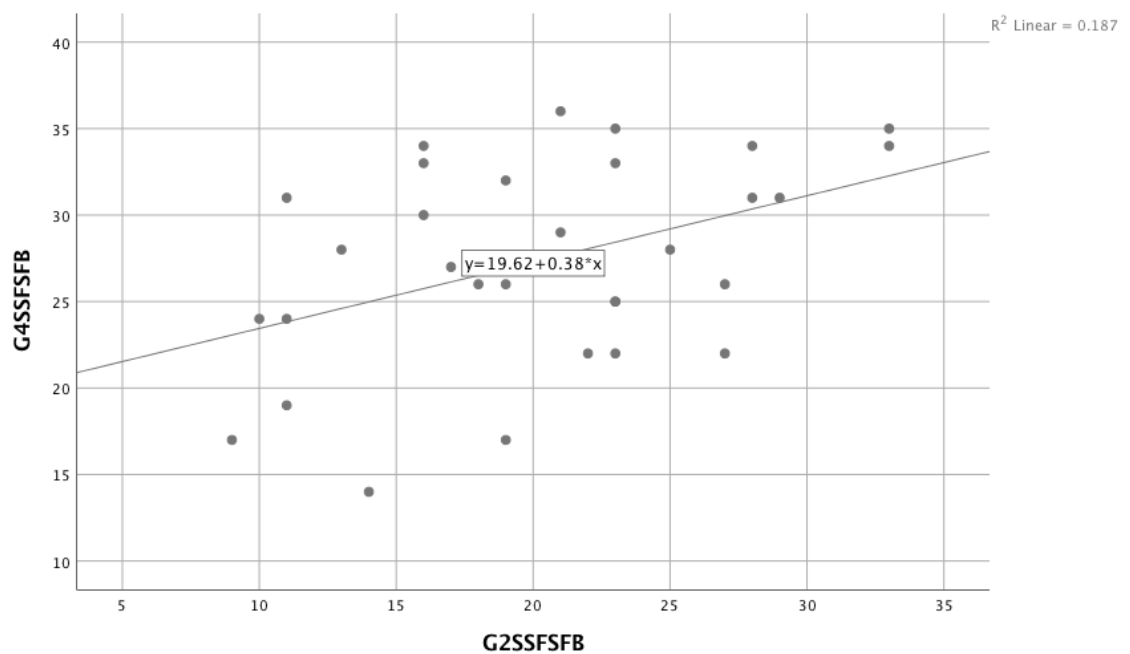


Figure A.23. Scatterplot with fit line demonstrating a linear relationship between State Self-forgiving Feelings and Actions at Time 2 (G2SSFsFB) and at Time 4 (G4SSFsFB)

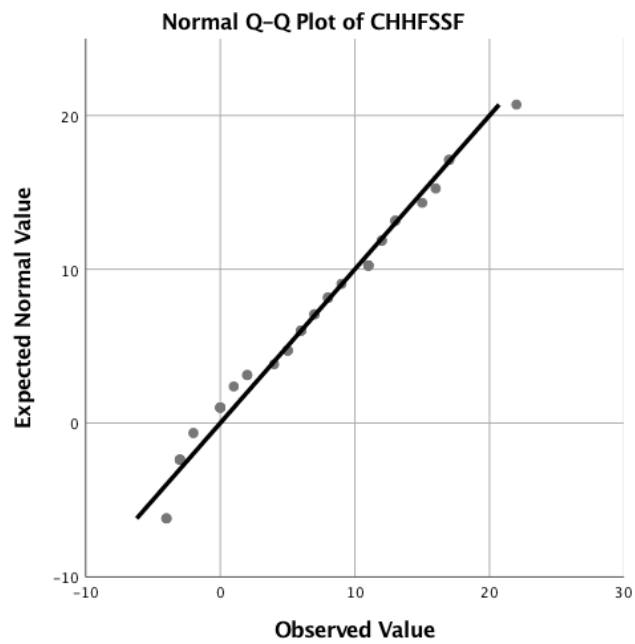


Figure A.24. A normal Q-Q plot of the change scores of the variable trait self-forgiveness (CHHFSSF) in Study 2.

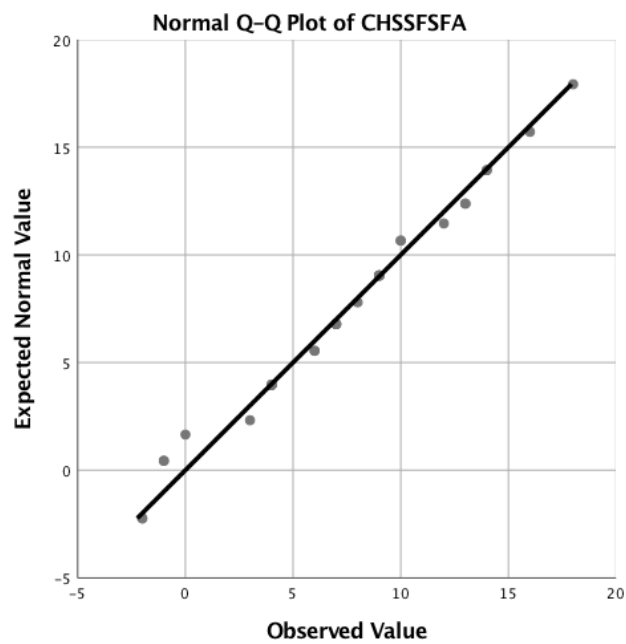


Figure A.25. A normal Q-Q plot of the change scores of the variable state self-forgiveness feelings and actions (CHSSFSA) in Study 2.

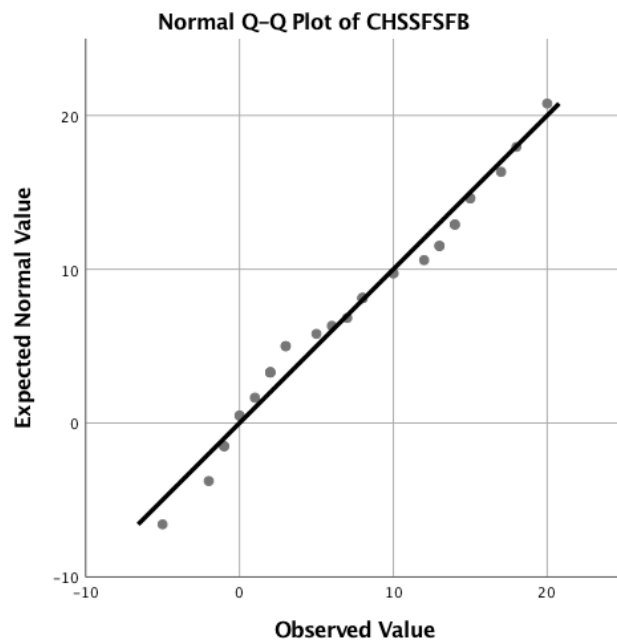


Figure A.26. A normal Q-Q plot of the change scores of the variable state self-forgiveness self-beliefs (CHSSF SFB) in Study 2.

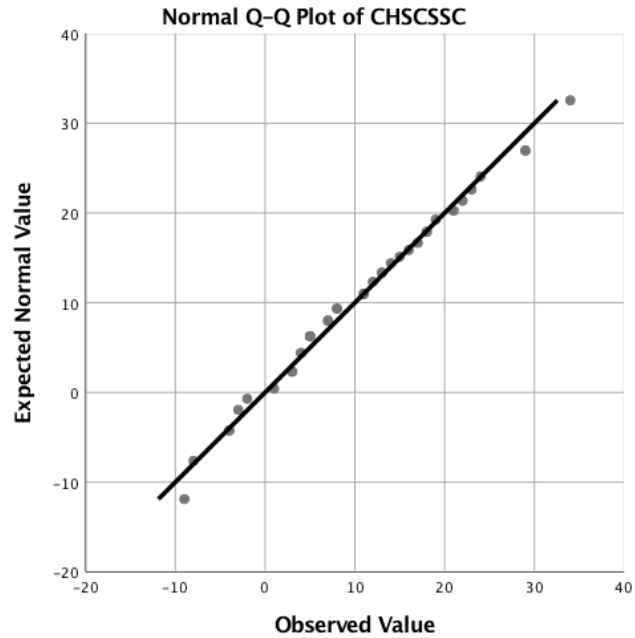


Figure A.27. A normal Q-Q plot of the change scores of the variable compassionate self-responding (CHSCSSC) in Study 2.

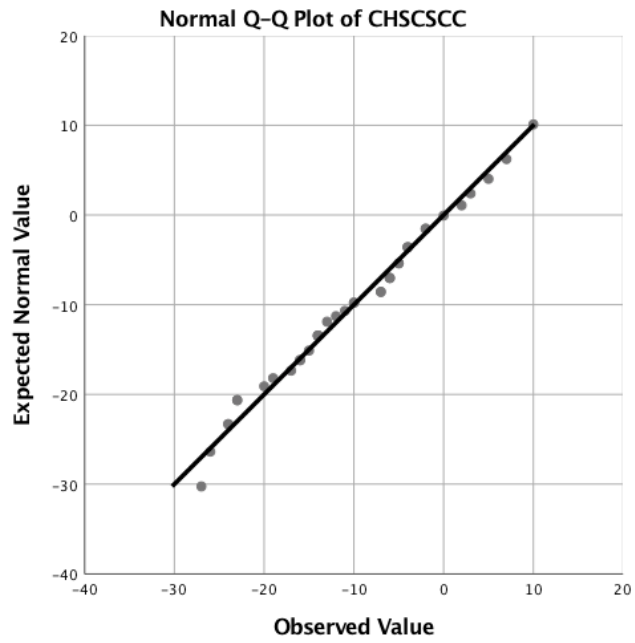


Figure A.28. A normal Q-Q plot of the change scores of the variable uncompassionate self-responding (CHSCSCC) in Study 2.

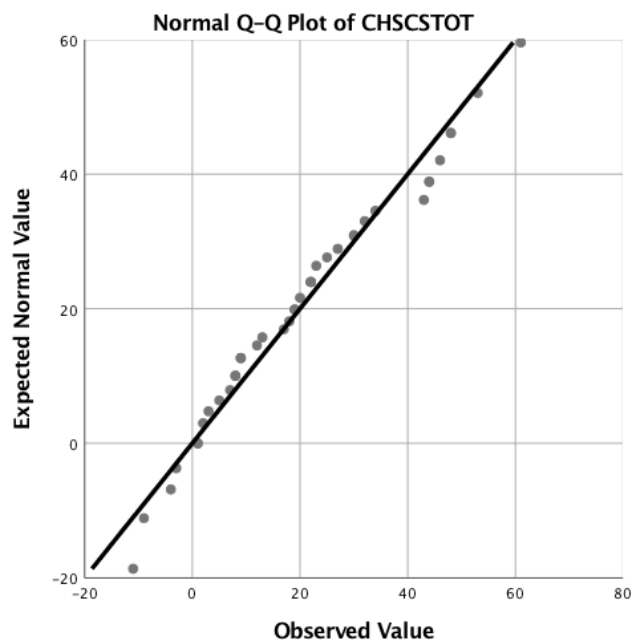


Figure A.29. A normal Q-Q plot of the change scores of the variable self-compassion scale total score (CHSCSTOT) in Study 2.

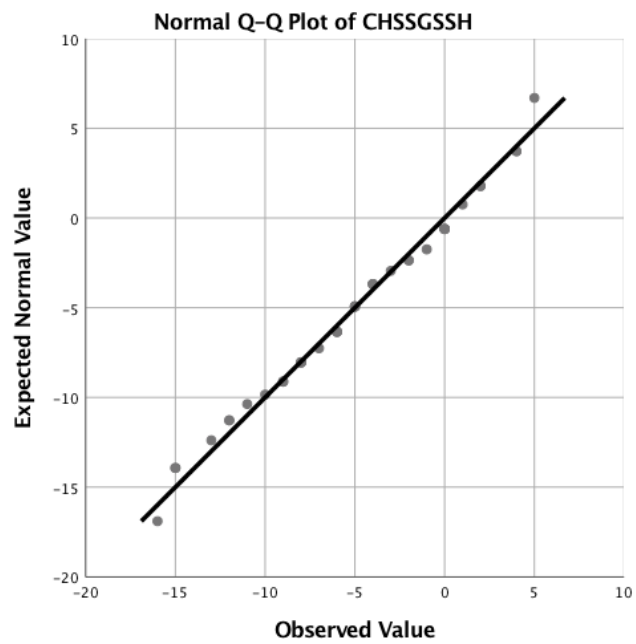


Figure A.30. A normal Q-Q plot of the change scores of the variable shame (CHSSGSH) in Study 2.

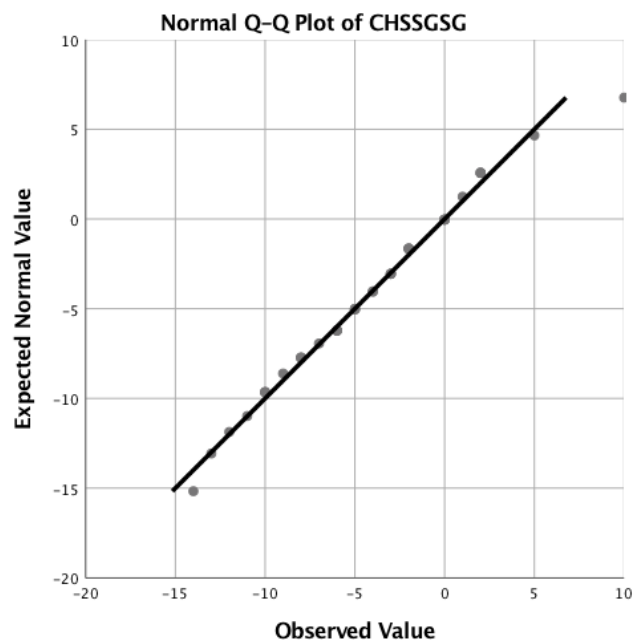


Figure A.31. A normal Q-Q plot of the change scores of the variable guilt (CHSSGSG) in Study 2.

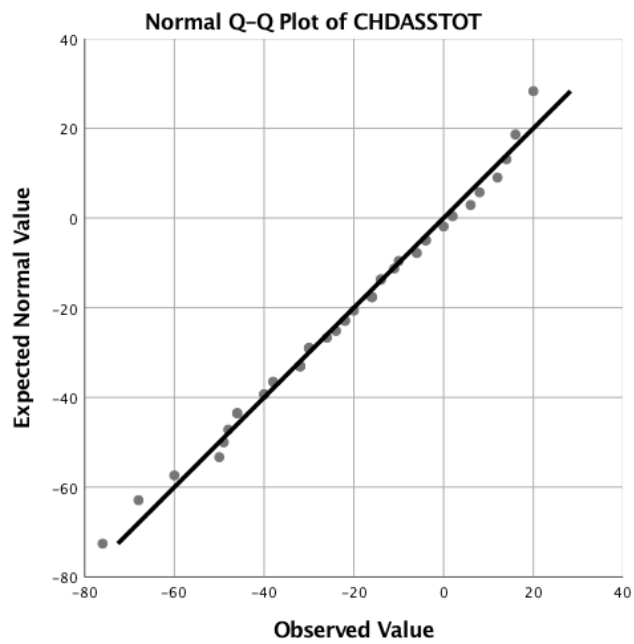


Figure A.32. A normal Q-Q plot of the change scores of the variable psychological distress (CHDASSTOT) in Study 2.

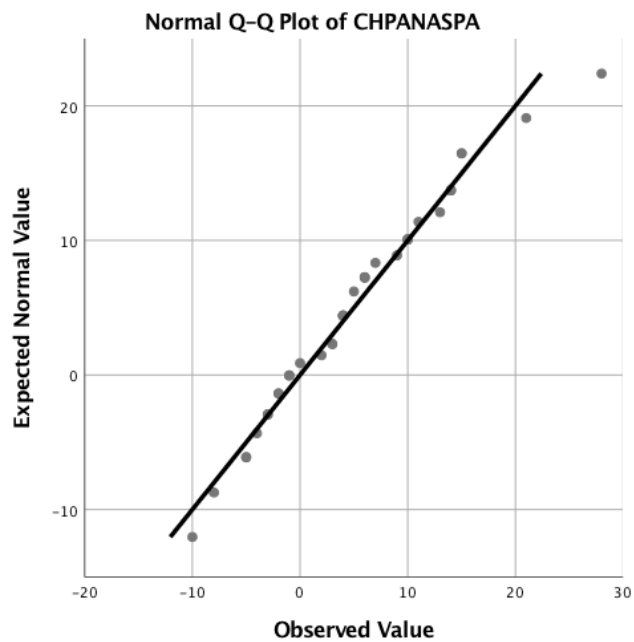


Figure A.33. A normal Q-Q plot of the change scores of the variable positive affect (CHPANASPA) in Study 2.

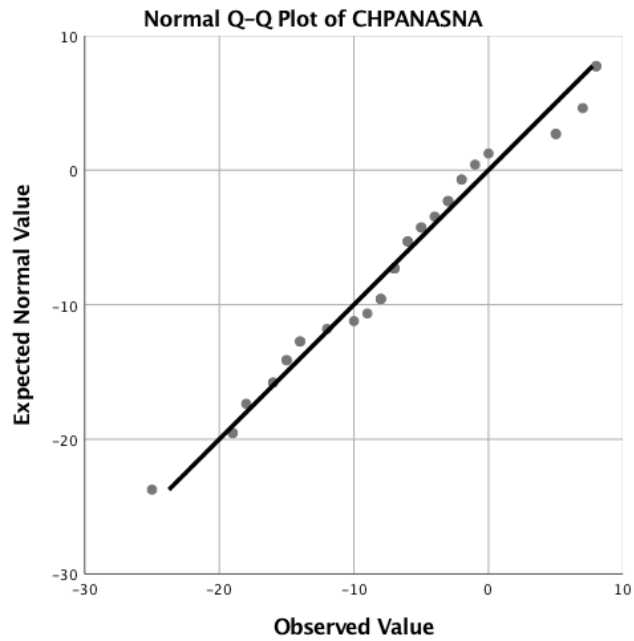


Figure A.34. A normal Q-Q plot of the change scores of the variable negative affect (CHPANASNA) in Study 2.

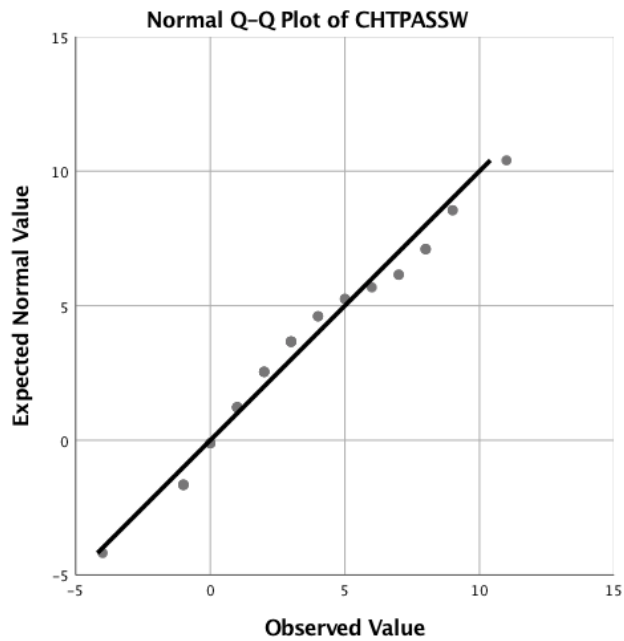


Figure A.35. A normal Q-Q plot of the change scores of the variable safe / content affect (CHTPASSW) in Study 2.

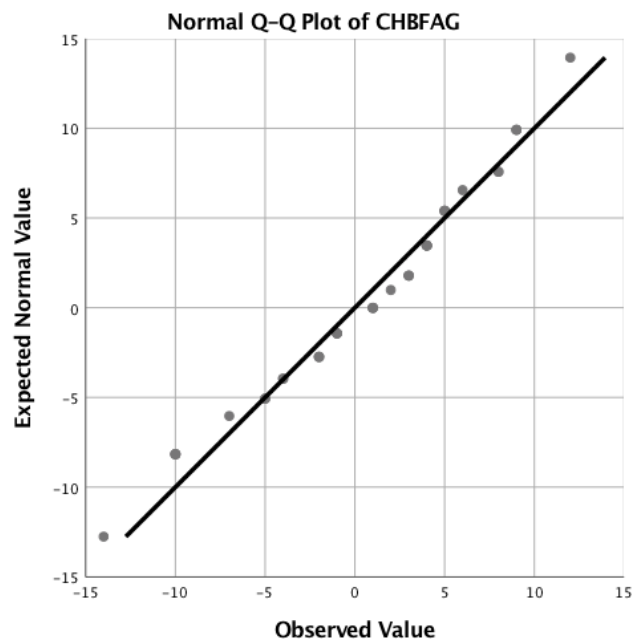


Figure A.36. A normal Q-Q plot of the change scores of the variable agreeableness (CHBFAG) in Study 2.

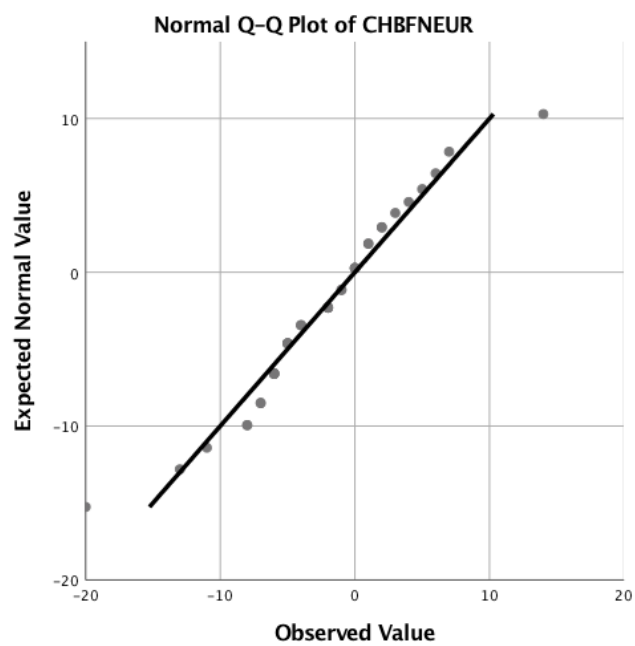


Figure A.37. A normal Q-Q plot of the change scores of the variable neuroticism (CHBFNEUR) in Study 2.

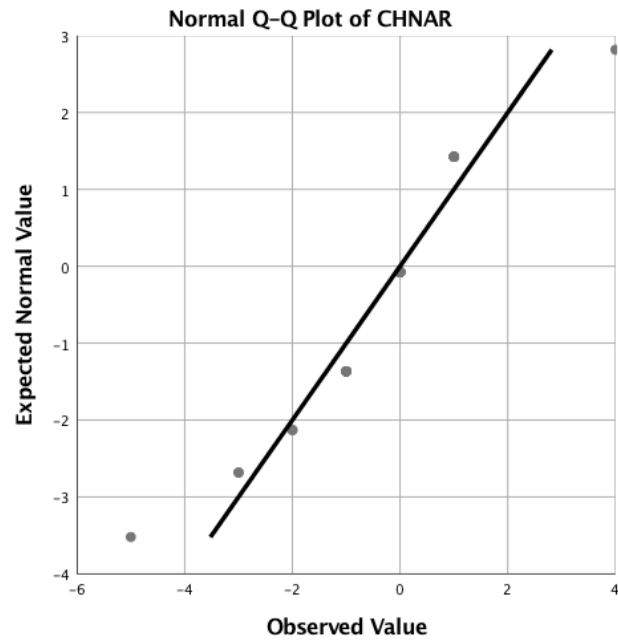


Figure A.38. A normal Q-Q plot of the change scores of the variable narcissism (CHNAR) in Study 2.

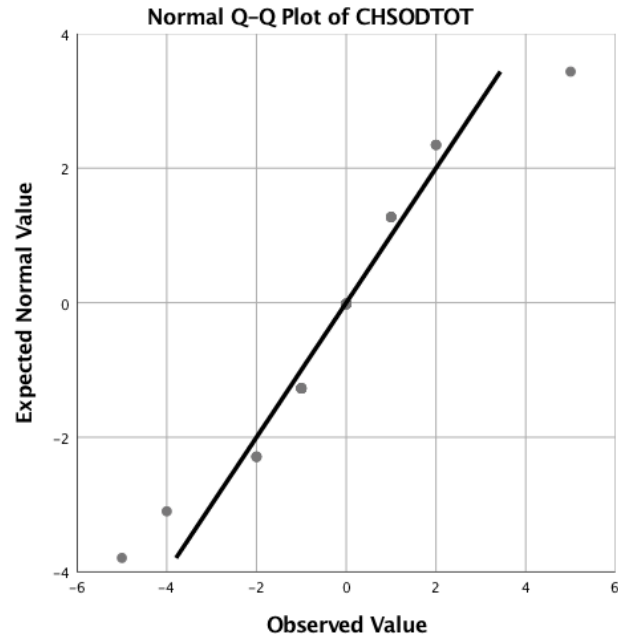


Figure A.39. A normal Q-Q plot of the change scores of the variable social desirability in Study 2.

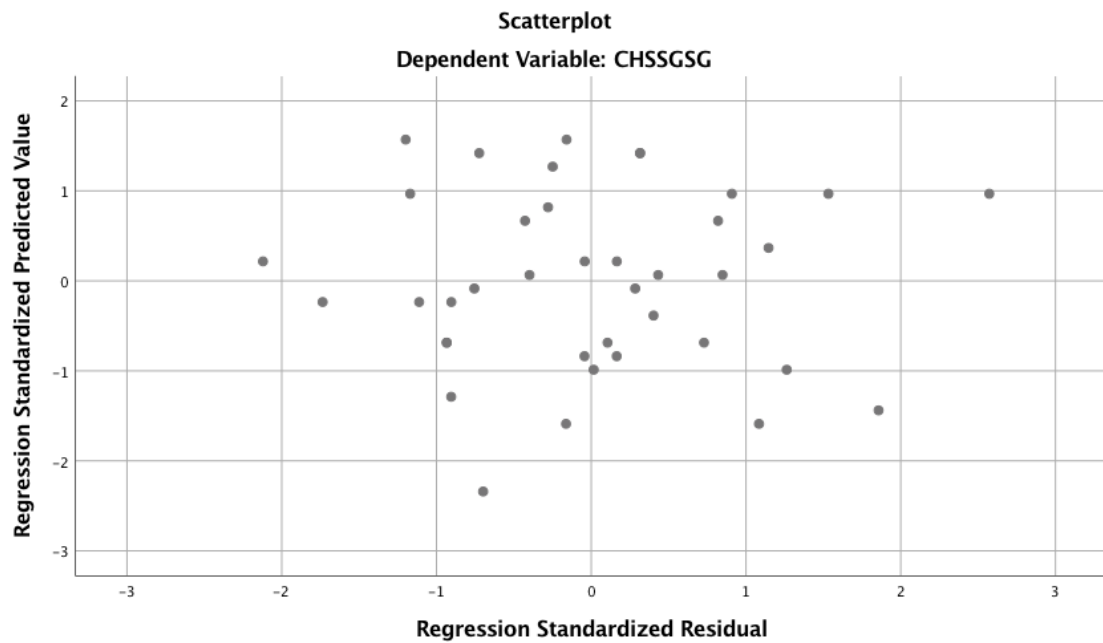


Figure A.40. A scatterplot of standardised residuals with trait self-forgiveness (X) against guilt (Y)

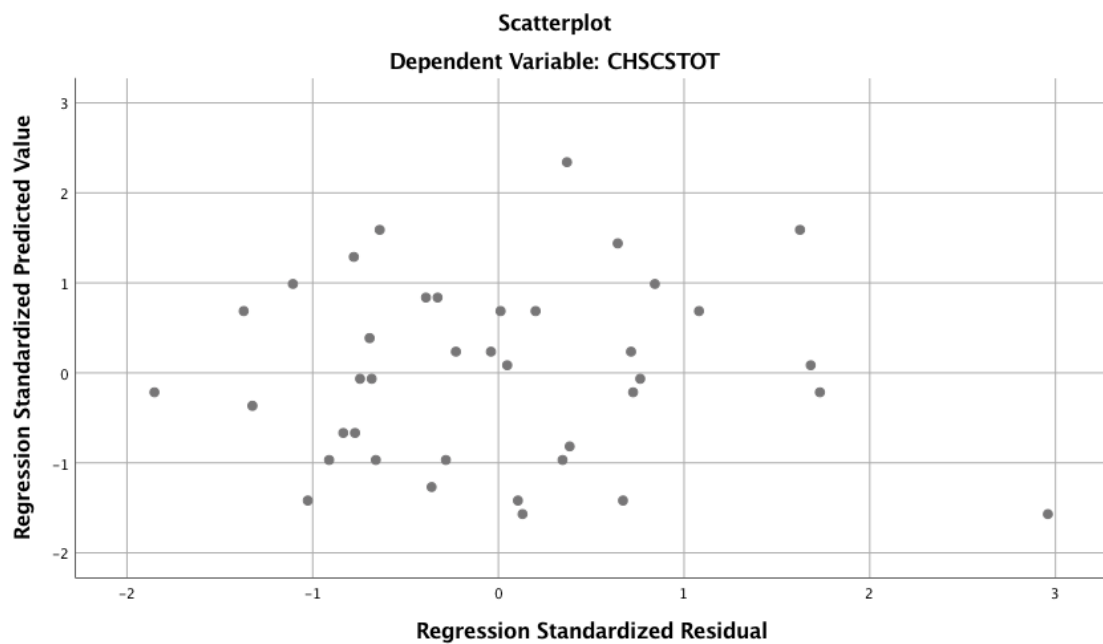


Figure A.41. A scatterplot of standardised residuals with trait self-forgiveness (X) predicting Self-compassion total (M)

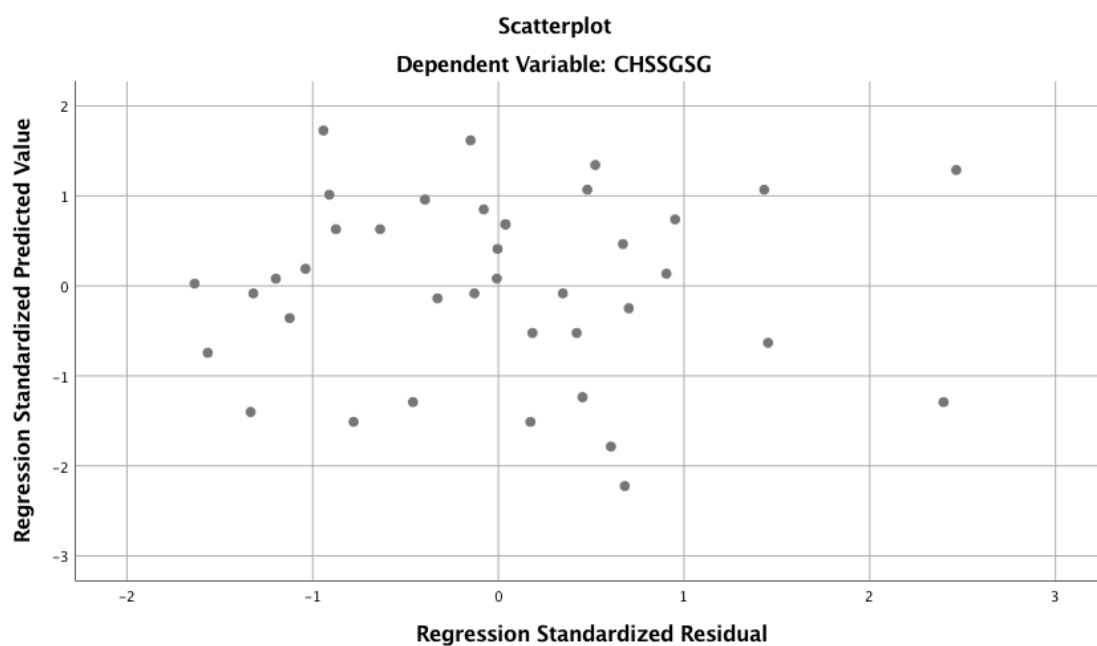


Figure A.42. A scatterplot of standardised residuals with Self-compassion total (M) predicting guilt (Y)

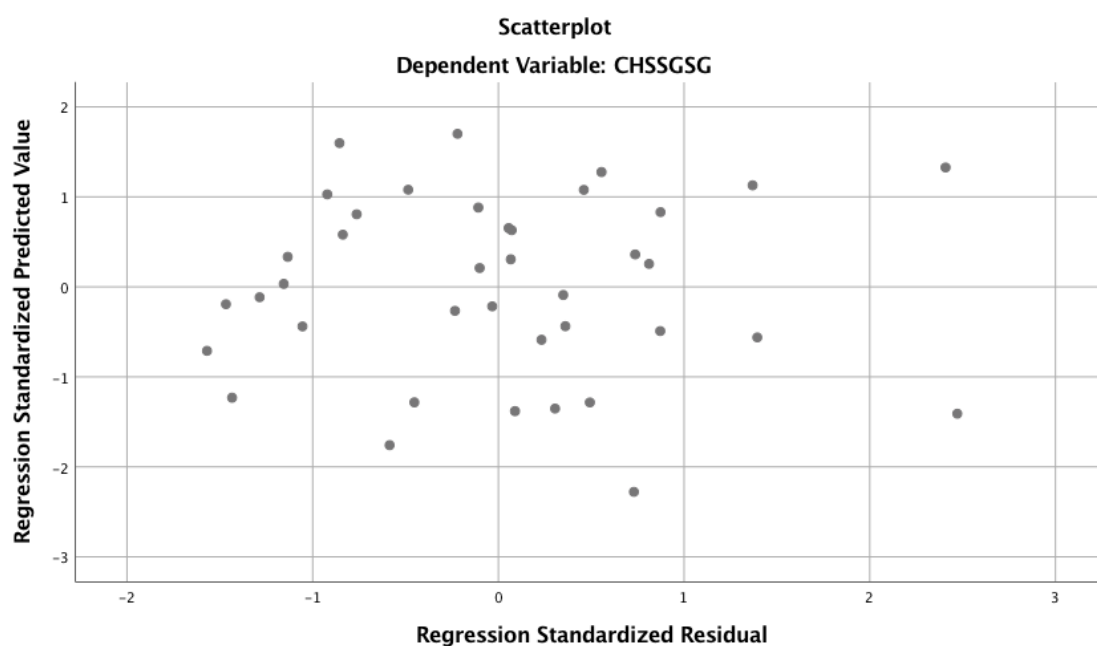


Figure A.43. A scatterplot of standardised residuals with trait self-forgiveness (X) and Self-compassion total (M) predicting guilt (Y).

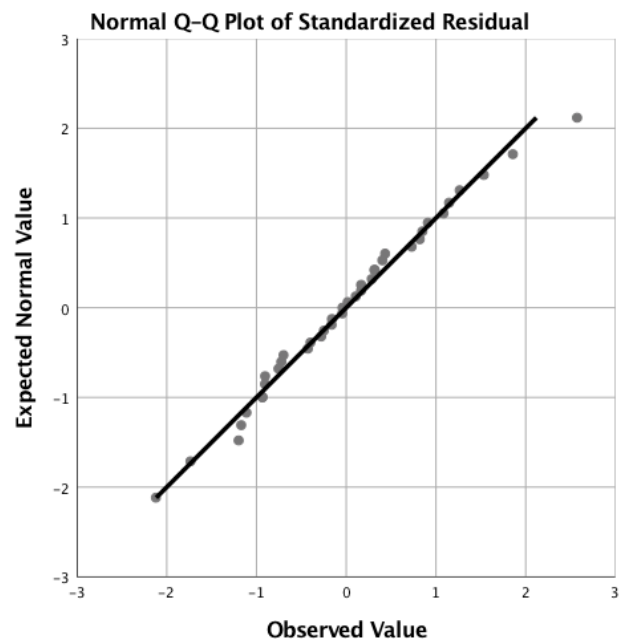


Figure A44. A Q-Q plot from the standardised regression residuals from regressing trait self-forgiveness (X) against guilt (Y)

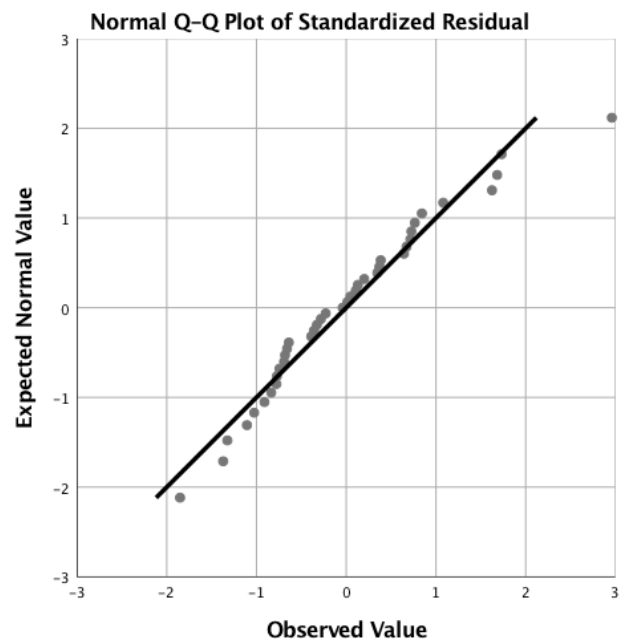


Figure A.45. A Q-Q plot from the standardised regression residuals from regressing trait self-forgiveness (X) predicting Self-compassion total (M)

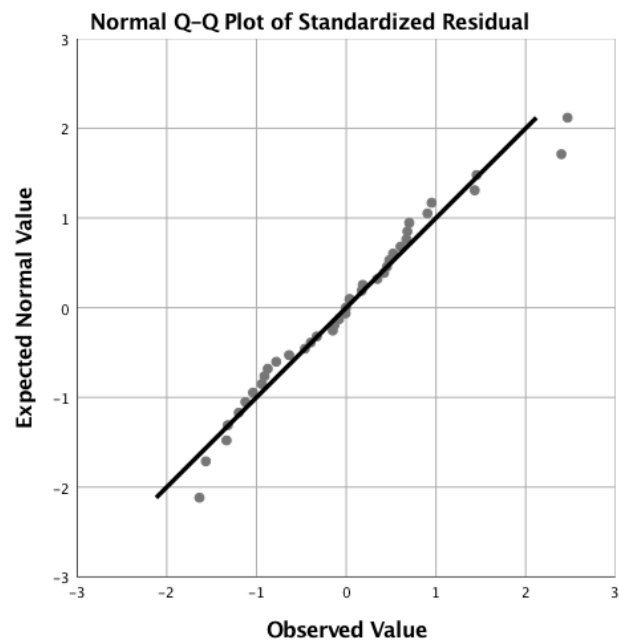


Figure A.46. A Q-Q plot from the standardised regression residuals from regressing trait self-forgiveness (M) predicting guilt (Y)

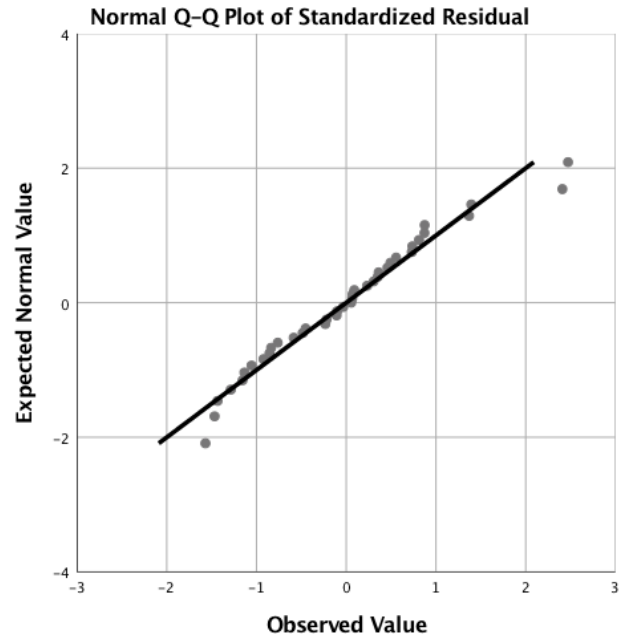


Figure A.47. A Q-Q plot from the standardised regression residuals from regressing trait self-forgiveness (X) predicting shame (Y)

APPENDIX B

Ethics consents / Local permission to undertake research.

HDEC Out of Scope Letter



Health and Disability Ethics Committees
20 Aitken Street
Freyberg Building
PO Box 5013
Wellington

0800 4 ETHICS
hdec@moh.govt.nz

Tuesday, 22 December 2015

Peter Maynard
Consultant Clinical Psychologist
Rodney Adult Mental Health Service
Waitemata DHB
Helensville Community Mental Health Team
65 Commercial Road
Helensville 0800

Dear Peter,

Study title: The Stress and Coping Model of Forgiveness: Self Forgiveness and the Mediating Role of Self Compassion and Affect upon Outcome.
--

Thank you for emailing HDEC a completed application form on 21 December 2015. The Secretariat has assessed the information provided in your form and supporting documents against the Standard Operating Procedures.

Your study will not require submission to HDEC, as on the basis of the information you have submitted, it does not appear to be within the scope of HDEC review. This scope is described in section three of the Standard Operating Procedures for Health and Disability Ethics Committees.

This study involves participants who are attending a Compassionate Focused Therapy group completing a questionnaire to observe the links between self-compassion and self-forgiveness. Participants will provide informed consent to participate in this study and will not be required to participate in any intervention as they are attending the therapy regardless of the study.

An observational study requires HDEC review only if the study involves more than minimal risk (that is, potential participants could reasonably be expected to regard the probability and magnitude of possible harms resulting from their participation in the study to be greater than those encountered in those aspects of their everyday life that relate to the study).

For the avoidance of doubt, an observational study always involves more than minimal risk if it involves one or more of the following:

- one or more participants who will not have given informed consent to participate, or
- one or more participants who are vulnerable (that is, who have restricted capability to make independent decisions about their participation in the study), or
- standard treatment being withheld from one or more participants, or
- the storage, preservation or use of human tissue without consent, or
- the disclosure of health information without authorisation.

Although participants in this study are recruited through the mental health system they are not considered a vulnerable population group as they have mild to moderate mood disorders and are considered a low risk group. All participants in your study will provide fully informed consent, including before their health information is accessed as they will be approached about the study by their treating clinician. All participants will receive

standard care as this observational study does not change any care they receive. Finally, this study does not involve the use of human tissue. Therefore, based on the information you have provided, your study is a minimal risk observational study outside the scope of HDEC review.

If you consider that our advice on your project being out of scope is incorrect please contact us as soon as possible giving reasons for this.

This letter does not constitute ethical approval or endorsement for the activity described in your application, but may be used as evidence that HDEC review is not required for it.

Please note, your locality may have additional ethical review policies, please check with your locality. If your study involves a DHB, you must contact the DHB's research office before you begin. If your study involves a university or polytechnic, you must contact its institutional ethics committee before you begin.

Please don't hesitate to contact us for further information.

Yours sincerely,



Fox Swindells
Advisor
Health and Disability Ethics Committees
hdec@mh.govt.nz

WDHB Approval of Research



RM13249 Investigating the Stress-and-Coping Model of Forgiveness: Social Comparisons, Self-Forgiveness and the Mediating Role of Self-Compassion, Self-Criticism and Affect upon Outcome.

WDHB Contact: Peter Maynard

Department: Rodney Team
Project Type: Clinical research
Duration: 1/05/2015 - 1/05/2019

Title Abbreviation:
External Reference:


Description: Study 1: The first study will utilise a non-experimental correlational design that will examine the predicted relationships between trait self-forgiveness and health outcomes (stress, anxiety, guilt, shame and depression). Clients who have been referred to the three CMHTs within Rodney Adult Mental Health Services (RAMHS) and diagnosed with an anxiety disorder and either Dysthymia or Major Depression, will be approached to participate within the study. A sample of (N = 80) will be required. A predominantly quantitative research approach will be used with participants' completing the following questionnaires in relation to a recalled transgression involving the violation of a personal moral, standard, value or expectation.
 Study 2: The second study will utilise a quasi-experimental repeated measures design (Time 1-6) that will utilise Structural Equation Modelling analyses (MacCallum & Austin, 2000) to test the hypothesised relationships longitudinally. Participants from the first study (Time 1) will be invited to take part in a 12-week group-based CFT programme that will comprise 8-10 people that will run on three occasions yielding somewhere between 24-30 participants in total.

Locality Review

The undersigned agree to the following:

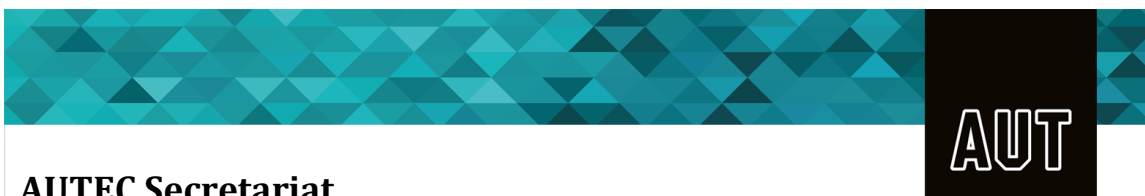
- The study protocol and methodology is ethical and scientifically sound.
- The local lead investigator is suitably qualified, experienced, registered and indemnified.
- Resources, facilities and staff are available to conduct this study, including access to interpreters if requested.
- Cultural consultations have occurred or will be undertaken as appropriate.
- Appropriate confidentiality provisions have been planned for.
- Appropriate arrangements are in place to notify other relevant local health or social care staff about the study, and for making available any extra support that might be required by participants.
- Conducting this study will have no adverse effect on the provision of publicly funded healthcare.
- There is a stated intent that the results of this study will be disseminated and where practical and appropriate the findings of the study will be translated into evidence based care.

Awhina Research & Knowledge can assist in the determination of ethics approval requirements, budgets, contracts, funding applications and statistical consultations. Enquires to research@waitematadhb.govt.nz

Dept/Org	Role	Name (Print Clearly)	Signature	Date
Mental Health	Clinical Governance Group	Contact Murray Patton		20/11/15

Please return completed form to Awhina Research & Knowledge Centre
 Alternatively, emails received from approvers are acceptable as electronic sign-off.

Original AUTECH Ethics consent



AUTECH Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

24 February 2016

Kirsten van Kessel
Faculty of Health and Environmental Sciences

Dear Kirsten

Re Ethics Application: **16/10 Investigating the stress-coping model of forgiveness: Self forgiveness and the mediating role of self-compassion and affect upon outcome.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTECH).

Your ethics application has been approved for three years until 23 February 2019.
The amendment to your questionnaire has been noted.

As part of the ethics approval process, you are required to submit the following to AUTECH:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 23 February 2019;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 23 February 2019 or on completion of the project.

It is a condition of approval that AUTECH is notified of any adverse events or if the research does not commence. AUTECH approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTECH grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

A handwritten signature in black ink, appearing to read 'K O'Connor', is placed above the printed name of the Executive Secretary.

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee
Cc: Peter Maynard, Jackie Feather; Chris Krageloh

AUTEC Consent Amendment 1

The logo for Auckland University of Technology (AUT) is displayed in white text on a black rectangular background.

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

15 September 2016

Kirsten Van Kessel
Faculty of Health and Environmental Sciences

Dear Kirsten

Re: Ethics Application: **16/10 Investigating the stress-coping model of forgiveness: Self forgiveness and the mediating role of self-compassion and affect upon outcome.**

Thank you for your request for approval of an amendment to your ethics application.

The minor amendment for the inclusion of additional questionnaire has been approved by the Chair of AUTEC.

I remind you that as part of the ethics approval process, you are required to submit the following to the Auckland University of Technology Ethics Committee (AUTEC):

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 23 February 2019;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 23 February 2019 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

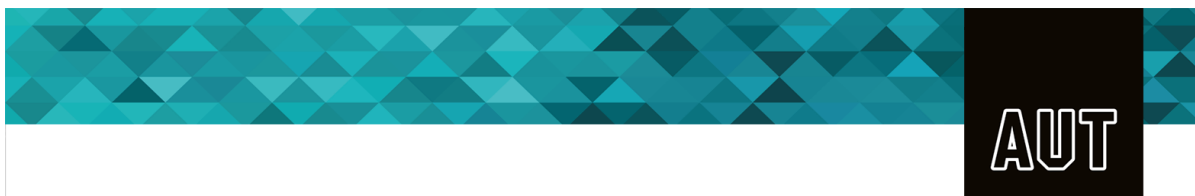
To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

A handwritten signature in black ink, appearing to read 'K O'Connor', is written over a light blue horizontal line.

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee
Cc: Peter Maynard; Jackie Feather; Chris Krageloh

AUTEC Consent Amendment 2



15 March 2017

Kirsten Van Kessel
Faculty of Health and Environmental Sciences

Dear Kirsten

Re Ethics Application: **16/10 Investigating the stress-coping model of forgiveness: Self forgiveness and the mediating role of self-compassion and affect upon outcome.**

Thank you for providing evidence as requested. The amendment to allow the collection of data from AUT undergraduate and post-graduate students is approved

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 23 February 2019;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 23 February 2019 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

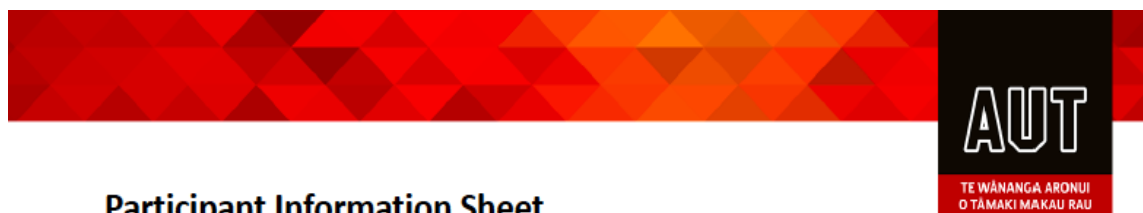
To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee
Cc: Peter Maynard, Jackie Feather, Chris Krageloh

APPENDIX C – Participant information sheets and consent forms

AUT Student participant information



Participant Information Sheet

Date Information Sheet Produced:

DATE 13th March 2017

Project Title

Investigating the Stress-and-Coping Model of Forgiveness: Self-Forgiveness and the Mediating Role of Self-Compassion and Affect upon Psychological Health

An Invitation

Kia Ora, my name is Peter Maynard. I am a Consultant Clinical Psychologist and I have been working for Waitemata District Health Board (WDHB) and Rodney Adult Mental Health Services (RAMHS) for the past ten years with the Helensville Community Mental Health Team. I would like to take this opportunity to invite you to participate in a research study that I am undertaking in part-fulfillment for a PhD in Psychology at Auckland University of Technology (AUT).

It is important that you know that your participation in the research study is entirely voluntary. You may withdraw from the study at any time with no negative consequences. If you do not want to take part you do not have to give a reason, and it won't affect you in anyway, but your help would be greatly appreciated.

If you agree to take part in this study, you will be asked to sign the Consent Forms that will be provided. You will be given copies of both the Participant Information Sheet and the Consent Form to keep.

What is the purpose of this research?

The purpose of this study is to better understand self-forgiveness and how it may be linked with problems like depression. We all make mistakes and self-forgiveness offers a way to heal ourselves. Forgiving yourself requires compassion, but we don't know how being self-compassionate affects our ability to be self-forgiving. It is hoped that the findings of the study will shed some light on this and provide information that will be useful for service users, practitioners and researchers.

How was I identified and why am I being invited to participate in this research?

You have been asked to participate in this research because part of my PhD involves testing a model and this requires a large sample of participants and your lecturer has given me permission to approach your class. If you choose to take part in this research we would ask your permission to use questionnaires and other evaluation data for research purposes.

What will happen in this research?

You will be asked to complete a series of questionnaires that will take you no more than 20 minutes to complete. The questionnaires focus on self-forgiveness, self-compassion, and a range of related emotions. The completed questionnaires will be put in a sealed envelope and de-identified by myself as part of the research.

What are the discomforts and risks?

The risks for completing the questionnaires are minimal as they focus upon everyday feelings and emotions.

How will these discomforts and risks be alleviated?

If for any reason you feel distressed as a result of completing the questionnaires, please contact either myself or AUT Student Services (see details at the end of this information sheet) who will be able to provide further support and guidance.

What are the benefits?

You will be helping me to complete my PhD research that has been designed to increase our knowledge of how self-compassion might affect self-forgiveness and psychological health that will be of benefit to future clients of the clinical services and the wider research community.

You will also be able to enter a prize draw where the following prizes will be offered:

25 x \$20 Countdown supermarket vouchers.

You will see that a coloured entry slip is stapled to your questionnaire booklet. Please complete the slip and include your name, phone number and email address. I will detach the coloured entry slip once you return the completed questionnaire so that your entry slips will not be linked to the actual responses. The entry slips will be stored safely and separately from your questionnaire responses.

Please be aware of the following protocol that outlines how the prize draw will take place.

- Every participant who returns a completed questionnaire and the entry slip will be entitled to enter the prize draw. **Twenty five draws** will be made each with a value of a **\$20 supermarket voucher**.
- The prize draw will take place at the reception of the AR Building, in the presence of administrative staff at the School of Public Health and Psychosocial Studies near the end of Semester 1.
- One of the administrative staff present on that day will be chosen to select the winner. This will ensure that an independent person draws the prizes.
- The School administrator will draw fifty slips from the box containing all returned entry slips.
- Winners will be notified within two days of the prize draw.
- The prize is non-transferable and there is no cash alternative.

How will my privacy be protected?

All AUT confidentiality protocols will be strictly followed and that no identifiable information about you will be presented in the final research report or will be given to third parties. All research information that will be sent to AUT for storing will be de-identified and will be destroyed in line with AUT guidelines.

What are the costs of participating in this research?

There are no costs involved in taking part in the study.

What opportunity do I have to consider this invitation?

You can take as much time as you need to consider whether to participate.

How do I agree to participate in this research?

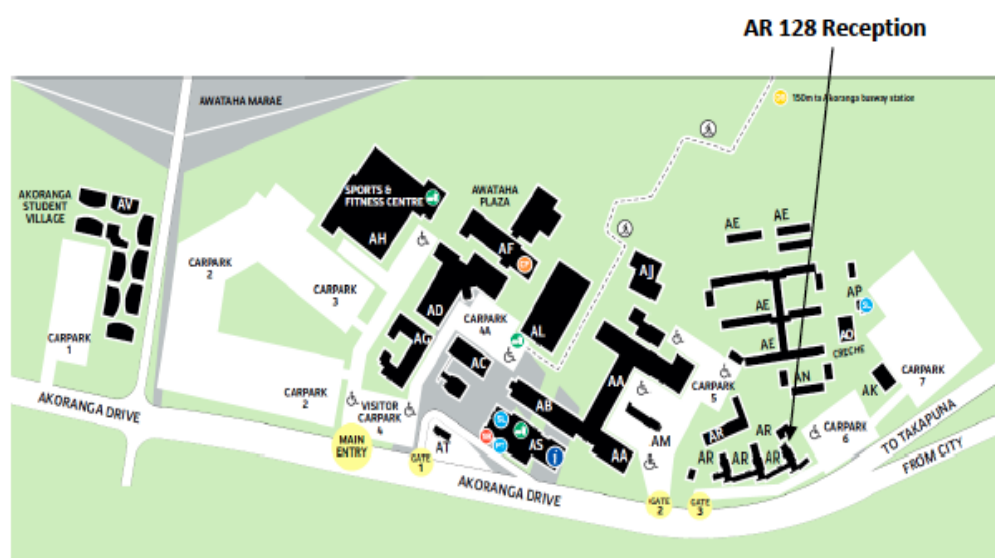
There are two consent forms for you to sign. The **COLOUR COPY** is the one that **YOU KEEP** and the **BLACK AND WHITE COPY** is the one that you **RETURN** with your questionnaires.

How do I return my consent form and my questionnaires?

Once you have completed your consent form questionnaires make sure you seal them in the envelope provided (ensuring you have also completed the yellow prize draw slip). Then make your way to the foyer of the **AR128 reception area** (see map) where you will find a **BLUE LOCKED DROP BOX** just under the stairs that has the study details written on its lid.

Place your questionnaires into the box in the envelope provided with the knowledge that the box will be kept secure and emptied regularly.

The envelopes will only be opened by myself at which point your questionnaires be de-identified by removing the consent sheet and the prize draw slip to ensure your confidentiality.



Will I receive feedback on the results of this research?

Yes. If you wish a written summary of the research findings please contact me by email (peter.maynard@waitematadhb.govt.nz)

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Kirsten van Kessel. kvankess@aut.ac.nz. 09 921 9999 ext. 7691.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, ethics@aut.ac.nz, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team and the cultural support / Maori health support as follows:

Researcher Contact Details:

Peter Maynard – Consultant Clinical Psychologist. 09 420 9450.
peter.maynard@waitematadhb.govt.nz

Project Supervisor Contact Details:

Dr Kirsten van Kessel – Senior Lecturer.
kvankess@aut.ac.nz. 09 921 9999 ext. 7691.

For AUT Māori Student Support Services (or if you have any concerns), please contact Kaimahi/Staff at maori@aut.ac.nz, who have offices at the following locations:

City Campus	North Campus	South Campus
Level 2 WB 203-208 63 Wellesley Street East Auckland 09 921 9903	AS building, Room 211 90 Akoranga Drive Northcote Auckland 09 921 9798	Level 1, MA building 640 Great South Road Manukau Auckland 09 921 9903

Approved by the Auckland University of Technology Ethics Committee on (24/2/2016), AUTEK Reference number (16/10)

Student Consent form



Consent Form

Project title: *Investigating the Stress-and-Coping Model of Forgiveness: Self-Forgiveness and the Mediating Role of Self-Compassion and Affect upon Psychological Health.*

Project Supervisor: *Dr Kirsten van Kessel.*

Researcher: *Peter Maynard*

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated ?
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that all relevant information including questionnaires will be destroyed.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐

Participant's signature:

Participant's name:

Participant's Contact Details:

Email

Address.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on (24/2/2016) AUTEK Reference number (16/10).

Note: *The Participant should retain a copy of this form.*



Participant Information Sheet

Date Information Sheet Produced:

22nd February 2016

Project Title

Investigating Self-Forgiveness and the Effect of Self-Compassion upon Depression.

An Invitation

Kia Ora, my name is Peter Maynard. I am a Consultant Clinical Psychologist and I have been working for Rodney Adult Mental Health Services (RAMHS) for the past eight years, the last five of which have been with the Helensville team. I would like to take this opportunity to invite you to participate in a research study that I am undertaking in part-fulfillment for a Doctorate in Psychology at Auckland University of Technology (AUT).

It is important that you know that your participation in the research study is entirely voluntary. You may withdraw from the study at any time up until the final 12th session of the Compassion Focused Therapy group.

If you do not want to take part you do not have to give a reason, and it won't affect the care you receive. You can still attend and complete the group if you wish, but your help would be greatly appreciated.

If you agree to take part in this study, you will be asked to sign the Consent Forms that will be provided. You will be given copies of both the Participant Information Sheet and the Consent Forms to keep.

What is the purpose of this research?

The purpose of this study is to better understand self-forgiveness and how it may be linked with problems like depression. We all make mistakes and self-forgiveness offers a way to heal ourselves. Forgiving yourself requires compassion, but we don't know how being self-compassionate affects our ability to be self-forgiving. It is hoped that the findings of the study will shed some light on this and provide information that will be useful for service users, practitioners and researchers.

How was I identified and why am I being invited to participate in this research?

The team clinicians who are involved in your care have identified that you have mild to moderate depressive symptoms and that your recovery may be helped through developing skills associated with self-kindness, understanding and self-compassion. You have been referred to a group that is based upon Compassion Focused Therapy that will help you to learn these skills. If you choose to take part in this research we would ask your permission to use questionnaires and other evaluation data used in the

group for research purposes

What will happen in this research?

This research has two separate studies. Normally people will undertake Study 1 first then Study 2 but circumstances (e.g. being referred late to the group) may mean that you may only be asked to participate and give consent for Study 2.

Study 1: You will be asked to complete five questionnaires that will take you no more than 15 minutes to complete. The questionnaires focus on self-forgiveness, self-compassion, and a range of related emotions. The completed questionnaires will be put in a sealed envelope and studied by myself and studied as part of the research. The information from your questionnaires will also be put into your clinical file and reviewed by your clinician, as it will be helpful in planning your treatment.

Study 2: Involves joining a 12-week Compassion Focused Therapy group that will be run in Helensville. Please see the additional material that has been provided about the group.

If do not live in the Helensville area you are very welcome to attend the group, but you will need to have your own transport to do so. If you are on a WINZ benefit it may be possible to get financial support for petrol costs. Please speak to your Keyworker / Primary Care Liaison (PCL) worker who will assist you in making this claim.

The group will help you become more self-compassionate and kind towards yourself and may improve your well being and mood. You will learn how to be more kind, sensitive and less judgmental to yourself. You will also learn skills such as compassionate breathing, thinking, and behaviour to help you manage your critical self-talk.

Each of the 2.5-hour sessions will follow a weekly plan and all materials will be provided. Everyone will be welcomed and the previous weeks' skills work will be discussed. After a break, the session topic will be introduced that will involve developing a further compassionate skill. You will receive a support call during the week from one of the co-facilitators to check your how you are doing.

You will be asked to complete the same questionnaires that you completed in Study 1 at the beginning of the group (Week 1), halfway through the group (Week 6), and then at the end of the group (Week 12).

At the end of the group the facilitators will also ask the group some open-ended questions about how you found the group and if and how it helped. This conversation will be audio-recorded, and professionally transcribed in confidence. Any personal information will be removed to protect your confidentiality. The recording will then be destroyed.

One of the co-facilitators will be able to give you feedback about your questionnaires after you have finished the group.

What are the discomforts and risks?

The risks for completing the questionnaires are minimal due to the selection process and the experience that we have in running groups.

How will these discomforts and risks be alleviated?

Myself and the other Co-Facilitator will support you during the group. You will also receive a weekly support call from one of us to support you and promote your skill development. If for any reason you might need further support, the resources of the team will be made available to help you.

What are the benefits?

Study 1: The benefits are that you may find out new information that will be helpful for your recovery.

Study 2: Participating in the group is free. The benefits are that you will learn new skills that may help you to feel kinder to your self and less depressed. You will be helping me to complete my PhD research that has been designed to increase our knowledge of how self-compassion might affect self-forgiveness and depression that will be of benefit to future clients of the service and the research community.

How will my privacy be protected?

WDHB and the AUT PhD programme are running this study together. This means that all WDHB / AUT confidentiality protocols will be strictly followed and that no identifiable information about you will be presented in the final research report or will be given to third parties. All research information that will be sent to AUT for storing will be de-identified and will be destroyed in line with AUT guidelines.

What are the costs of participating in this research?

Taking part in the study and attending the group is free and all materials will be provided. The group runs for 12 weeks and each session is two and a half hours long. The group will take place in Helensville and there is no payment of compensation for attending.

What opportunity do I have to consider this invitation?

You do not have to decide today whether or not you will participate in this study. Before you decide you may want to talk about the study with other people, such as family, whānau, friends, or healthcare providers. If you require any cultural support please ask and it will be arranged.

How do I agree to participate in this research?

There are two consent forms to sign, one for each of the two studies. Your supporting clinician will provide these forms.

There may be reasons (e.g. transport problems) that prevent you from attending the group. Therefore it is okay if you only participate in Study 1 and decide not to participate in Study 2. All you need to do is indicate this on the consent form by just giving consent to Study 1. Alternatively, after handing the questionnaires back, if your circumstances change or you change your mind and wish to participate in the group

you would need to speak to your clinician and give your signed consent for Study 2 before the group begins.

Will I receive feedback on the results of this research?

Yes. Your keyworker or one of the co-facilitators will contact you within 3 weeks of completing the group to review your progress during the study. The results of the study will be fed back in a written report. If you wish to receive a summary of the study findings please include an email address on the consent form so you can be contacted.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Kirsten van Kessel. kvankess@aut.ac.nz. 09 921 9999 ext. 7691.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTECH, Kate O'Connor, ethics@aut.ac.nz, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team and the cultural support / Maori health support as follows:

Researcher Contact Details:

Peter Maynard – Consultant Clinical Psychologist. 09 420 9450.
peter.maynard@waitematadhb.govt.nz

Project Supervisor Contact Details:

Dr Kirsten van Kessel – Senior Lecturer.
kvankess@aut.ac.nz. 09 921 9999 ext. 7691.

For WDHB Māori health support (or if you have any concerns), please contact :

Hori Ashby – Māori Cultural Advisor WDHB / He Kamaka Waiora
09 420 9450 / 09 486 8324 x 2324
hor.ashby@waitematadhb.govt.nz

Approved by the Auckland University of Technology Ethics Committee on (24/2/2016), AUTECH Reference number (16/10)



Consent Form (Study 1)

Project title: Investigating Self-forgiveness and the Effect of Self-Compassion upon Depression

Project Supervisor: Dr Kirsten van Kessel.

Researcher: Peter Maynard

- ☐ I have read and understood the information provided about this research project in the Information Sheets dated 22/2/2016
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that all relevant information including questionnaires will be destroyed.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐

Participant's signature:

Participant's name:

Participant's Contact Details:

Email

Address.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on (24/2/2016) AUTEK Reference number (16/10).

Note: The Participant should retain a copy of this form.

Consent Form (Study 2)

Project title: Investigating Self-forgiveness and the Effect of Self-Compassion upon Depression

Project Supervisor: Dr Kirsten van Kessel.

Researcher: Peter Maynard

- ☐ I have read and understood the information provided about this research project in the Information Sheets dated 22/2/2016.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that identity of my fellow group participants and our discussions in the focus group is confidential to the group and I agree to keep this information confidential.
- ☐ I understand that notes will be taken during the focus group and that it will also be audio-taped and transcribed.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that while it may not be possible to destroy all records of the focus group discussion of which I was part, the relevant information about myself including tapes and transcripts, or parts thereof, will not be used.
- ☐ I agree to take part in this research.

Participant's signature:

Participant's name:

Date:

Approved by the Auckland University of Technology Ethics Committee on (24/2/2016) AUTEK Reference number (16/10).

Note: The Participant should retain a copy of this form.

APPENDIX D – Questionnaire instruments

1. Age _____

2. Gender (please tick) ☐ Male ☐ Female

3. Relationship status ☐ Single ☐ Married ☐ De-facto
☐ Divorced / separated ☐ Widowed

4. Ethnicity (please tick you ethnic affiliation)

Do you have ancestors who are **Maori**? ☐ Yes ☐ No

Do you identify as **Maori**? ☐ Yes ☐ No

☐ Pacific Peoples ☐ NZ / European ☐ Asian
☐ Middle Eastern / Latin American / African ☐ Other _____

5. Occupation (Present or last job) _____

6. Income (yearly) ☐ below \$20,000 ☐ \$20-30,000 ☐ \$30-40,000

Paid/benefit ☐ \$50-60,000 ☐ \$60-70,000 ☐ \$70-80,000
☐ \$80-90,000 ☐ \$90-100,000 ☐ \$100,000 +

7. Background Have you ever been diagnosed with the following? (please tick)

☐ Depression / Anxiety ☐ Schizophrenia ☐ Drug and alcohol issues
☐ Learning difficulties ☐ Developmental issues (e.g., Autism, Asperger's).

8. Religiosity/Spirituality Please tick/circle your religious affiliation and the following questionnaire

☐ Christian, ☐ Muslim ☐ Jewish ☐ Buddhist ☐ Hindu ☐ Sikh
☐ Atheist/Agnostic ☐ Other ☐ None

Please circle your response	Definitely Not true	Tends not to be true	Unsure	Tends to Be true	Definitely true of me
1. In my life, I experience the presence of the spiritual / divine	1	2	3	4	5
2. My spiritual / religious beliefs are what lie behind my whole approach to life	1	2	3	4	5
3. I try hard to carry my spirituality / religion over to all other dealings in life	1	2	3	4	5

Please make sure that you have answered every question before you turn the page ➡

FORGIVENESS SCALE

Directions: In the course of our lives negative things may occur because of our own actions, the actions of others, or circumstances beyond our control. For some time after these events, we may have negative thoughts or feelings about ourselves, others, or the situation.

Think about how you **typically** respond to such negative events. Next to each of the following items write the number (from the 7-point scale below) that best describes how you **typically** respond to the type of negative situation described. There are no right or wrong answers. Please be as open as possible in your answers.

1	2	3	4	5	6	7
Almost Always False of Me		More Often False of Me		More Often True of Me		Almost Always True of Me
___						1. Although I feel bad at first when I mess up, over time I can give myself some slack.
___						2. I hold grudges against myself for negative things I've done.
___						3. Learning from bad things that I've done helps me get over them.
___						4. It is really hard for me to accept myself once I've messed up.
___						5. With time I am understanding of myself for mistakes I've made.
___						6. I don't stop criticising myself for negative things I've felt, thought, said, or done.
___						7. I continue to punish a person who has done something that I think is wrong.
___						8. With time I am understanding of others for the mistakes they've made.
___						9. I continue to be hard on others who have hurt me.
___						10. Although others have hurt me in the past, I have eventually been able to see them as good people.
___						11. If others mistreat me, I continue to think badly of them.
___						12. When someone disappoints me, I can eventually move past it.
___						13. When things go wrong for reasons that can't be controlled, I get stuck in negative thoughts about it.
___						14. With time I can be understanding of bad circumstances in my life.
___						15. If I am disappointed by uncontrollable circumstances in my life, I continue to think negatively about them.
___						16. I eventually make peace with bad situations in my life.
___						17. It's really hard for me to accept negative situations that aren't anybody's fault.
___						18. Eventually I let go of negative thoughts about bad circumstances that are beyond anyone's control.

For office use only	SF	OF	Sit-F	SFT-T
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Please make sure that you have answered every question before you turn the page ➡

SELF-FORGIVENESS SCALE

Please indicate how you **CURRENTLY** feel about the following questions using the scale below.

PLEASE INDICATE YOUR RESPONSE IN RELATION TO HOW YOU FEEL ABOUT THE MOST SIGNIFICANT MISTAKES YOU MAY HAVE MADE DURING YOUR LIFE.

Please indicate your response (1-4) for each item in the space provided.

All items quantified as:

Not at all 1 2 3 4 Completely

- ___ 1. As I consider what I have done wrong..... I feel compassionate toward myself.
- ___ 2. As I consider what I have done wrong..... I feel rejecting of myself.
- ___ 3. As I consider what I have done wrong..... I feel accepting of myself.
- ___ 4. As I consider what I have done wrong..... I feel dislike of myself.
- ___ 5. As I consider what I have done wrong..... I show myself acceptance.
- ___ 6. As I consider what I have done wrong..... I show myself compassion.
- ___ 7. As I consider what I have done wrong..... I punish myself.
- ___ 8. As I consider what I have done wrong..... I put myself down.
- ___ 9. As I consider what I have done wrong..... I believe I am acceptable.
- ___ 10. As I consider what I have done wrong..... I believe I am okay.
- ___ 11. As I consider what I have done wrong..... I believe I am awful.
- ___ 12. As I consider what I have done wrong..... I believe I am terrible.
- ___ 13. As I consider what I have done wrong..... I believe I am decent.
- ___ 14. As I consider what I have done wrong..... I believe I am rotten.
- ___ 15. As I consider what I have done wrong..... I believe I am worthy of love.
- ___ 16. As I consider what I have done wrong..... I believe I am a bad person.
- ___ 17. As I consider what I have done wrong..... I believe I am horrible.

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Please make sure that you have answered every question before you turn the page

SELF-COMPASSION SCALE

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

- | | Almost
Never | 1 | 2 | 3 | 4 | 5 | Almost
always |
|--|-------------------------|----------|----------|----------|----------|----------|--------------------------|
| _____ 1. | | | | | | | |
| I'm disapproving and judgmental about my own flaws and inadequacies. | | | | | | | |
| _____ 2. | | | | | | | |
| When I'm feeling down I tend to obsess and fixate on everything that's wrong. | | | | | | | |
| _____ 3. | | | | | | | |
| When things are going badly for me, I see the difficulties as part of life that everyone goes through. | | | | | | | |
| _____ 4. | | | | | | | |
| When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world. | | | | | | | |
| _____ 5. | | | | | | | |
| I try to be loving towards myself when I'm feeling emotional pain. | | | | | | | |
| _____ 6. | | | | | | | |
| When I fail at something important to me I become consumed by feelings of inadequacy. | | | | | | | |
| _____ 7. | | | | | | | |
| When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am. | | | | | | | |
| _____ 8. | | | | | | | |
| When times are really difficult, I tend to be tough on myself. | | | | | | | |
| _____ 9. | | | | | | | |
| When something upsets me I try to keep my emotions in balance. | | | | | | | |
| _____ 10. | | | | | | | |
| When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people. | | | | | | | |
| _____ 11. | | | | | | | |
| I'm intolerant and impatient towards those aspects of my personality I don't like. | | | | | | | |
| _____ 12. | | | | | | | |
| When I'm going through a very hard time, I give myself the caring and tenderness I need. | | | | | | | |
| _____ 13. | | | | | | | |
| When I'm feeling down, I tend to feel like most other people are probably happier than I am. | | | | | | | |
| _____ 14. | | | | | | | |
| When something painful happens I try to take a balanced view of the situation. | | | | | | | |
| _____ 15. | | | | | | | |
| I try to see my failings as part of the human condition. | | | | | | | |
| _____ 16. | | | | | | | |
| When I see aspects of myself that I don't like, I get down on myself. | | | | | | | |
| _____ 17. | | | | | | | |
| When I fail at something important to me I try to keep things in perspective. | | | | | | | |
| _____ 18. | | | | | | | |
| When I'm really struggling, I tend to feel like other people must be having an easier time of it. | | | | | | | |

Please make sure that you have answered every question before you turn the page ➡

- | | Almost
Never | 1 | 2 | 3 | 4 | 5 | Almost
always |
|-----------|---|----------|----------|----------|----------|----------|--------------------------|
| _____ 19. | I'm kind to myself when I'm experiencing suffering. | | | | | | |
| _____ 20. | When something upsets me I get carried away with my feelings. | | | | | | |
| _____ 21. | I can be a bit cold-hearted towards myself when I'm experiencing suffering. | | | | | | |
| _____ 22. | When I'm feeling down I try to approach my feelings with curiosity and openness. | | | | | | |
| _____ 23. | I'm tolerant of my own flaws and inadequacies. | | | | | | |
| _____ 24. | When something painful happens I tend to blow the incident out of proportion. | | | | | | |
| _____ 25. | When I fail at something that's important to me, I tend to feel alone in my failure. | | | | | | |
| _____ 26. | I try to be understanding and patient towards those aspects of my personality I don't like. | | | | | | |

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Please make sure that you have answered every question before you turn the page

State Shame and Guilt Scale

Please answer the following questions thinking about how you feel as you **think about yourself and the mistakes you have made**.

Be as honest and as accurate as possible. Use the following scale:

Strongly disagree	1	2	3	4	5	Strongly agree
------------------------------	----------	----------	----------	----------	----------	---------------------------

1. ____ I feel good about myself.
2. ____ I want to sink into the floor and disappear.
3. ____ I feel remorse, regret.
4. ____ I feel worthwhile, valuable.
5. ____ I feel small.
6. ____ I feel tension of what I have done.
7. ____ I feel capable, useful.
8. ____ I feel that I am a bad person.
9. ____ I cannot stop thinking about the bad thing that I have done.
10. ____ I feel proud.
11. ____ I feel humiliated, disgraced.
12. ____ I feel like apologising, confessing.
13. ____ I feel pleased about what I have done.
14. ____ I feel worthless, powerless.
15. ____ I feel bad about what I have done.

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Please make sure that you have answered every question before you turn the page ➤

Positive and Negative Affect

This scale consists of a number of words that describe different **feelings and emotions**.

Read each item and then mark the appropriate answer **in the space to the right of each word**. Please indicate to what extent you have **commonly felt like this**. Use the following scale to record your answers in the arrowed boxes.

1	2	3	4	5
Very slightly or not at all	A little	Moderately	Quite a bit	Extremely

1. Interested		11. Irritable	
2. Distressed		12. Alert	
3. Excited		13. Ashamed	
4. Upset		14. Inspired	
5. Strong		15. Nervous	
6. Guilty		16. Determined	
7. Scared		17. Attentive	
8. Hostile		18. Jittery	
9. Enthusiastic		19. Active	
10. Proud		20. Afraid	

Below are a series of words that describe other positive emotions. We are interested in the degree to which you commonly experience these feelings. We would like you to rate how characteristic these feelings are of you by using the following scale:

1	2	3	4	5
Not at all characteristic of me		Fairly characteristic of me		Very characteristic of me



1. Safe	
2. Content	
3. Secure	
4. Warm	

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PA

PA-S

NA

Please make sure that you have answered every question before you turn the page ➤

PERSONALITY SCALE

Here are a number of characteristics that may or may not apply to you.

Please write a number next to each statement to indicate the extent to which you agree or disagree with that statement.

1	2	3	4	5
Strongly	Mildly	Agree	Mildly	Strongly
Disagree	Disagree	Disagree	Agree	Agree
		Equally		

I see myself as someone who...

1. ___ Is depressed, blue.
2. ___ Is relaxed, handles stress well.
3. ___ Can be tense.
4. ___ Worries a lot.
5. ___ Emotionally stable, not easily upset.
6. ___ Can be moody.
7. ___ Remains calm in tense situations.
8. ___ Gets nervous easily.
9. ___ Tends to find fault with others
10. ___ Is helpful and unselfish with others
11. ___ Starts quarrels with others
12. ___ Has a forgiving nature
13. ___ Is generally trusting
14. ___ Considerate/kind to almost everyone
15. ___ Is sometimes rude to others
16. ___ Likes to cooperate with others
17. ___ Can be cold and aloof

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AG

N

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Please make sure that you have answered every question before you turn the page 

Depression Anxiety and Stress Scale 21

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the **PAST WEEK**. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all
- 1 Applied to me to **some degree**, or **some of the time**
- 2 Applied to me to a **considerable degree**, or a **good part of the time**
- 3 Applied to me **very much**, or **most of the time**

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg., sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

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DEP ANX STRS Total

**THANK YOU FOR TAKING THE TIME TO PARTICIPATE IN THIS RESEARCH.
PLEASE PLACE YOUR QUESTIONNAIRES IN THE ENVELOPE PROVIDED**

Focus group questions

General introductory questions

1. Can you tell me what you have learnt as a result of participating in the group?
2. Can you tell me what you have learnt about yourself and your family (Whanau) as a result of participating in the group?

Questions about the impact of the group on symptoms

3. How has learning about self-compassion affected your beliefs about yourself and others?
4. How has learning about self-compassion affected you emotionally (e.g., anxiety, sadness, stress, shame, guilt)?

Questions about the impact of the group on symptoms

5. Can you tell me how learning about self-compassion has affected your ability to forgive yourself and others when you make mistakes?

Questions about skills gained

6. Can you tell me what skills you have learnt in group that will help you to maintain your self-compassion and self-forgiveness in the future?

Ending questions

7. Of all the things we have talked about, what is the most important thing that you have learnt as a result of participating in the group?
8. Would you recommend the group and why?
9. Is there anything you would change about the group?
10. Have I missed anything out ... is there anything else that you want to say?

APPENDIX E – Study 2 Contact letter and patient information



Waitemata
District Health Board
Te Wai Awhina

**RODNEY ADULT MENTAL
HEALTH SERVICES**
65 Commercial Road,
Helensville
Telephone: (09) 420 9450
Facsimile: (09) 420 7050

17/2/2016

Dear

We are writing to offer you a place on the forthcoming Compassion Focused Therapy group that will start at the following day / date / time venue:

Day / Date **Friday 4th March 2016**
Time **10:15am – 1:00pm**

Venue Alison McKenzie Community House
51 Commercial Rd
Helensville 0840



The 12 session group will run on consecutive Fridays from 4th March to 3rd June from 10:15am-1:00 pm.

We include some information / dates / times about the group for you interest.

To avoid any confusion we would suggest that you come along to our Waitemata DHB offices that are located at 65 Commercial Rd next door to Alison Mackenzie House. If you are unable to attend could you please ring the Helensville office 09 420 9450.

We look forward to meeting you then

Kind regards

Peter Maynard
Consultant Clinical Psychologist

Karina Cooke
Clinical Coordinator / CBT Therapist

THE COMPASSION FOCUSED THERAPY GROUP

This information is intended to help you understand how the Compassion Focused Therapy group works and help you to decide whether you wish to participate.

How can the group help me?

Shame and self-criticism are associated with a range of psychological difficulties including depression. For a variety of reasons, many of us find that we develop a negative, self-critical part of our thinking that can complicate our lives. This can often be in response to harsh critical treatment from important people within our lives, or a sense that receiving kindness and care is dependent upon us achieving or caring for others. In this way our self-worth becomes linked to what we do, so we are not acceptable just as we are.

This self-critical part of ourselves can tell us that we are no good, worthless, and that we deserve little in life. Over time this inevitably becomes the overwhelming way that we feel about ourselves. It lowers our self-worth and contributes to anxious and depressive thoughts and feelings. It becomes difficult to soothe ourselves and might lead us to feel that other people are threatening, as our experiences of others may have been quite frightening and abusive.

For many of us, self-attacking is something that is ‘felt’ rather than ‘thought.’ Despite the efforts of others to persuade us that we have strengths and positive qualities, we may feel awkward and find it difficult to accept what they are saying, or we may be able to rationally see what they are saying but we just don’t believe it. This is referred to as the “head heart lag”. It is for this reason that the work that we will undertake will focus on our feelings rather than our thoughts.

Working with self-criticism can focus on the values of compassion, kindness and taking care of the self that we call Compassionate Mind Training that will form the basis for this group.

The Compassion Focus Therapy group will help you become more self-compassionate and kind towards yourself and with practice will hopefully improve your well-being and mood. You will learn how to be kind, sensitive and less judgmental to yourself. You will also learn skills such as compassionate breathing, thinking, and behaviour to help you manage your critical self-talk.

What does attending the Compassion Focused Therapy group involve?

The group last 12 weeks and each session will last 2.5 hours and will take place in Helensville at the same time each week. Each of the sessions will follow a weekly plan. The dates / times of these sessions are as follows:

Session Number	Day	Date	Time
1	Friday	4 th March	10:15 am - 1:00 pm
2	Friday	11 th March	10:15 am - 1:00 pm
3	Friday	18 th March	10:15 am - 1:00 pm
		25 th March	10:15 am - 1:00 pm
4	Friday	1 st April	10:15 am - 1:00 pm
		8 th April	10:15 am - 1:00 pm
5	Friday	15 th April	10:15 am - 1:00 pm
6	Friday	22 nd April	10:15 am - 1:00 pm
7	Friday	29 th April	10:15 am - 1:00 pm
8	Friday	6 th May	10:15 am - 1:00 pm
9	Friday	13 th May	10:15 am - 1:00 pm
10	Friday	20 th May	10:15 am - 1:00 pm
11	Friday	27 th May	10:15 am - 1:00 pm
12	Friday	3 rd June	10:15 am - 1:00 pm

Everyone will be welcomed and the previous weeks' compassionate skills work will be discussed. After a 15 min break, the session topic will be introduced that will involve developing a further compassionate skill in the week ahead. You will receive a support call during the week from one of the co-facilitators to check how you are doing.

Are there any group rules?

As with all groups there are rules that are designed to increase safety for all participants. The rules of the group are as follows:

1. You must attend all of the sessions. Our experience is that missing more than two consecutive sessions will make it difficult for you to keep up with the material being taught, therefore if this does occur you would need to contact you keyworker to reapply for the next course.
2. The group will start on time and end on time and is for the purpose of teaching skills (rather than being an individual therapy session).
3. If you are going to be late or miss a session please call ahead of time.
4. Please do not come to sessions under the influence of alcohol or other non-prescription drugs.

5. Please do not discuss past, or even immediate, suicidal or self-harm behaviour with other clients. The forum for discussion of these issues is with your contact person within the service.
6. Helensville and its surrounds are a relatively small area. Therefore in order to maintain confidentiality any information discussed during sessions, as well as the names of other clients in the group, must remain confidential.
10. All mobile phones and pagers are to be switched off (or put on vibrate) during group time.

Research

Part of WDHB's commitment to developing clinical knowledge is to help with facilitating research projects.

Peter is undertaking a PhD at AUT about self-compassion and self-forgiveness, which is very relevant considering the focus of the group. You may be asked if you wish to participate in his study. It is important that you know that any participation in his study is **completely voluntary** and choosing not to participate in the study **will not mean that you can't do the group**.

It would be expected that participating in the study will enhance your experience of attending the group and we will be able to give you feedback about your progress. You will also be contributing to the development of psychological knowledge as the findings of the research will be published nationally and internationally.

We look forward to working with you in the weeks ahead to help you resolve the difficulties that have brought you to our team.

Further information can be obtained about CFT from the following website
<http://www.compassionatemind.co.uk/>