

Using compassionate language: Faking it with others or directing it toward oneself

by

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DEDICATION

This dissertation is dedicated to all of the people who made it possible over the years: the mentors who honed my skills, the research assistants who fought in the trenches, and the friends and family who used compassionate language during trying times.

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Chapter I: Overview

Abstract

In two lines of work, I explore the effects of using compassionate language. In the first line, I examine how social support that is not backed by sincere emotion is perceived, and whether it can be effective for making people feel better. In a between-subjects online study ($N = 200$) and a lab study with dyads of strangers ($N = 144$), I show that provider sincerity is less important for effective support than support recipients believe. Since recipients' accuracy is limited and biased with regard to sincerity, being supportive without emotional motivation could in cases be just as effective as the 'real' thing. The second line of work asks whether self-distancing promotes self-compassion. In four online experiments ($Ns = 209, 411, 224, 567$) where subjects write about a problem for which they blame themselves, those who wrote from a distanced perspective consistently used more compassionate language to discuss it than those who wrote from an immersed perspective. There was evidence that this kind of compassionate language was associated with feeling more self-compassion. Basic science and clinical implications of both lines of work are discussed.

Research Overview

Broadly, the following lines of work investigate compassionate language use. I am interested in how speaking in a supportive manner can help people feel better about their problems. I investigate two unusual cases of this. First, can empathic statements which are given without matching internal empathic feelings still make people feel better? Are people able to detect this insincere empathy, and if so, what are the consequences? Secondly, I investigate whether getting people to view the self as an other (self-distance) will make them be more supportive in the language they use to talk about their own problems, and whether this language use will make them feel better.

Decades of research have found that being unsupported socially can negatively influence one's well-being. However, we do not always encounter ideal circumstances for this kind of support. Sometimes as support providers we do not possess the mental resources to emotionally engage with someone in need (Stebnicki, 2000), even when we still wish them the best. Sometimes as the person in need, we are unable to find another to help us out, and we must turn to ourselves for our own help, and under such circumstances may at times respond to our need with harshness and criticism instead of kindness and understanding.

The first line of work deals with situations in which one offers social support when one is not empathically invested in the situation. I investigate if recipients can detect this pseudo-empathic support, or if they are biased to see more of it than may actually be present. If people are not skilled at detecting pseudo-empathy, this might imply that it can in some cases be just as beneficial as real empathy. Healthcare professionals are encouraged at times to be emotionally objective, for example, but are still required to try to be supportive of their patients, and teaching these doctors how to act empathic while remaining objective could have major healthcare implications.

The second line of work asks whether we can encourage compassionate language use toward ourselves by having people imagine themselves as an other. In essence, does self-distancing increase self-compassion? Separate research groups have independently investigated both self-distancing and compassion, finding beneficial effects for each. Although self-compassion is supposedly bolstered by emotional distance from one's problems (Neff, 2003), there have not yet been any attempts to see whether self-distancing promotes self-compassion. If the evidence shows that self-distancing does promote self-compassion, and if other work is correct in saying that being compassionate with oneself is beneficial, then mental health professionals and future researchers will have a relatively simple technique they can teach in order to bolster people's resilience toward negative life experiences.

Chapter II: Non-empathic Social Support

Over the course of their lives, people encounter countless stressful situations, spanning the gamut from relatively minor frustrations like traffic on a commute to potentially devastating events like the loss of a loved one. Sometimes we manage these on our own as they arise, but other times we turn to those around us in order to cope. Although individual variation in preferences for type and source of support exist (Chen, Kim, Mojaverian, & Morling, 2012; Warwick, Joseph, Cordle, & Ashworth, 2004), a wide body of research has shown that believing that one has an effective network of such providers has a host of physical and mental health benefits (e.g., Selcuk & Ong, 2013; Stroebe & Stroebe, 1996). Indeed, studies have found that the perception of support may be more important than the reality of it (for review see, Reis, Clark, & Holmes, 2004). Reis (2014) argued that this 'perceived responsiveness' is predicated on demonstrations that the provider *authentically* values the recipient and cares about their well-being. My research attempts to address the importance of this authenticity, and whether support recipients are biased to see ineffective support as also being insincere, even if it is well intentioned.

Empathy and Insincere Empathy

Researchers have proposed numerous definitions of empathy (e.g., Cialdini, Brown, Lewis, Luce, & Neuberg, 1997; Preston & de Waal, 2002; Singer, Seymour, O'Doherty, Kaube, Dolan, & Frith, 2004; Wondra & Ellsworth, 2015). For the present research, however, I use empathy to refer to warm, compassionate feelings for a target in need (Batson, Early, & Salvarani, 1997). Empathy is usually accompanied by outward displays of these emotions

(Stephens & Clark, 1997), and I define pseudo-empathy and non-empathic support as instances when these external displays are not matched by internal affective states. While in some cases these terms may describe malicious attempts to deceive, pseudo-empathy is not pejorative by default: if one were a doctor, for example, one might give non-empathic support out of a professional desire to help a patient. This action is still positive or potentially moral, even if it were not motivated by the warm, compassionate feelings of empathy.

The Importance of Perceptions

Perceiving that a partner is responsive to one's needs is important to relationship well-being (Fekete, Stephens, Mickelson, & Druly, 2007; Lippert & Prager, 2001; Reis, 2014). For instance, perceiving a provider as sincerely empathic leads to more forgiveness (Pansera & La Guardia, 2012), perceiving social support increases rates of smoking cessation (Derrick, Leonard, & Homish, 2013), and can even decrease all-cause mortality (Selcuk & Ong, 2013). These benefits can translate into the future as well, with perceived responsiveness increasing positive ratings of strangers a week later (Kleiman, Kashdan, Monfort, Machell, & Goodman, 2015), and predicting cortisol levels of marital partners 10 years down the line (Slatcher, Selcuk, & Ong, 2015). In fact, research strongly suggests that actual emotional support only matters insofar as it is perceived (Lippert & Prager, 2001; Reis, 2014; Reis et al, 2004; Selcuk & Ong, 2013).

Deception and Detection

Humans have a well documented capacity to mislead (Bond & DePaulo, 2006). Some theorists have even proposed that the development of our large brains was in part the result of an evolutionary arms race between deceptive defectors seeking advantage in cooperative tasks and their partners trying to avoid being cheated (Dunbar, 1998). Work shows that

although cheaters can be detected through their expressions (Verplaetse, Vanneste, & Braeckman, 2007), they are adept at seeming trustworthy through the use of fake smiles (Okubo, Kobayashi, & Ishikawa, 2012). While lying may be an activity in which most people have engaged (DePaulo, Kashy, Kirkendol, Wyer, & Epstein, 1996), recent research suggests that the majority of lies are told by a few individuals and the majority of our interactions are truthful (Serota & Levine, 2015). This results in a 'truth bias,' which while potentially normative given the base rate of deception in the world, can make it difficult to notice lies (Serota & Levin, 2015).

While both lay people and professionals believe they can detect liars (Akehurst, Köhnken, Vrij, & Bull, 1996; Massip & Herrero, 2015), a meta-analysis revealed that on average people can detect falsehoods only around 54% of the time—barely above chance (Bond & DePaulo, 2006). Although those who are more reliably able to separate truth from lies tend to come from law enforcement professions (e.g., the Secret Service; Ekman, O'Sullivan, & Frank, 1999), this is by no means a sufficient condition for accuracy (Akehurst et al., 1996). Even most officers believe that demeanor (e.g., vocal tone, prosody, eye gaze, tics, etc.) is what reveals lies, but research has found this to be less telling (Massip & Herrero, 2015), and true experts' strategy is to actively obtain invalidating information, not to passively observe behavior (Levine, Clare, Blair, McCornack, Morrison, & Park, 2014). According to Bond and DePaulo (2008) however, the most important determinant of deception detection is not the observer, but the credibility of the deceiver, and how believable it is that this person would be telling the truth. For detecting pseudo-empathy, this could imply that people might use heuristics regarding the source and situation to decide whether the other is genuine, rather than the ability to know.

Empathic Accuracy

Our ability to identify the emotional displays of others is called empathic accuracy (Ickes & Tooke, 1988), and though we are far from perfect, humans can correctly label another's emotions even from subtle cues (for review see, Zaki & Ochsner, 2011). Empathic accuracy in a support provider often leads to better outcomes for the other person (Verhofstadt, Buysse, Ickes, Davis, & Devoldre, 2008), yet it can sometimes backfire (Ickes, Simpson, & Oriña, 2005), and support recipients may even sometimes down regulate their own empathic accuracy in the face of potentially threatening information (Ickes & Simpson, 1997; Simpson, Oriña, & Ickes, 2003).

The majority of research into empathic accuracy, however, tested people's ability when the emotional display was honest, and did not test humans' accuracy when being deliberately misled. There is reason to believe the empathic accuracy account is incomplete as a result. For instance, in the realm of positive emotion, the Duchenne smile, or smiles that use both mouth and eye muscles, was long believed to be a cue to detect true enjoyment (Ekman, 1992). More recent work, however, has shown that these 'real' smiles can be faked (Krumhuber & Manstead, 2009), and that individuals who report higher capacity for displaying insincere emotion are able to generate these fake Duchenne smiles more convincingly (Gunnery, Hall, & Ruben, 2013). So, while we may be able to correctly label emotional displays, we may be no better at knowing whether those displays are sincere than we are at knowing whether someone is telling the truth.

Emotional Deception

While much of the research in deception has focused on concealing factual information, many organizational psychology researchers have investigated the effects of

emotional deception, primarily in the context of businesses (e.g., Gaspar & Schweitzer, 2013). Many organizations have expectations about the emotional displays of their employees (e.g., flight attendants should be positive and obliging), but because it is impossible that all workers will feel the desired emotions at all times, they must perform 'emotional labor' to maintain these displays (Hochschild, 1983). Hochschild (1983) noted that there are two paths to maintaining these displays: one can simply mimic the outward displays of these emotions (surface acting), or one can try to generate the emotions themselves (deep acting). For our definition, only surface acting would qualify as insincere empathy: someone engaging in deep acting would have a matching internal state to their displays.

Overview of Predictions

Together, previous work suggests that inauthentic or faked empathy should not be readily detected, and therefore may be an effective means of social support. Research on emotional labor shows that people are capable of generating convincing emotional displays (Hochschild, 1983), while deception researchers have demonstrated that humans are relatively bad at detecting intentional deception (Bond & DePaulo, 2006). Furthermore, improving this detection requires actively seeking invalidating information, for example tricking someone into making contradictory statements (Levine et al., 2014)—something unusual in typical emotional support scenarios. So, recipients of social support are likely to perceive most pseudo-empathy as genuine, and given the importance of perceptions, non-empathic support should still result in the recipient feeling better. Furthermore, since one of the most important factors for getting away with a lie is one's credibility (Bond & DePaulo, 2008), people may be biased to see pseudo-empathy from people or in situations in which they would expect it, even when it is not really present. For example, if we expected that someone would not feel

much empathy for us (e.g., a stranger), we might be biased to interpret signs of awkwardness or discomfort as signs of insincerity, even if that other person truly felt empathic.

I predict that when asked about their experience as support recipients, people will have overconfident senses of their own accuracy and be biased to believe that ineffective support is insincere. When someone makes an effort to be convincing, for example using compassionate language with the right prosody and facial expressions, the recipient should see them as being sincere, and the only memories of inauthentic empathy they would have to draw on would be the poor, awkward attempts at it that they were able to easily detect. Furthermore, people may over-generalize the signals of pseudo-empathy, like awkwardness, to times when the provider was sincere in their emotion but unskillful in their support. This should give people an overinflated sense of their ability to detect pseudo-empathy and of the importance of authentic emotion, since they would have salient memories of times they thought they detected insincerity, and these instances would be disproportionately composed of poorly provided support. So, I hypothesize that a provider's reported sincerity will not predict recipients feeling better, but a measure of their support skill or effort would.

In my first study, I asked subjects to report about a previous experience of social support, manipulating whether they reported about a time they had either provided or received help, and also whether that support had been effective or ineffective to test whether recipients were biased to see more inauthenticity than was present. In my second study, I brought dyads of strangers into the lab to discuss a problem in one of their lives in real time to help interpret the results from Study 1.

Study 1

The first study examined people's beliefs regarding pseudo-empathy and attempted to provide preliminary evidence demonstrating that people are biased to see pseudo-empathy when it may not be present, and that this fake empathy may still be effective for providing social support. In this between-subjects experiment, I manipulated two different variables: subjects described the most recent time they had either provided or received support, which was either effective or ineffective at making the recipient feel better. Additionally, they answered a few questions about this interaction.

There is informational asymmetry between recipients and providers, where recipients should have inaccurate memories of whether the provider was being sincere versus insincere (mistaking pseudo as real, and vice-versa), whereas the provider should have a more accurate recollection of these instances due to their privileged access of their own state at the time. So, I hypothesized that recipients would report more pseudo-empathy in the ineffective than effective conditions, but that subjects reporting on support they provided would not show a difference between these conditions because well-delivered pseudo-empathy should be perceived as sincere and still help the support recipient feel better.

To assess these hypotheses, I asked for retrospective accounts of either provided or received support, and further varied whether they were recalling an instance of support that was effective or ineffective. After describing the incident, subjects would describe either their feelings or perceptions of sincere and insincere empathy.

Method

Participants. We collected 200 responses (56%, 111 female) online via Amazon's Mechanical Turk (MTurk). All subjects were US residents at least 18 years old who had a

worker rating of 95% or greater on MTurk. Some participants did not complete all questions, resulting in different degrees of freedom for some analyses. Participants were compensated \$0.50 for their time.

Procedure. The experiment was advertised as a research study on people's personality and behavior. In a 2(Role: provider, recipient) x 2(Support success: effective, ineffective) between-subjects design, participants were asked about the most recent time they had either provided or received support which had either been effective or ineffective at making the recipient feel better. The phrasing of all questions was modified very slightly to match the participant's condition.

Participants first gave a free response description of the situation and why they felt it turned out the way it did. Next, they described what kind of relationship they had with the other person, and rated on the Inclusion of the Other in the Self scale how close they felt to that person (IOS; Aron, Aron, & Smollan, 1992). Participants were asked a series of guided questions about the interaction in randomized blocks. Two blocks contained only one question, but where there was more than one question in the block, they were shown one at a time in a random order.

Importance and effectiveness. In the first single item block, subjects answered how they thought the recipient felt differently after the interaction (1 *Much Worse* ... 4 *No change* ... 7 *Much Better*). In another block, participants rated how important the topic was for each person (1 *Not at all* ... 7 *Extremely*).¹

Sincerity items. In the next stage, participants were asked questions about their levels of "sympathy, compassion, or tenderness." One question asked "To what extent [did you/do you think the other person] *truly felt* sympathetic, compassionate, or tender toward them

¹ Descriptive statistics for all variables can be found in Appendix C

during this event?" (1 [I/They] did not feel this way at all ... 4 [I/They] felt this way somewhat ... 7 [I/They] felt that way deeply). Two other questions substituted "motivated to seem" or "displayed" for "truly felt" (1 *Not at all* ... 4 *Somewhat* ... 7 *Extremely*)

The final block always came after the other blocks, and we directly measured pseudo-empathy by asking participants to rate the extent to which they thought the other person or they themselves "pretended to care about the problem even though [they weren't/I wasn't] really feeling it," (1 *Completely untrue* ... 4 *Somewhat true* ... 7 *Completely true*).

Results

As a manipulation check, an independent samples *t*-test showed that the manipulation worked. When participants described instances of effective support, the recipient of support felt significantly better ($M = 6.09$; $SD = 0.85$) than when describing ineffective support ($M = 3.80$; $SD = 0.98$), $t(198) = 17.74$, $p < .001$, Cohen's $d = 2.52$.

I conducted a series of planned contrasts to test my hypotheses that recipients are biased in their perceptions of insincere empathy. First, the "truly felt" empathy question and the reverse scored "only pretended to care" item were collapsed into a single measure of sincerity.² When participants were describing provided support, there were no differences on sincerity between ineffective ($M = 5.87$; $SD = 1.14$) or effective support ($M = 5.81$; $SD = 1.13$), $t(96.91) < 1$. However, recipients of support reported that they thought the provider was less sincere during ineffective support ($M = 4.50$; $SD = 1.75$) than during effective cases ($M = 5.94$; $SD = 1.09$), $t(63.32) = 4.72$, $p < .001$, Cohen's $d = 0.99$ (see Figure 1).³

² All significant differences on the collapsed item were significant for the both sub items for all tests run

³ All interactions for these planned contrasts are significant, $p < .001$.

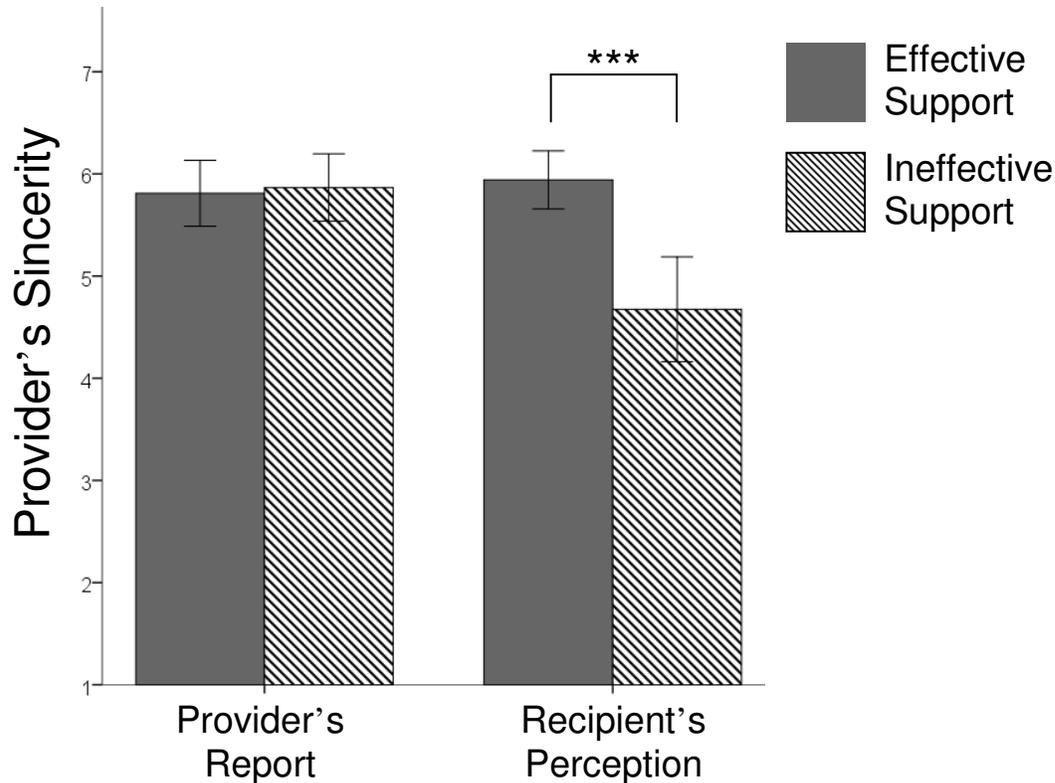


Figure 1. Mean differences in sincerity between conditions. Recipients reported significant less empathy for ineffective than effective aid, but no such difference existed for providers. Error bars represent 95% confidence

Discussion

My hypothesis was that people are biased to see ineffective support as being insincere while missing cases where non-empathic support was helpful. Supporting this theory, recipients said that providers were less sincere when providing ineffective support relative to effective support, while support providers reported no such differences. I argue that this difference is because recipients see awkward but real empathy as fake, and fake but convincing empathy as real. However, this study alone is insufficient to conclude that inauthentic empathy is an effective tool for emotional support. First, these are retrospective accounts and may be vulnerable to memory biases both in the events that they originally recalled, as well as their evaluation of the details. Furthermore, I am unable to rule out the

hypothesis that the recipients are correctly perceiving the inauthentic empathy, but the providers are misperceiving the effectiveness of their support themselves since they too lack privileged access to the recipient's state.

In either interpretation however, the most likely outcome is that only one group is correct, and this leads to competing predictions. If the providers were accurate, then recipients could not detect the provider's empathy, and non-empathic support can still make people feel better. So then, the provider's report of their own empathy should not predict the recipient's report of how much better the recipient felt. What instead likely leads to the recipient feeling better is the quality of support given. If the recipients were the ones who were accurate however, and providers are unable to tell how much better the recipient felt, then non-empathic support should not be effective at making people feel better. This leads to the prediction that the provider's report of empathy *should* predict the recipient's report of feeling better. Finally, it is also possible that the asymmetry arose from providers being biased to report more empathy than they actually felt. If social desirability were the cause of Study 1's results, then no socially desirable variables reported by the provider should predict the recipient feeling better. However, to test these predictions, we would need both reports from both providers and recipients about the same situation, and our data in Study 1 only provide one side of the story.

Study 2

To address the problems with using singled-sided, retrospective accounts in Study 1, the second experiment brought in two participants to have them interact and report their reactions immediately. The first subject was assigned to talk about a problem in her life, while the other was instructed to discuss that problem with the first. Afterwards, they each

filled out measures of sincere and pseudo- empathy. If they were providing support, they self-reported how much they felt these emotions, whereas those receiving support reported their perceptions of these emotions in the other person. Support recipients indicated whether they felt better or worse after talking as the main dependent variable. As a proxy of support quality, providers reported how much effort they put forth to be supportive.

If recipients can detect pseudo-empathy but providers cannot detect the effectiveness of their support, provider empathy and effort should both predict recipients feeling better. If recipients can detect pseudo-empathy but social desirability lead to over-reporting, then neither provider empathy nor effort should predict the recipient feeling better as both are socially desirable responses. Finally, if non-empathic support can be beneficial and recipients cannot detect pseudo-empathy well, then the provider's report of effort but *not* empathy should predict the recipient feeling better.

Method

Participants. Recruitment was limited to students in the Introductory Psychology Pool at a large public university in the Midwestern United States. Because social support styles and preferences can interact with gender in complex ways (Geller & Hobfoll, 1993), only females were recruited for this study. A total of 288 participants were run in pairs, resulting in 144 dyads. One participant reported having no problems in her life at all, so the data from this dyad were removed prior to analysis, leaving 143 pairs. No participants reported knowing one another prior to arriving for the study. Participants were each compensated with a 1/2 hour of research credit.

Procedure. This study brought two undergraduate strangers together to interact. One was randomly assigned to speak about a problem in their life (the recipient), and the other

was assigned to listen and ask questions about this problem (the provider). Participants completed all survey measures in separate rooms. During the interaction, participants were seated across a table from one another. A camera was placed on a bookshelf above and behind each participant.

The experimenter first asked the participants whether they knew one another prior to coming to the study. After this, subjects were given two informed consent sheets, one for the study and one releasing the experiment recordings for use in future studies. Declining the second consent did not exclude them from participation.

The experimenter explained that the purpose of the study was to investigate how people interact, and that parts of the study would be video recorded. Once consented, subjects were placed by coin toss in separate testing rooms to fill out surveys. Before subjects arrived, the experimenter had randomly set up one room to have the surveys for the recipient and the other room for the provider.

Pre-interaction questions. The first set of questions asked both participants to think about and briefly describe a problem in their life. To anchor them, subjects were asked to think of a problem they would rate as a 3 or a 4 on a 1 (*Not at all*) to 6 (*Extremely*) scale for how distressed they felt about it. Next, they rated their current emotional state on the negative items of the Positive and Negative Affect Schedule Short Form (PANAS-SF; Watson, Clark, & Tellegen, 1988) as well as the adjectives "positive" and "neutral." They were also asked whether they had spoken to others about that problem, if they felt the problem was easily solvable, had already reached resolution on the problem, and how comfortable they felt talking to strangers. The PANAS-SF always came before these questions, but question order was randomized within each set.

Subject interaction. After finishing these questions, the survey informed subjects of their study role and asked the participants to go inform the experimenter. Once both participants had finished, the experimenter brought them back to the interaction room and asked the participants to introduce themselves. They explained that the next part of the study would be videotaped, and that the participants would be talking for 10 minutes about the problem the recipient had chosen earlier. The provider was instructed to let the recipient describe the problem for "around two minutes" without interruption, but after that or when the recipient had finished describing it, they could both interact however they wanted. The only restriction was that they were asked not to use theirs or others' real names. The experimenter then turned on the cameras, left the room, and returned 10 minutes later.

Post-interaction questions.

Recipient questions. After the interaction, participants were sent to their separate testing rooms to answer more questions. For my primary DV, 'Feeling Better,' the recipient was asked "After talking about my problem today, I am feeling _____ about it" (*Much Worse; Worse; Somewhat Worse; No Change; Somewhat Better; Better; Much Better*). They then completed the same emotion items from before the interaction. The recipient rated on the IOS how connected they felt to the person to whom they felt closest and the provider from today. Finally, they rated how true or untrue a series of statements were (-3 *Very Untrue ... 0 Unsure ... 3 Very True*). The statements, presented one at a time in this order, were: 1) "I think the other person truly felt sympathetic or compassionate about me or my problem," 2) "I felt supported by the other person," 3) "The other person was displaying more sympathy than they actually felt," and 4) "The other person was only pretending to care about my problem." Items #1, #2, & the reverse coded #4 were reliably related to one another,

Chronbach's $\alpha = .76$, and so were collapsed into a single measure of Perceived Responsiveness.

Provider questions. The provider completed the same IOS questions as the recipient. They also answered how much better or worse they believed the recipient felt on the same scale as above. They also rated the truth of the following statements: "I could identify with the other person's situation," "I have experienced a similar problem in my life before," and "I do not understand why this is a problem for the other person." The items in this block were shown one at a time in random order.

In the next block, items were presented one at a time in the following order. For my measure of Provider Effort, they were asked to rate the truth of "I put in real effort to support the other person with her problem." Provider Empathy was measure by asking how sympathetic or compassionate they were feeling (1 *Not at all* ... 4 *Somewhat* ... 7 *Extremely*). Finally, I had two measures of Pseudo-Empathy where they rated the truth of the statements, "I tried to convey more sympathy than I actually felt," and "I was only pretending to care about their problem." This final question was used as the index of pseudo-empathy in the regression analyses.⁴ Once they completed their surveys, the participants were debriefed and sent home.

Results

Does empathy predict improvement? I hypothesized that the provider's level of either real or faked empathy would be irrelevant to problem improvement, but that the quality of support they gave, measured by their effort to be supportive, should predict the

⁴ Substituting the other item ("I tried to convey more sympathy than I actually felt") does not change the pattern of results. The items did not cohere very strongly $\alpha < .6$ and so they were not collapsed.

person they are helping feeling better. Faked empathy was tested using the "I only pretended to care" item.

The providers reports of sincerely felt and pseudo- empathy, as well as their effort to be supportive, were significantly correlated with one another at $p < .001$. Provider empathy was strongly correlated with effort, $r(139) = .53$, and moderately anti-correlated with pretending to care, $r(139) = -.35$. Effort and pretending to care were similarly anti-correlated, $r(139) = -.34$.

To test my theory, I used hierarchical regression, entering sincere empathy as the first predictor before all others⁵. Consistent with my hypothesis, when entered alone in the first step, the provider's reported empathy did not predict the recipient feeling better, $\beta = 0.11$, $t(137) = 1.25$, $p = .213$. In the second step, the provider's reported pseudo-empathy and effort to provide support were added to the model. Real empathy still did not predict problem improvement, $\beta = -0.06$, $t(135) = -0.61$, $p = .540$, nor did pseudo-empathy, $\beta = 0.01$, $t(135) = 0.15$, $p = .880$. However, the provider's effort to support did predict improvement in this step, $\beta = 0.33$, $t(135) = 3.30$, $p = .001$.

Finally, the recipient's composite Perceived Responsiveness was added to the model, which did predict problem improvement, $\beta = 0.37$, $t(134) = 4.38$, $p < .001$. Adding this to the model partially but not completely reduced the significance of effort, $\beta = 0.21$, $t(134) = 2.12$, $p = .036$. Once again supporting my predictions, neither felt empathy, $\beta = -0.10$, $t(134) = -1.05$, $p = .298$, nor pseudo-empathy predicted problem improvement, $\beta = 0.01$, $t(134) = 0.02$, $p = .986$ (see Table 1).

⁵ If sincere empathy had an effect on the recipient feeling better, but was mediated by another variable, this would not be revealed by entering all variables simultaneously. Although this uses more comparisons, the multiple comparisons are in favor of the alternative hypothesis and it is a more conservative test of my theory.

Table 1

IE Study 2 Hierarchical Regression Predicting Recipient Feeling Better

<u>Regression Entry</u>	<u>Predictor</u>	β	p
Step 1			
Step 2	Felt Empathy	0.11	.213
	Felt Empathy	-0.06	.540
	Pseudo-Empathy	0.01	.880
Step 3	Effort to Support	0.33	.001
	Felt Empathy	-0.10	.298
	Pseudo-Empathy	0.01	.986
	Effort to Support	0.21	.036
	<i>Perceived Responsiveness</i>	0.37	<.001

Note. Predictors in italics indicate they were collected from the recipient.

Perceived Responsiveness is a composite measure of the recipient's perceived felt and faked empathy, and how supported they felt.

Are people empathically accurate? Several questions were mirrored between providers and recipients, allowing me to test for the accuracy of perceptions. To support my interpretation of Study 1's data that people providing support could perceive effectiveness but those receiving support had difficulty detecting sincerity, I need to show two things. First, that providers are able to perceive the effectiveness of their support at least as well as recipients can detect empathy. Secondly, that what recipients perceive when they think someone is being sincerely empathic is actually the effort the provider puts forth. While that effort may be often driven by empathy, it is not exclusively driven by it.

Supporting Study 1's interpretation, the providers' perceptions of the recipients' improvement on their problems significantly correlated with actual improvement, $r(139) = .18, p = .035$. This finding suggests that the alternative interpretation of Study 1 is less likely.

Additionally, recipients' perceptions of empathy were positively correlated with the providers' reports of their empathy, $r(139) = .24, p = .005$. However, the provider's effort to support also predicted perceptions of empathy, $r(139) = .33, p < .001$ and significantly mediated the relationship between providers' reports of empathy and recipients' perceptions of empathy⁶, $B_{direct} = 0.08, 95\% \text{ CI } [-0.08, 0.24]$, $B_{indirect} = 0.15, 95\% \text{ CI } [0.06, 0.26]$ (see Figure 2). Thus, what recipients actually detect is effort, not empathy.

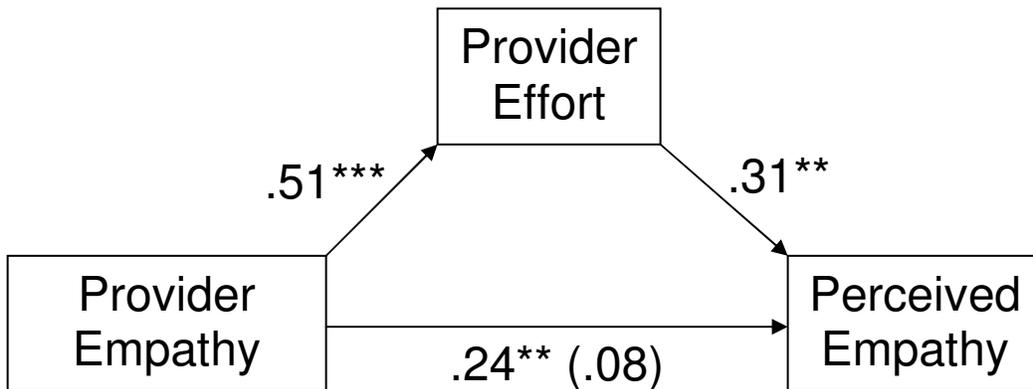


Figure 2. Provider effort mediates the link between empathy felt by the provider and empathy perceived by the recipient.

Do recipients overestimate pseudo-empathy? Although I predicted that recipients might be able to tell to some extent whether the provider was empathic, since they would interpret effort as empathy, I did not believe the same for pseudo-empathy. I speculated that recipients would have poor accuracy because they would sometimes misidentify real (but potentially awkwardly delivered) empathy as fake, while also being unaware of the times in which the provider successfully used non-empathic support. Two questions were mirrored regarding faked empathy. The providers' forms of these questions were: "I tried to convey more sympathy than I actually felt," and "I was only pretending to care about their problem." Recipients were inaccurate with their perceptions on both of these items, $r_{Show>Feel}(139)$

⁶ The reverse is not true: empathy does not mediate the effect of effort.

= .03, $p = .722$, $r_{Pretending}(139) = 0.11$, $p = .193$. Furthermore, recipients felt that the provider was pretending significantly more ($M = -1.53$; $SD = 1.33$) than the provider reported ($M = -2.39$; $SD = 0.97$), paired samples t -test, $t(138) = 6.56$, $p < .001$, and believed that they conveyed more sympathy than they felt ($M_{recipient} = -0.65$; $M_{provider} = -1.06$; $SD_{recipient} = 1.44$; $SD_{provider} = 1.51$).

Discussion

The evidence supported the interpretation that while support recipients believe authenticity is important for feeling better, they are not good at detecting this sincerity. Among the competing predictions, I found evidence for the interpretation of Study 1 that non-empathic support can help people feel better. Providers' reports of empathy did not predict the recipient feeling better, yet their reports of how much effort they put forth to be supportive did predict it. While there was a degree of empathic accuracy on the part of the recipients, where they could somewhat identify empathy in the provider, this actually appeared to be driven by the effort the provider put forward. Recipients on the other hand felt much better when they believed the other person sincerely cared for them. Finally, recipients were not able to tell accurately whether the providers were being pseudo-empathic, frequently reporting that they were faking without matching reports from their counterparts.

Some might claim that the failure of provider empathy to make recipients feel better is because the providers were being dishonest when reporting how they felt, and thus it was not able to correlate with this outcome. While it is true that socially desirable responses can cause such issues, participants should have been equally motivated to report in a socially desirable manner for the effort to support question: though it is desirable to be compassionate for people in pain, it is also desirable to say one did one's best. Since they are both desirable

responses, and effort did end up predicting the recipient feeling better, this explanation for sincere empathy's failure to predict the recipient feeling better is less likely to be true.

It is important to say, however, that the levels of pseudo-empathy in this study were relatively low. Most providers said that they actually felt reasonably empathic for the other person's misfortunes. Though this restricted range does limit my ability to draw conclusions from the null correlation between reports and perceptions of inauthentic empathy, it more strongly supports the hypothesis that recipients are not good at detection. Prior work on deception suggests that while almost everyone lies at some point, most people are honest the vast majority of the time (Serota & Levin, 2015), and my results mimicked this. There was very little faking reported (or occurring if the providers are believed to be honest), yet recipients consistently overestimated the amount of faking. I speculate that this discrepancy may be because they are biased to see poorly executed (yet sincere) empathy as being faked. Given that the subjects were complete strangers before being put in a lab and asked to talk to each other about serious issues, it should come as no surprise that they may have felt awkward performing the task. It is possible that this awkwardness of not knowing what to say or perhaps even looking visibly uncomfortable may have lead the recipients to believe the provider was only pretending to care about their problem. Furthermore, since credibility is the most important aspect of deception detection (Bond & DePaulo, 2008), recipients may have expected that these strangers would not feel empathy for them, and thus were biased to see insincerity when it was not present.

General Discussion

In Study 1, we found asymmetry between support providers' and recipients' reports of authentic and pseudo- empathy depending on whether the support was helpful or not.

Recipients felt that ineffective support was more insincere than in effective cases, while providers showed no such distinction. In the second study, recipients' perceptions of empathy predicted them feeling better, whereas the provider's reports of empathy did not. Instead, what seemed to matter was the effort the provider put forth to be supportive. Furthermore, recipients overestimated the amount of insincerity that occurred. Together, these results provide evidence to support the idea that sincerity, while potentially helpful in that it may motivate effort, is not a necessary or sufficient condition for effective support, and that recipients may see insincerity where it does not exist.

In the model proposed and tested, providers are motivated in some way to put forth a supportive display, which is then perceived by the recipient and leads to the supported person feeling better. Recipients, I claimed, were assuming a much stronger link between sincere empathy and these provider displays, even to the point of assuming that ineffective support was insincere. They ignore the fact that there could be other things motivating a support display, or that a poor display could in fact be sincere.

Just as there is a truth bias for detecting falsehoods due to the base rate of deception in the world, there is probably an "empathy bias" for interpreting effort on the part of a support provider. Most of the time, people probably feel empathy for the person in need, and most of the time the provider feels empathy, they are motivated to make an effort and give a good display. However, the current studies suggest that we may overestimate the linkages between these emotions and behaviors. It is possible to feel sincere empathy for someone, yet still botch our display of support. If we overestimate the connection between display and sincerity, we will think that these poor displays are also insincere.

Simultaneously, there are many factors which could motivate someone to do a good job supporting a person in need, and this "doing a good job" is what seems to matter, at least from the present data. One could be motivated to support by social pressures, by ulterior concerns, or by obligation. Not all motives need be anti-social either: therapists, for instance, could be motivated to be supportive while remaining emotionally detached by their professionalism. How much these motivations, if they became known, would change the recipient's feelings is uncertain, but it is clear there are more ways to motivate supportive displays and compassionate language use than just genuine empathy.

The current study cannot address the extent to which subjects feel better because of observable emotional support behaviors actually changing affect and attitudes, or whether it is about using these behaviors as signals that others value them, and this feeling of being worthwhile in general is what makes them feel better. While this would be an interesting and fruitful topic for research in its own right, for the question of whether pseudo-empathy can make one feel better, it is not necessary. Skillfully executed non-empathic support would accomplish both or either: it would contain the instrumental behaviors and it would convince the recipient that one was sincere.

A counter-argument for our interpretation of the Study 1 results is that just as the recipients do not have privileged access to the provider's empathic state, neither do the providers have access to the recipient feeling better. It could be that some recipients are also motivated to pretend that talking to their friend made them feel better. In essence, providers could not identify correctly when the other person felt better or not, and so there was no difference in their reports of efficacy between authentic and inauthentic support. This is a fair criticism. However in Study 2, providers and recipients each had similar accuracy into each

others' relevant states. This alternative interpretation of Study 1 required that the recipients correctly identified the providers authenticity (explaining their different perceptions of effective and ineffective help), but that providers could not identify the effectiveness of their help (explaining why there was no difference between their sincerity for effective and ineffective help). Since the recipients are not markedly better at perceiving sincerity than recipients are at perceiving effectiveness, this hypothesis is also unlikely.

In sum, the studies show that recipients are biased to see ineffective displays of support as being insincere, and that as a provider, feeling empathy is not a sufficient condition for producing an effective support display. This could have important ramifications for the types of interventions we attempt. In the medical field, for example, patient perceptions of their doctor's caring has ramifications for their health outcomes (Post et al., 2014), and so interventions have been established to increase empathy (Kelm, Womer, Walter, & Feudtner, 2014). My model does not claim that this is a waste of time: increasing empathy should in theory increase motivation to provide a supportive display. However, the findings do suggest this may not be the best use of time or training. If what actually matters is the nature of the display itself, then perhaps more direct interventions into training people how to provide quality support, i.e., say the right things and do the surface acting, might be more effective. Furthermore, empathy is an emotionally taxing state to experience and can lead to burnout, especially in healthcare workers (Stebnicki, 2000). Unpublished work from our lab suggests that people who fake empathy may experience less burnout (Humphrey, senior thesis). In the future, interventions should consider whether more direct manipulations of display skills are more appropriate than attempting to increase empathy.

Chapter III: Self-Distancing & Self-Compassion

The reality of human existence is that we will encounter painful events. Whether the trauma is physical or emotional, as a social species we often turn to those around us in order to alleviate our distress. However, sometimes we are either unwilling or unable to seek others' help, and we must attempt to regulate our own emotions. Over the past decade, two techniques for managing negative feelings received increased attention: self-compassion and self-distancing. Though dissimilar in many regards, at their core, each involves an 'othering' of the self. In self-compassion, having emotional distance from one's problems and treating oneself like a close friend are considered necessary components to the practice. In self-distancing, one can achieve emotional distance by imagining the self as an other. The following studies seek to examine whether the techniques of self-distancing can promote self-compassion.

Self-Compassion

Emerging after the failure of the self-esteem movement, self-compassion was proposed as an alternative method for buffering people against life's stresses (Neff, 2003). Where the self-esteem programs sought to build people up, and thereby often created overinflated views of self-worth, self-compassion's goal is to prevent people from tearing themselves down. While self-favoring biases most likely exist (e.g., Krueger, 1998), common experience also show that at times we can be our own worst critics, being far harsher on ourselves than we would ever be with others. For example, after forgetting to buy milk at the grocery store, one might declare, "I'm such an idiot!" However, it is unthinkable that we

would call a spouse that, for example, if he or she did the same, at least in any healthy relationship. In self-compassion, the idea is to have with ourselves that same healthy relationship we have with others (Neff, 2003).

Self-compassion has three sub-components: self-kindness, mindfulness, and common humanity (Neff, 2003). When one is self-kind, one responds to negative events with the understanding and care we would give to our friends, rather than harshness and judgment. Mindfulness encourages a balanced view of one's negative feelings, avoiding become over-immersed in them or allowing them to dominate ones thoughts. Finally common humanity says to view one's suffering as part of life, as something that all humans go through. Being in pain does not mean one is weaker than others or isolated from them, but rather actually connects one to the rest of humanity through shared experience. While each of these principles is seen as distinct from one another, they are also mutually reinforcing. For instance, mindfulness gives one the "mental distance" required to deal compassionately with oneself without becoming swept up in the negative experience or so dissociated from it that it is ignored (Neff, 2003).

The benefits of Self-Compassion. A mounting body of work is finding that self-compassion is good for mental health. As a trait, self-compassion has been linked to a variety of positive outcomes. It is associated with lower incidence and severity of eating disorders (Braun, Park, & Gorin, 2016; Kelly & Stephen, 2016), with better PTSD symptoms for combat veterans (Hiraoka, Meyer, Kimbrel, DeBeer, Gulliver, & Morissette, 2015), and overall protection from negative affect (Krieger, Hermann, Zimmerman, & Holtforth, 2015; Marshall, Parker, Ciarrochi, Sahdra, Jackson, & Heaven, 2015). Positive mental health (empirically distinct from the absence of psychopathology) can protect against mental illness

(Keyes, Dhingra, & Simoes, 2010), and recent evidence suggests that self-compassion may be the resilience mechanism behind this buffering effect (Trompetter, de Kleine, & Bohlmeijer, 2016).

While the correlational results are promising, experimental work is still in its early stages. A pilot intervention in adolescents was successful at increasing self-compassion and decreasing depressive symptoms (Bluth, Gaylord, Campo, Mullarkey, & Hobbs, 2016), but the aims of the pilot were limited, and it did not contrast its effectiveness with other more established interventions. When researchers attempted to include self-compassion in expressive writing therapy, the augmented version performed no better than the traditional one (Baum & Rude, 2013). However, a self-compassion augmented meditation intervention was more effective than either meditation alone or a control group at getting dieting soldiers to adhere to their self-planned diets and lose weight (Mantzios & Wilson, 2015). Furthermore, people suffering from major depressive disorder were able to use purposeful cognitive reappraisal to manage their mood more effectively if they engaged in self-compassion exercises beforehand than if they were instructed to either accept their emotions or just wait (Diedrich, Hofmann, Cuijpers, & Berking, 2016). The interventions to increase self-compassion, and thereby hopefully increase people's resilience, are still in their relative infancy, and more research is required before firm conclusions can be drawn about their efficacy.

Self-Distancing

While the mindfulness piece of self-compassion claims that a certain "mental distance" from one's suffering is a key component for it to be effective (Neff, 2003), this claim has not received much direct examination. However, an independent line of work has

investigated what effects self-distancing (being less immersed in one's own problems) alone has for well-being, as well as ways to generate this self-distance. When self-distancing, the goal is first to take oneself out of one's typical self-centered point of view (Kross, Ayduk, & Mischel, 2005). This is often accomplished by having people either use visuo-spatial imagery to see themselves from a "fly-on-the-wall" perspective (Kross et al., 2005; Mischkowski, Kross, & Bushman, 2012) or by having them write or think using non-first-person pronouns (e.g., you instead of I; Kross, et al., 2014). By removing oneself in this manner, one is less likely to become locked in ruminative cycles when reflecting on negative life experiences, and with this objective perspective one will have an easier time making meaning out of those aversive events (Kross & Ayduk, 2008).

The benefits of self-distancing. These self-distancing manipulations have positively influenced a variety of negative outcomes. People suffering from depression experienced less negative affect and fewer thoughts typical of the disorder when reflecting on an experience from a distanced perspective (Kross, Gard, Deldin, Clifton, & Ayduk, 2012). Self-distancing can help break ruminative cycles both at the time of writing and buffer against negative affect a week later (Kross & Ayduk, 2008). It can reduce anger when recalling past events (Kross et al., 2005), as well as in the moment (Mischkowski et al., 2012). In children, adopting a distanced perspective can help them adaptively analyze their negative experiences (Kross, Duckworth, Ayduk, Tsukayama, & Mischel, 2011), and after age five, adopting a self-distanced perspective can enhance executive function (White & Carlson, 2016). It can reduce physiological reactivity when recalling traumatic events (Wisco, Marx, Sloan, Gorman, Kulish, & Pineles, 2015) or when ruminating (Ayduk & Kross, 2008). However, some work suggests that while self-distancing is effective at regulating basic emotions such

as anger or distress, feelings that rely on understanding others' perception of the self (e.g., shame) are not attenuated by this technique (Katzir & Eyal, 2013; Cf. Kross et al., 2014).

Merging Self-Distancing and Self-Compassion

When self-compassion encourages people to have mental distance, the goal is to simply acknowledge their emotions and then let them go. While the initial phase of stepping out of the self-centered perspective in self-distancing is similar to traditional meditation practices, afterward they begin to diverge. In traditional practice, when one has achieved self distance, one is able to observe one's thoughts and feelings from a detached perspective, avoid becoming immersed in them, and move on (Begley, 2008). However, in self-distancing, one uses the objective perspective not to accept internal experiences and continue forward, but to analyze and understand those thoughts without becoming distressed by them. Meaning making, rather than acknowledgement, is one goal of self-distancing (Kross et al., 2005).

Given self-compassion's roots in mindfulness (Neff, 2003) and the overlapping goals of self-distancing and mindfulness training, it is reasonable that self-distancing might help people be more self-compassionate. We argue that self-distancing and self-compassion may be two distinct, but potentially related, techniques for managing distress. When one engages in self-distancing, it should give the "mental distance" necessary to deal with one's thoughts in a mindful way, and in theory therefore free one up to be more self-compassionate.

To this end, I believe that the self-distancing manipulation of having people write about distressing events as though they were talking to someone else directly, (e.g., using "you/your" instead of "I/me/mine") may be effective in also engendering self-compassion. In addition to this, compassionate language is typically other-directed. Unless one is using the generic "you", the second person is usually used to refer directly to someone present. It may

be the case that using second-person pronouns to refer to the self will prime linguistic uses, such as compassion, which are most common when speaking directly to someone.

The current studies seek to show that self-distancing instructions, in addition to the benefits studied by previous researchers, may also be an effective way of increasing self-compassion. My primary prediction is that relative to self-immersed instructions, distancing should make people spontaneously use more compassionate language when working through their feelings surrounding a problem. Additionally, I investigated whether using this compassionate language would make people feel better about their problems.

My approach was to have people write about a problem for which they felt at least partly to blame. Subjects worked through their thoughts and feelings about this blameworthy event in writing, and I evoked distancing by instructing them to write about it in different distanced ways from study to study. Researchers then coded the level of compassionate language use in their short response, and analyzed whether those codes predicted any positive outcomes for the subjects.

General Method

Over four studies, I investigate what benefits to self-compassion, if any, are granted by self-distancing, the latter achieved by writing in the second person or by imagining that one's problem happened to a friend and one was writing to them. The first two studies are preliminary investigations of these distancing manipulations independently to provide a first look and to help develop my manipulations, while the third and fourth improves on the instructions from the earlier studies and directly contrasts these types of distancing in a more powerful way. In general, there were two categories of dependent variables which were of interest: whether subjects *wrote* in a self-compassionate way, and whether they *felt* self-

compassionate. While my prediction is that these constructs are related, these should be seen as conceptually distinct as it is possible that using compassionate language does not result in benefits to ones well-being in the form of actually feeling more self-compassionate.

Participants. Subjects were recruited online via Amazon's Mechanical Turk and compensated with \$0.50 for their time. Subjects were prevented from participating in multiple studies in this project through the use of TurkGate software (Goldin & Darrow, 2013). In Study 1, 250 responses were collected; in Study 2, 500⁷ responses were collected, and 302 were collected in Study 3. In each study, subjects who failed to follow our writing instructions, such as writing in the first person when asked to write in the second, writing about a problem a friend had rather than about their own problem, or writing about things that were not problems (e.g., "i write you pay me now"), were removed from analysis. The final Ns for each study were: 209 (54%, 112 female) in Study 1; 411 (62%, 235 female) in Study 2, and 246 (57%, 149 female) in Study 3.

General Procedure. The following procedure was used for Studies 1-4, with deviations reported in each study procedure. After consenting, subjects were asked to report their current affect on a 100-point sliding scale (1 *Very Negative*, 100 *Very Positive*). Next, subjects wrote 1-2 sentences describing the most recent problem for which they still felt "at least partly to blame." They then indicated whether this problem was resolved or still ongoing. After describing their problem, they were asked to work through their feelings in open-ended writing, with instructions for how to do so varying between studies and conditions (see Appendix A). In all studies and conditions, subjects were asked to take as

⁷ 250 responses were collected at first, and after internally contradictory results, a second batch of 250 responses was collected again to clarify.

much time as they need to try to understand why they felt the way they did and to try to find closure.

Once they had completed writing, they were asked a series of questions about their current emotional state. These questions were divided into two blocks, which were presented in random order, and all questions within these blocks were presented one at a time in random order. All questions used a 7-point scale (1 *Strongly disagree*, 2 *Disagree*, 3 *Somewhat disagree*, 4 *Neither agree nor disagree*, 5 *Somewhat agree*, 6 *Agree*, 7 *Strongly agree*).

In one block, two questions assessed forgiveness, "I feel guilty for my part in causing this problem," and "I forgive myself for my part in this problem." An additional question, "I intend to make amends for my part in causing this problem," was included. The "forgive myself" and "make amends" questions had an additional choice for subjects to indicate that the question was not relevant to them, and subjects who chose that option were excluded from analysis of those questions only. Subjects who had previously indicated that their problem was "ongoing" were given an additional item, "I feel like I achieved resolution after writing about my problem today."

The second block of questions was adapted from the Self-Compassion Scale short form (SCS-SF; Raes, Pommier, Neff, & Van Gucht, 2011). The original version tests trait levels of self-compassion, and we altered the language of the items to be relevant to the specific problem about which they had just written (see Appendix B). After answering all variables of interest, subjects filled out a brief demographics form and were provided with a code to receive their compensation.

Coding essays. For each study, two trained, independent, hypothesis and condition blind coders rated essays for the extent to which it exhibited a theme of compassion, 0 (*No theme*), 1 (*Clear but minor theme*), 2 (*Moderate theme*), or 3 (*Predominant theme*). Coders counted language as compassionate if it was self-kind (e.g., "Don't be so hard on yourself"), anti-catastrophizing (e.g., "It's going to be okay), or if it indicated good intentions (e.g., "You did what you thought was right"), effort exculpation (e.g. "You did everything you could"), or common humanity (e.g., "You're only human"). Condition blinding was achieved by translating the pronoun usage of essays, balancing it between studies by going either from first to second person or second to first person. The different coding pairs were generally reliable across studies: in order of studies $\alpha_s = .79, .72, .64,$ and $.85$. Below is an example of an essay two coders rated a 3.

[Participant's own name], it's ok my man. You did all that you could to get in and they didn't see how awesome of a kid you are. In reality I'm glad you didn't get into that house, you are too awesome of a kid to be corrupted by the crap that they do. You don't need to be dtched[sic] from the big picture in life, this minuscule thing won't mean anything in a few years from now. Focus on what will making you a successful person, partying and not paying attention on getting an education will not help you be successful, So [Name], pck[sic] your head up champ.

Preliminary Study 1

Our first study in this line of work used established methods of generating self-distancing in order to test whether it could improve people's self-compassion (Kross et al., 2014). Subjects would distance by using "you" instead of "I" while writing. I predicted that distanced subjects would use more compassionate language to describe their problem than immersed subjects, and that in turn this language use would predict positive outcomes for the writer's well-being.

Procedure

Study 1 used the manipulation from Kross et al. (2014) for inducing self-distancing. Subjects in the self-distancing condition were instructed to write about their problem using second-person pronouns and their own name, whereas subjects in the self-immersed condition were told to write using first-person pronouns.

Results

Manipulation checks. Baseline affect was the same across conditions coming into the study, ($M_{1st} = 69.73$; $M_{2nd} = 67.00$; $SD_{1st} = 20.16$; $SD_{2nd} = 19.88$), $t(180.42) = 0.96$, $p = .339$, as were the average words written per condition, ($M_{1st} = 74$; $M_{2nd} = 74$; $SD_{1st} = 61$; $SD_{2nd} = 42$), $t(208.63) = 0.07$, $p = .947$.

Instructions to use second person language resulted in 21 subjects using third-person language instead. While this is a form of distancing, speaking in the third person is more like speaking *about* someone and less like speaking *to* someone. Since other-directed writing was of hypothesized importance and these subjects did not follow instructions, they fit my *a priori* exclusion criteria.⁸ In the second-person condition, those who followed directions ($M = 0.94$; $SD = 0.97$) used marginally more compassionate language than those who wrote in the third person ($M = 0.62$, $SD = 0.69$), $t(42.52) = 1.75$, $p = .088$, Cohen's $d = 0.50$. Due to their failure to follow instructions, and my theory emphasizing the importance of other-directed language use specifically, this code of third-person language use was included as a covariate in the compassionate language main analysis.⁹

Compassionate language use. The ratings of compassionate language use between first- and second-person conditions were compared with an independent-samples t -test. As

⁸ Initially these subjects were excluded entirely. However on the advice of the dissertation committee, they were included in the sample, and third person language was coded and used as a covariate.

⁹ Analyses without the covariate are still significant at the $\alpha = .05$ level.

predicted, results showed that people who wrote in the second-person ($EMM = 0.91$; $SEM = 0.08$) used significantly more compassionate language than those who wrote in the first person ($EMM = 0.55$; $SEM = 0.08$), $F(1,221) = 9.75$, $p = .002$, $\eta^2 = .04$ (see Figure 3).

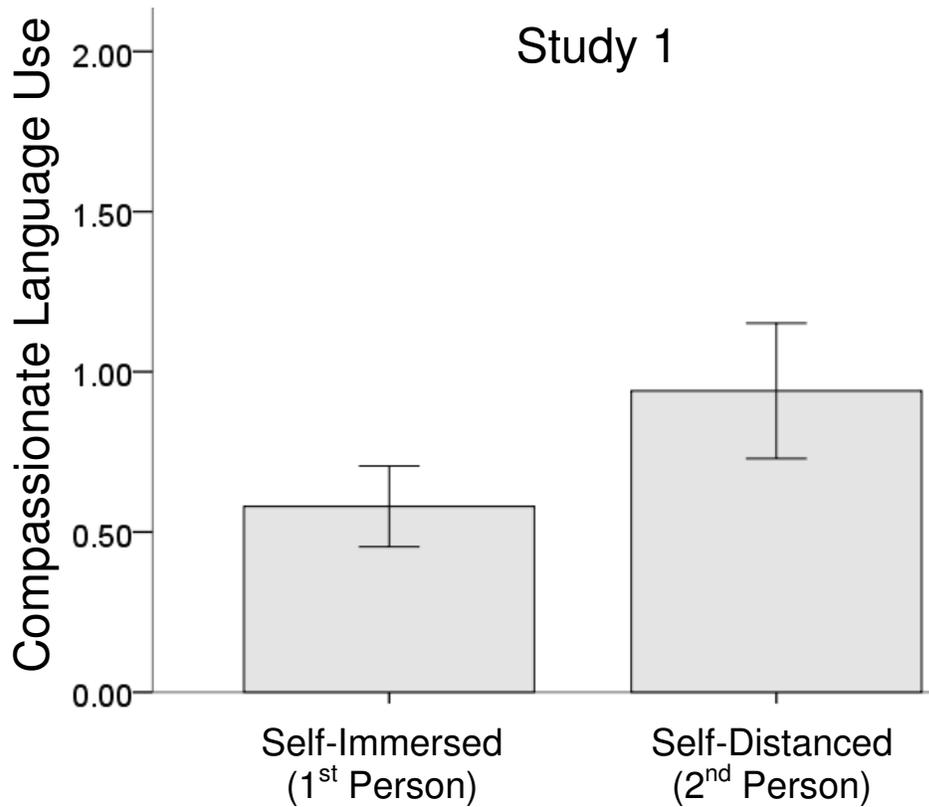


Figure 3. Mean differences in compassionate language use in immersed versus distanced subjects in Study 1. Distanced subjects used significantly more compassionate language than immersed subjects. Error bars represent 95% confidence intervals.

Condition differences for positive outcomes. As the reverse scored guilt and self-forgiveness items had low reliability with one another, $\alpha = 0.53$, we assessed these as separate outcomes, and guilt was scored normally. No significant differences emerged across conditions on the SCS, guilt, or self-forgiveness, $ts < |.33|$, $ps \geq .742$ (see Table 2). However, subjects with ongoing problems¹⁰ who wrote in the second person achieved significantly

¹⁰ Only subjects who indicated they had an ongoing problem were asked about resolution

more resolution on their problem ($M = 4.29$; $SD = 1.24$) than those who wrote using the first person ($M = 3.57$; $SD = 1.57$), $t(91.21) = -2.50$, $p = .014$, Cohen's $d = 0.51$.

Compassionate language use and positive outcomes. I predicted that writing with self-compassion would lead to better outcomes for subjects. Across the whole sample, writing with compassionate language correlated negatively with guilt, $r(224) = -.14$, $p = .036$. It marginally positively correlated with self-forgiveness, $r(219) = .12$, $p = .079$, and with self-compassion, $r(224) = .12$, $p = .087$. It did not, however, correlate with resolution, $r(98) = -.05$, $p = .609$ (see Table 3). Furthermore, compassionate language use did not mediate the condition difference for resolution, $B_{indirect} = -.01$, 95% CI [-0.15, 0.04].

I also tested whether there were indirect effects of condition mediated by compassionate language use for the positive outcomes. The indirect effect of condition on self-compassion was not significant, self-compassion: $B_{indirect} = .03$, 95% CI [0.00, 0.11]. There was, however, a significant indirect effect for guilt, $B_{indirect} = -.08$, 95% CI [-0.24, -.01], and for self-forgiveness, $B_{indirect} = .08$, 95% CI [0.01, 0.22].

Table 2

<i>SDSC Study 1 Positive Outcomes</i>		
<u>Outcome</u>	<u>1st Person</u>	<u>2nd Person</u>
Self-Compassion	4.53 (0.88)	4.54 (0.75)
Guilt	5.10 (1.70)	5.03 (1.58)
Self-Forgiveness	4.94 (1.78)	5.00 (1.55)
Problem	3.57	4.29
Resolution*	(1.57)	(1.24)

Note. Standard deviations in parentheses.

* indicated t -test $\leq .05$

Table 3

Whole-sample Correlations with CLU and Outcomes between Studies

	<u>Study 1</u>	<u>Study 2</u>	<u>Study 3</u>
Self-Compassion	.10	.02	.19**
Guilt	-.14*	.03	-.09
Self-Forgiveness	.12	.07	.10
Problem Resolution	-.05	.21*	.10

Note. * $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

Discussion

By manipulating distanced versus immersed perspectives via pronoun use, I was able to confirm my primary hypothesis. Subjects who wrote using "you" instead of "I" used significantly more compassionate language when exploring their feelings about their problem. However, the consequences of this compassionate language use (CLU) were less straightforward. There were no direct effects of condition, and the indirect effects of compassionate language use were not wholly consistent across the positive outcomes in this preliminary study. Finally, using second person pronouns resulted in the achievement of more resolution than using first person pronouns, but this difference was not mediated by CLU. This resolution effect may reflect the previously discovered effects of distancing on making meaning out of experiences (Kross et al., 2014).

While the evidence was marginal in cases, compassionate language use correlated in beneficial ways with three of the positive outcomes. Furthermore, there were significant indirect effects of condition on two of these constructs mediated by CLU. As a preliminary investigation, my hypotheses were supported, with our distancing instructions prompting people to spontaneously use more compassionate language, and this language use predicting positive outcomes.

Preliminary Study 2

In self-compassion, the goal is to treat oneself with the same kindness with which one would treat a friend. I chose to invoke this directly by having people imagine that their problem happened to a friend, and they were helping that friend work through their feelings about it. The goal was that imagining the problem happening to a friend would be similar to imagining seeing the problem happen to oneself from a third-person perspective, thus generating a distance effect. Additionally, having them imagine a friend could prime the prosocial linguistic uses associated with talking to someone else. I hypothesized that subjects who wrote as though to a friend would use more self-compassionate language and have better positive outcomes than their self-immersed counterparts.

When collecting the original sample for this study (250 subjects), we found internally inconsistent results where distanced subjects used more compassionate language but felt worse after writing than their immersed counterparts. A second sample of 250 was collected with no changes made to the procedure, and the data presented here are from the combined sample of 500. Had the original result been real, the larger sample should have been a more robust test of it.

Procedure

I manipulated distancing by having subjects write as though the problem had happened to a specific friend (whose first name they were asked to write down), and that they were helping a friend work through his or her feelings about that problem. Subjects in the self-immersed condition also tried to work through their feelings about that problem but wrote about it from their own perspective.

Results

Manipulation checks. Baseline affect was the same in both conditions ($M_{1st} = 68.83$; $SD_{1st} = 21.25$; $M_{Friend} = 66.88$; $SD_{Friend} = 22.95$), $t(360.70) = 0.88$, $p = .381$. Subjects wrote an average of 71 words ($SD = 57$), and conditions did not vary significantly on the number of words written, $t(409) = 1.60$, $p = .111$.

Compassionate language used. Conceptually replicating the Study 1 findings, an independent samples t -test showed that subjects who wrote as though talking to a friend used significantly more compassionate language ($M = 0.78$; $SD = 0.87$) than those who wrote in the first person ($M = 0.31$; $SD = 0.56$), $t(279.97) = -6.21$, $p < .001$, Cohen's $d = -0.64$ (see Figure 4).

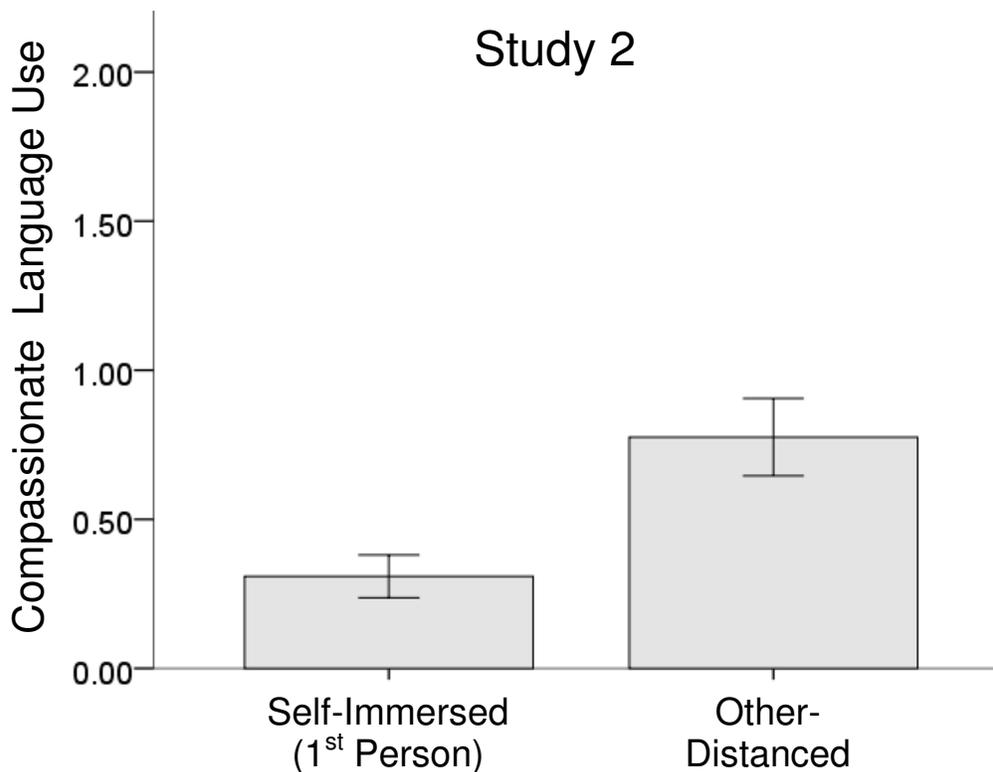


Figure 4. Mean differences in compassionate language use in immersed versus distanced subjects in Study 2. Distanced subjects used significantly more compassionate language than immersed subjects. Error bars represent 95% confidence intervals.

Condition differences on positive outcomes. There were marginally significant differences where immersed subjects felt more self-compassionate than distanced writers ($M_{1st} = 4.62; M_{Friend} = 4.49; SD_{1st} = 0.81; SD_{Friend} = 0.77$), $t(387.70) = 1.69, p = .092$.¹¹ There were no significant differences for guilt, self-forgiveness, or resolution, $ts < |1.07|, ps > .286$ (see Table 4).

Compassionate language use and positive outcomes. Across the whole sample, the use of compassionate language did not correlate with most of the positive outcomes: SCS, guilt, and self-forgiveness, $rs < |.02|, ps > .82$ (see Table 4). However, it did significantly correlate with resolution, $r(151) = .21, p = .011$, and there was a significant indirect effect of condition on this outcome mediated by compassionate language use such that distanced subjects achieved more resolution, $B_{indirect} = 0.09, 95\% \text{ CI } [0.03, 0.19]$.

Discussion

Table 4

I again confirmed my primary hypothesis that self-distancing promotes compassionate language use: subjects who wrote as though talking to a friend used more compassionate language than those who wrote in the first person. However, as in Study 1, the effects of using

<i>SDSC Study 2 Positive Outcomes</i>			
	<u>Outcome</u>	<u>1st Person</u>	<u>2nd Person</u>
compassionate language use: subjects who	Self-Compassion	4.62 (0.81)	4.49 (0.77)
	Guilt	4.95 (1.75)	5.05 (1.62)
wrote as though talking to a friend used	Self-Forgiveness	4.86 (1.36)	4.65 (1.92)
	Problem	3.94	4.00
more compassionate language than those	Resolution	(1.40)	(1.39)

Note. Standard deviations in parentheses.
* indicated t -test $\leq .05$

compassionate language were more mixed. There were no significant condition differences on any positive outcomes, and most of these outcomes did not correlate with compassionate language use. The exception was for subjects with ongoing problems feeling like they had achieved resolution after writing about it. While there were no condition differences, CLU

¹¹ This appears to be driven almost entirely by the first half of the sample, $p = .777$ in second sample.

predicted problem resolution, and there were indirect effects of condition on resolution mediated by CLU. This was reversed from my Study 1 findings with problem resolution. There, I found that distanced subjects achieved more resolution than immersed subjects, but that resolution was not predicted by CLU, and the condition difference was not mediated by CLU.

Study 3

Given the problems in Study 2 for the positive outcomes and various issues with subjects following instructions, the third experiment was designed to improve the quality of our manipulations and directly contrast the two distancing manipulations with each other and with the immersed condition. I hypothesized that by self-distancing, subjects would be able to treat themselves more like an other, and therefore speak to themselves more like they would to someone else. This study directly contrasts the two distancing manipulations to compare their effects on Self-Compassion.

When we receive support from another person, we have to infer whether they truly mean the things they say, and as my work on inauthentic empathy showed, we do not seem to be very accurate at these inferences. So, fake empathy can be effective coming from others when we miss that they are faking. However, when we support ourselves (i.e., using self-compassion), we automatically know whether we truly mean these compassionate statements. It could be that having people self-distance primes them to speak to themselves the way they would speak to others, but does not prime actual empathic emotion. In other words, self-distancing may cause people to engage in fake empathy with themselves. Two questions asking the extent to which subjects believed what they had written were added to assess whether this could explain the relative weakness of the positive outcomes for using

compassionate language in the first two preliminary studies, or whether this was an effect of a relatively weaker manipulation.

Procedure

Study 3 combined and improved upon the manipulations from Studies 1 and 2 in order to directly contrast them. These changes included language to make it clearer what pronouns should be used, and that the friend they were imagining came to them to discuss the problem. In the self-immersed condition, subjects were instructed to write using first-person pronouns. However, there were two different self-distanced instructions. In the self-distanced condition, subjects wrote using their own name and second-person pronouns (as though they were addressing themselves). In the other-distanced condition, they imagined that they were talking to a friend who had the same problem, writing with their friend's name and second-person pronouns (as though they were addressing their friend). As in Study 2, subjects in the friend distanced condition wrote the name of the specific friend they imagined.

Furthermore, a new block of two questions was created, always appearing immediately after subjects finished writing. Both questions were intended to assess whether subjects actually believed what they wrote: "I wrote how I want to feel about my problem, rather than how I currently feel," and "What I wrote is how I really feel about my problem." These items used the same scale as all other questions.

Results

Manipulation checks. Baseline affect was *not* the same across conditions, ($M_{1st} = 68.96$; $M_{2nd} = 66.57$; $M_{Friend} = 74.33$; $SD_{1st} = 20.63$; $SD_{2nd} = 15.71$; $SD_{Friend} = 17.84$), $F(2,243) = 3.47$, $p = .033$, and so it was included as a covariate in the primary hypothesis test of compassionate language use and when it predicted the outcome (SCS, self-forgiveness,

and resolution). Subjects wrote 77 words on average, and this did not vary significantly across conditions, $F(2,299) = 0.97, p = .379$.

As before, a number of subjects (24) who were told to use the second person did not follow instructions used the third person language instead (e.g., "Jason felt he should have been more upfront."). Again, in the second-person condition, those who followed directions ($M = 0.93; SD = 1.02$) used significantly more compassionate language than those who wrote in the third person ($M = 0.52; SEM = 0.60$), $t(69.82) = 2.22, p = .029$. Due to their failure to follow instructions, their significant difference on our key variable, and the proposed the importance of other-directed language use specifically, these codes for third-person language use were included as a covariate in the principle analyses.¹²

Compassionate language use. To test my primary hypothesis, I compared the use of compassionate language across our conditions in a one-way ANOVA including baseline affect and third-person language use as covariates, with those writing to a friend using the most compassionate language ($EMM = 1.22; SEM = 0.11$), followed by those using second-person pronouns ($EMM = 0.80; SEM = 0.12$), and with those writing in the first person using the least compassionate language ($EMM = 0.41; SEM = 0.10$), $F(2, 242) = 19.67, p < .001, \eta^2 = .13$ (see Figure 5). Baseline affect was not a significant covariate, $p = .303$, nor was third person language use, $p = .099$. Planned contrasts showed that all groups differed significantly from each other, $ps \leq .013$.

¹² As in Study 1, removing the covariate does not substantively change the principle analyses.

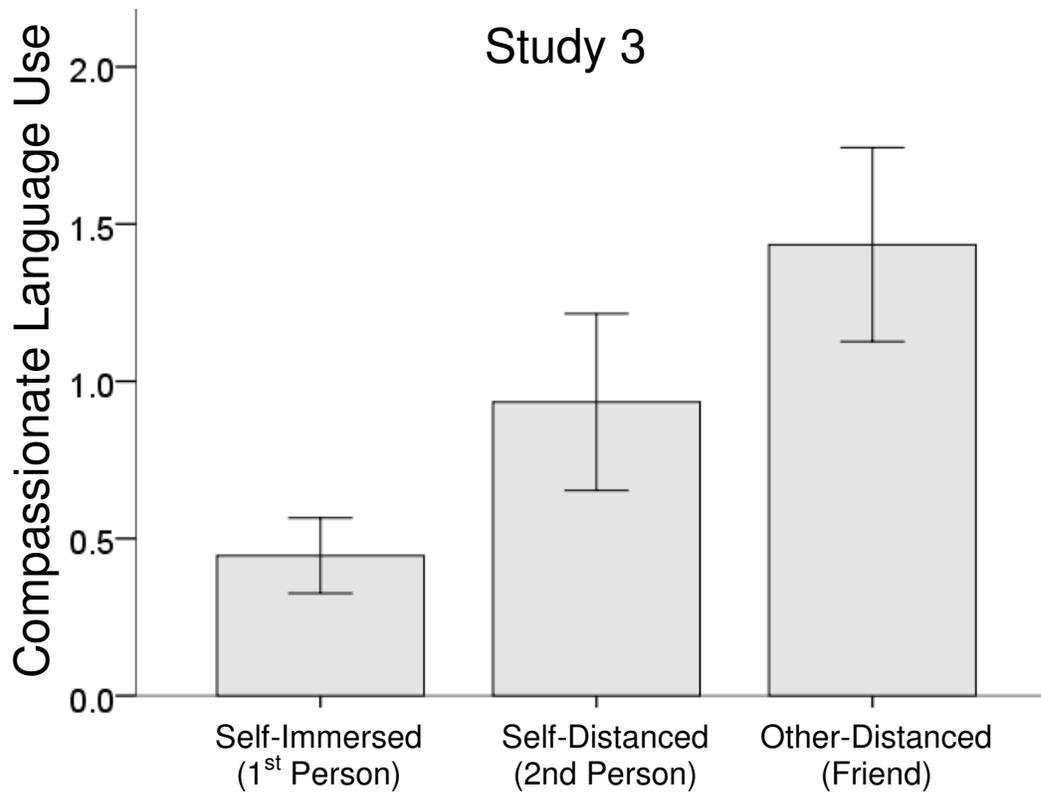


Figure 5. Mean differences in compassionate language use in immersed versus distanced subjects in Study 3. Distanced subjects used significantly more compassionate language than immersed subjects, with those writing to friends using the most. Error bars represent 95% confidence intervals.

Condition differences for positive outcomes. I tested for differences across conditions for the positive outcomes such as self-compassion, self-forgiveness, guilt, and resolution. On the SCS both distancing instructions felt better than the immersed condition, with the friend condition having the highest self-compassion ($M = 4.76$; $SD = 0.78$), followed by the second-person condition ($M = 4.70$; $SD = 0.71$), and the first-person condition ($M = 4.47$; $SD = 0.72$), $F(2, 265) = 3.30$, $p = .039$, $\eta^2 = .02$. After including covariates, pairwise contrasts showed that self-distancing was marginally different from self-immersion, $p = .078$, other-distancing was significantly different from self-immersion, $p = .027$, and the two distancing instructions did not vary significantly, $p = .855$.

The groups did not vary significantly in how forgiving they were of themselves, $F(2,255) = 1.01, p = .364$, how guilty they felt, $F(2,255) = 1.01, p = .364$, or whether those with ongoing problems achieved resolution on them, $F(2, 130) = 1.26, p = .097$ (see Table 5).

Table 5

SDSC Study 3 Positive Outcomes

<u>Outcome</u>	<u>1st Person</u>	<u>2nd Person</u>	<u>Friend</u>
Self-Compassion*	4.47 (0.72)	4.70 (0.72)	4.76 (0.78)
Guilt	5.00 (1.54)	5.04 (1.44)	4.75 (1.83)
Self-Forgiveness	4.87 (1.47)	5.16 (1.64)	4.94 (1.63)
Problem Resolution	3.88 (1.68)	4.32 (1.83)	4.31 (1.42)

Note. Standard deviations in parentheses.

* indicated F -test $\leq .05$

Compassionate language use and positive outcomes. I also tested whether compassionate language use predicted any positive outcomes. Across the whole sample, using compassionate language correlated with higher scores on the SCS, $r(270) = .19, p = .002$. It did not predict self-forgiveness, $r(260) = .10, p = .114$, guilt, $r(270) = -.09, p = .135$, or resolution, $r(135) = .10, p = .250$ (see Table 3).

Furthermore, I tested whether compassionate language use mediated the difference between conditions on the SCS. Mediation with a total effect model for multicategorical variables was run using the PROCESS macro (Hayes & Preacher, 2014). Compassionate language use mediated both distancing differences from immersion as well as overall, $B_{Direct\ 1st-2nd} = 0.19, 95\% CI_{direct} [-0.03, 0.41]$, $B_{Indirect\ 1st-2nd} = 0.04, 95\% CI_{indirect} [0.01, 0.08]$, $B_{Direct\ 1st-Friend} = 0.19, 95\% CI_{direct} [-0.03, 0.41]$, $B_{Indirect\ 1st-Friend} = 0.04, 95\% CI_{indirect} [0.02, 0.18]$ (see omnibus Figure 6).

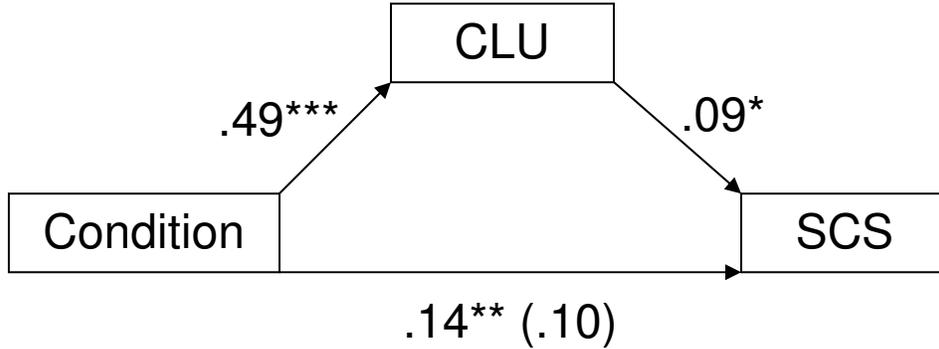


Figure 6. Compassionate language use (CLU) mediates the condition difference on our adapted Self-Compassion Scale (SCS)

Discussion

The findings supported the primary hypothesis about language use: self-distancing promoted self-compassion via compassionate language use. Both distancing instructions resulted in subjects using more compassionate language than their immersed counterparts. Furthermore, evidence emerged to support the hypothesis that other-directed language might be important for this self-compassion: subjects who distanced by imagining talking to a friend were the most likely to make supportive statements in their essay, followed by the second-person condition.

As in the previous two studies, there were indications that compassionate language use (CLU) was associated with some better outcomes for subjects. There were significant condition differences on our adapted measure of self-compassion, and these differences in self-compassion were mediated by CLU. However, CLU did not predict all positive outcomes: it did not significantly predict guilt, self-forgiveness, or achieving resolution. It may be that CLU does not affect these variables, or it may be that our relatively minimal intervention was not powerful enough to cause significant movement on these outcomes.

Study 4

I conducted a fourth experiment to replicate Study 3's results in a larger sample with an alternative measure of self-compassion. The primary intent of this study was to demonstrate convincingly that self-distancing promotes compassionate language use, which in turn promotes self-compassion. Secondly, Study 4 aimed to provide some insight as to why the other-distanced condition in Study 3 (those writing as though to a friend) used more compassionate language than those just writing in the second person. One possibility is that the other-distanced condition more naturally prompted people to use other-directed speech when writing (e.g., they were imagining actually talking to someone), and the instructions were altered so that all subjects would use the vocative case to account for this possibility. Finally, because the measure of self-compassion used in the first three studies was adapted to be a state measure from a trait measure, there were times at which the items were not wholly relevant to my intended construct. For example, one of the items in the original asks, "*When I'm going through a very hard time, I give myself the caring and tenderness I need.*" While as a trait this captures a tendency toward self-compassionate behavior, the behavior as we ask it in this study would be prospective, rather than a current state feeling of self-compassion.

In this study, I used a validated measure of state self-compassion, the Self-Compassion & Self-Criticism Scales (SCCS; Falconer, King, and Brewin, 2015).

Method

Participants. To more robustly replicate the results from Study 3, I doubled the sample size. To that end, I recruited 611 subjects from MTurk, of whom 44 met the exclusion criteria described in the general method, leaving 567 (384, 68% female). All subjects were compensated \$0.50 for their time.

Procedure. The instructions for writing were the same as in Study 3 except that a model sentence was added to each condition. The goal of this sentence was to decrease the number of people who used the wrong pronouns when writing and to increase the amount of people using the vocative case in the self-distanced condition (e.g., the self-distanced condition had the following added to the instructions 'For example, if your name were Jason, you might write, "Jason, you felt that...").

Additionally, a new measure of self-compassion, the SCCS, replaced the adapted version of the SCS we used in the previous studies. The SCCS consists of six emotion items loading onto two factors. Critical, Harsh, and Contemptuous comprise the 'Self-Critical' factor, while Soothing, Reassuring, and Compassionate comprise the 'Self-Compassion' factor. Subjects were asked "To what extent do you feel the following emotions toward yourself with regard to your problem?" on a 1 (*Not at all*) to 7 (*Highly*) scale.

Results

Manipulation checks. Baseline affect was the same across conditions, ($M_{1st} = 67.42$; $M_{2nd} = 68.88$; $M_{Friend} = 66.58$; $SD_{1st} = 23.40$; $SD_{2nd} = 21.17$; $SD_{Friend} = 22.45$), $F(2,563) = 0.50$, $p = .605$.

Instructions to use second person language resulted in 14 subjects using third person language instead (e.g., "Jason felt he should have been more upfront."). In the second-person condition, those who followed directions ($M = 0.84$; $SD = 1.01$) used significantly more compassionate language than those who wrote in the third person ($M = 0.21$; $SD = 0.38$), $t(32.03) = 4.94$, $p < .001$. Due to their failure to follow instructions and the proposed the importance of other-directed language use specifically, these codes for third-person language use were included as a covariate in the principle analyses.

Compassionate language use. To test my primary hypothesis, I compared the use of compassionate language across my conditions in a one-way ANOVA. The omnibus test was significant, $F(2, 563) = 43.23, p < .001, \eta^2 = .13$. Third person language use was a significant covariate, $p = .007$. After controlling for the third person, immersed subjects used the least compassionate language ($EMM = 0.21; SEM = 0.06$), while the self-distanced, second person writers ($EMM = 0.83; SEM = 0.06$) used similar amounts compared to the other-distanced subjects writing to friends ($EMM = 0.94; SEM = 0.06$). Planned contrasts showed that while both distancing conditions differed significantly from the immersed condition, $ps < .001$, they did not differ significantly from one another, $F(1,369) = 1.22, p = .271$ (see Figure 7).

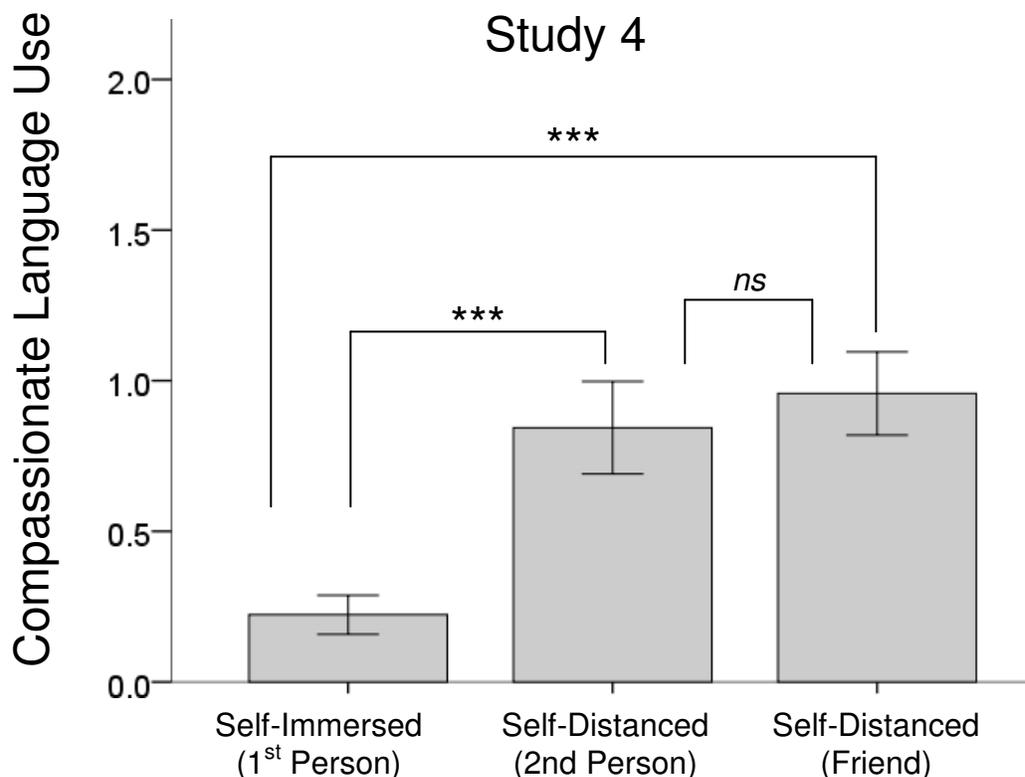


Figure 7. Mean differences in compassionate language use in immersed versus distanced subjects in Study 4. Error bars represent 95% confidence intervals.

Condition differences on positive outcomes. Other-distanced writers were significantly less self-critical ($M = 3.36; SD = 1.65$) than either the self-distanced ($M = 3.96;$

$SD = 1.50$) or self-immersed subjects ($M = 4.41$; $SD = 1.20$), $F(2,564) = 24.87$, $p < .001$, $\eta^2 = .08$. Other-distanced writers were also more self-compassionate ($M = 4.40$; $SD = 1.73$), than either self-distanced ($M = 3.99$; $SD = 1.52$) or self-immersed subjects ($M = 3.49$; $SD = 1.39$), $F(2,564) = 16.69$, $p < .001$, $\eta^2 = .06$ (see Figure 8). There were no significant difference for guilt or forgiveness, $F_s(2,564) < 1.17$, $p > .312$, or for resolution, $F(2,300) = 1.67$, $p = .191$ (see Table 6).

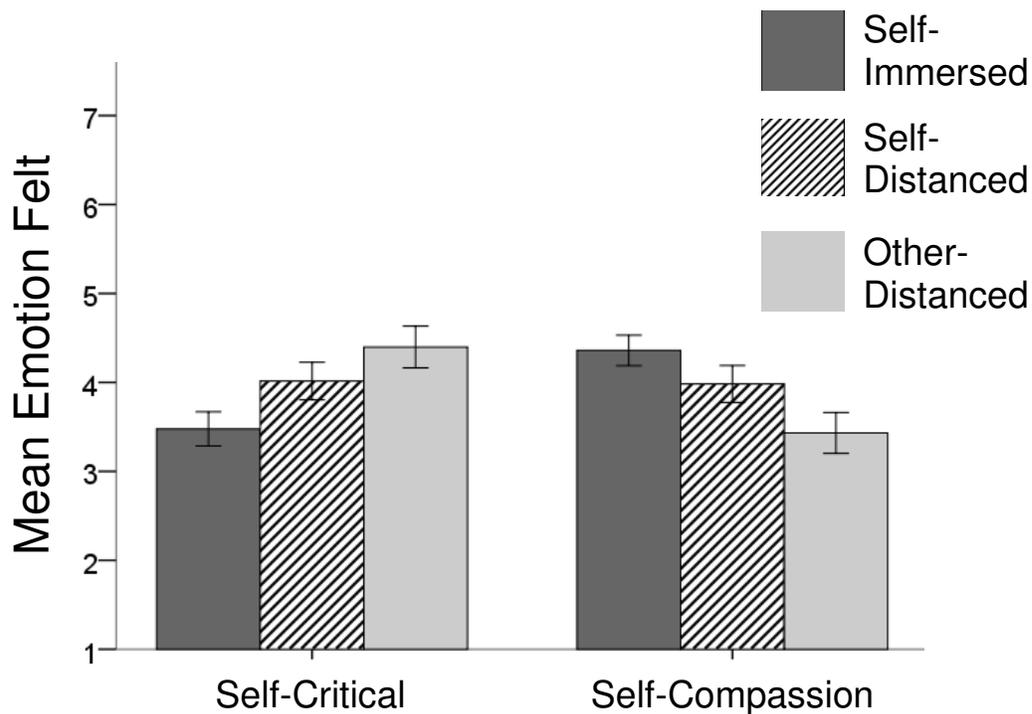


Figure 8. Mean emotion felt for the sub-measures of the SCCS. Distanced subjects were less critical and more compassionate than immersed subjects. Error bars represent 95% confidence intervals.

Table 6

SDSC Study 4 Positive Outcomes

<u>Outcome</u>	<u>1st Person</u>	<u>2nd Person</u>	<u>Friend</u>
Self-critical	4.41 (1.20)	3.96 (1.50)	3.36 (1.65)
Self-compassionate	3.49 (1.39)	3.99 (1.52)	
Guilt	5.23 (1.54)	5.33 (1.44)	5.13 (1.83)
Self-Forgiveness	4.71 (1.67)	4.95 (1.35)	4.84 (1.53)
Problem Resolution	3.87 (1.62)	4.17 (1.54)	4.25 (1.66)

Note. Standard deviations in parentheses.

* indicated F -test $\leq .05$

Compassionate language use and positive outcomes. CLU positively correlated with the SCCS self-compassionate measure, $r(567) = .20, p < .001$, and negatively with the self-criticism factor, $r(567) = -.19, p < .001$. It did not significantly correlate with guilt, $r(567) = -.05, p = .285$, with self-forgiveness, $r(547) = .07, p = .082$, or with achieving resolution, $r(303) = .10, p = .100$. Because there were no significant differences between the two distancing instructions on the amount of compassionate language used, for testing mediation of CLU they were collapsed into a single distancing condition. CLU partially but significantly mediated the difference between immersed and distanced writers for self-compassion, $B_{indirect} = 0.16, 95\% \text{ CI } [0.06, 0.27]$, and for self-criticism, $B_{indirect} = -0.13, 95\% \text{ CI } [-0.25, -0.03]$.

Discussion

Replicating the effects of Study 3, distancing was associated higher self-compassion, both in the compassionate language used to describe ones problem and in the self-reported emotional outcomes after writing. Furthermore, compassionate language use accounted for at least part of the difference between distanced and immersed writers on these positive

outcomes. Overall, my hypotheses were supported in a more robust sample with a new measure of self-compassion.

By altering the instructions so that second person writers used more other-directed language, I was able to eliminate the difference between self- and other-distanced conditions on the amount of compassionate language they used. This may indicate that the extent to which one treats oneself like a distinct, other entity when distancing is an important component of the effect overall. However, while the distancing groups were equated on CLU, the other-distanced friend writers still had slightly better positive outcomes than the self-distanced subjects. It is possible that while being other-directed may be a primary component of the language one uses, imagining one's problem happening to a friend may be a more powerful distancing induction in general, and this lead to better outcomes for them. Future research would do well to examine the mechanisms behind these benefits.

General Discussion

In four studies, distancing increased the amount of compassionate language people used to describe their problems. In the final two studies with improved instructions, whether it was by having them just write in the second person, or imagine that a friend had come to them with the same problem, when writing to understand their feelings and find closure, subjects who used self-distancing were much more caring and understanding towards themselves. Furthermore, there is some preliminary evidence that treating oneself like a distinct other (one goal of self-compassion) when distancing may explain this effect.

This primary achievement should not be undersold, as it demonstrates a simple, straightforward way to get people to be more self-kind. Therapists could easily add self-distancing to the toolbox of techniques they teach to clients who are overly self-critical for

example, or fold it into the expressive writing practices that already occur. Given that most studies on self-compassion to date have used pseudo-experiments with pre-existing differences on the trait variable, future work now also can easily manipulate self-compassion in practice to see what effects it may actually have on well-being.

Furthermore, in each study there was at least some indication that compassionate language use (CLU) was associated with positive outcomes. When instructions were improved in later studies, we saw not just indirect effects of distancing on these outcomes, but direct effects as well which were still mediated by CLU.

One caveat of the present work is that the positive outcomes were self-reported and immediately after performing the distancing manipulation. Future work could investigate other measures of well-being and test whether the benefits of self-distancing on self-compassion have staying power longitudinally.

I achieved my primary goal in this line of work, demonstrating a technique by which one can change the way people talk to themselves about their problems, making them more understanding, caring, and compassionate when reflecting on unpleasant experiences. Self-distancing clearly seems to be a method one can employ not only to gain the benefits described in previous research (Kross et al., 2014; Grossman & Kross, 2014; White & Carlson, 2016), but also to increase self-compassion. As the science backing up the efficacy of self-compassion continues to mount, medical health professionals can recommend self-distancing as an easy, straightforward practice to help deal with life's stresses.

Conclusions

This dissertation explored two different, unusual ways in which supportive language can be used to help someone in distress. In the first line of work, I showed that when receiving support, people believe that true empathy is necessary for it to be effective, but that support providers making an effort seems to be the real driver of improvement. In the second line of work, I found that self-distancing, the practice of removing oneself from the typical egocentric point of view, increased the amount of compassionate language people used when writing about their problems, being less critical and more understanding. There was indication as well that this type of language use could lead to better outcomes after writing about a problem.

Unlike when one attempts to support someone else, when one engages in self-compassion, one has privileged access to one's own thoughts. So, when one gives encouragement to oneself, one knows whether it is sincere or not. We know from our third study in the self-distancing/self-compassion line that our different conditions evoked different levels of belief in what one was saying. Independently, this belief correlated with positive outcomes. However, it did not relate to compassionate language use or mediate the effects of compassionate language use on positive outcomes, nor did it mediate the condition differences on these positive outcomes. It seemed, at least from this evidence, that the direct act of using supportive language and the sincerity of that support operated independently.

However, it is possible that this independence was a result of the fact that subjects were self-distancing. Prior experimental work has had mixed success at telling people to write to or treat themselves more compassionately and them feeling better that their problems. One could speculate that this is because without distancing, one's metacognitions are more

accessible, and people are aware that they do not really mean the things they are telling themselves—in essence they know that they are being pseudo-empathic. As my first line of work showed, this would result in the support they self-provide being ineffective. Perhaps some level of self-distancing is necessary, or at least beneficial, to the effectiveness of providing support to oneself. More replication and exploration is required though, before too much can be made of this result, but it does suggest a potentially productive avenue for future research.

In the future, both of these lines of work have strong potential for translational research. In the case of inauthentic empathy, while it seems to be the sort of behavior we would not want to encourage in our close others, there are many professions which could benefit from the practice. Doctors and therapists, for example, often experience empathy fatigue, and interventions to make them more compassionate towards their patients, which while helpful for the patients, might be harmful to the doctors. My evidence suggests that more direct interventions on social skills might still benefit patients while protecting doctors. Future work could look more directly at these populations to see if these results are generalizable. In the case of self-distancing and self-compassion, there are many clinical disorders characterized by excessive self-criticism, and it would be worthwhile to see if the type of expressive writing performed in the current work is more effective than current techniques for these people. Whatever future work might hold, we must continue exploring the nuances of social support so that we might more effectively care for ourselves and each other when in need.

Appendix A: Condition Instructions For Self-Distancing

The following appendix contains the writing instructions for the Self-Distancing & Self-Compassion Studies. Differences between conditions are bolded.

Self-Distancing & Self- Compassion Study 1 Writing Instructions	
<u>Immersed (1st Person)</u>	<u>Distanced (2nd Person)</u>
<p>People have different approaches to how they try to solve their problems. One of the things that we are interested in in this study is the language people use to understand their feelings.</p>	<p>People have different approaches to how they try to solve their problems. One of the things that we are interested in in this study is the language people use to understand their feelings.</p>
<p>Take a moment to work-through your feelings surrounding the problem you just described.</p>	<p>Take a moment to work-through your feelings surrounding the problem you just described.</p>
<p>When you are ready, we would like you to work through your feelings in writing, referring to yourself using the first-person pronouns "I" and "MY" as much as possible.</p>	<p>When you are ready, we would like you to work through your feelings in writing, referring to yourself using the second-person pronouns "YOU" and "[YOUR OWN NAME]" as much as possible.</p>
<p>Try to understand why you felt the way you did during the event. Try to find closure.</p>	<p>Try to understand why you felt the way you did during the event. Try to find closure.</p>
<p>Take as much time as you need to do this. When writing, remember to refer to yourself with first-person pronouns as much as possible.</p>	<p>Take as much time as you need to do this. When writing, remember to refer to yourself with second-person pronouns or your own name as much as possible.</p>

Self-Distancing & Self- Compassion Study 2 Writing Instructions	
<u>Immersed (1st Person)</u>	<u>Distanced (Friend)</u>
<p>People have different approaches to how they try to solve their problems. We want you to imagine the problem you chose.</p> <p>Take a moment to think how you might work through your feelings surrounding the problem.</p> <p>When you are ready, we would like you to write out how you would work through your feelings.</p> <p>Try to understand why you felt the way you did during the event and/or afterwards. Try to find closure. Take as much time as you need to do this.</p> <p>Don't write about it generally; write as if you are working through it at that moment.</p>	<p>People have different approaches to how they try to solve their problems. We want you to imagine the problem you chose happened to a specific friend.</p> <p>Take a moment to think how you might help your friend work through his or her feelings surrounding the problem.</p> <p>When you are ready, we would like you to write out how you would help your friend work through his or her feelings.</p> <p>Try to help your friend understand why he or she felt the way they did during the event and/or afterwards. Help them try to find closure. Take as much time as you need to do this.</p> <p>Don't write about it generally; write as if you are helping them work through it at that moment.</p>

Self-Distancing & Self- Compassion Study 3 Writing Instructions		
<u>Immersed (1st Person)</u>	<u>Distanced (2nd Person)</u>	<u>Distanced (Friend)</u>
<p>People have different approaches to how they try to solve their problems. One of the things that we are interested in in this study is the language people use to understand their feelings.</p> <p>We want you to imagine the problem you just wrote about. Take a moment to consider how you might work through your feelings surrounding the problem you just described.</p> <p>When you are ready, we would like you to work through your feelings in writing, using the first-person pronouns "I" and "MY" as much as possible.</p> <p>Try to understand why you felt the way you did during the event. Try to find closure.</p> <p>Write as if you are working through it at that moment, and when you write please try to refer to yourself with first-person pronouns as much as possible.</p> <p>Take as much time as you need to do this.</p>	<p>People have different approaches to how they try to solve their problems. One of the things that we are interested in in this study is the language people use to understand their feelings.</p> <p>We want you to imagine the problem you just wrote about. Take a moment to consider how you might work through your feelings surrounding the problem you just described.</p> <p>When you are ready, we would like you to work through your feelings in writing, using "[YOUR OWN NAME]" and the second-person pronoun YOU as much as possible.</p> <p>Try to understand why you felt the way you did during the event. Try to find closure.</p> <p>Write as if you are working through it at that moment, and when you write please try to refer to yourself with second-person pronouns or your own name as much as possible.</p> <p>Take as much time as you need to do this.</p>	<p>People have different approaches to how they try to solve their problems. One of the things that we are interested in in this study is the language people use to understand their feelings.</p> <p>We want you to imagine the problem you just wrote about happened to a specific friend and they came to you. Take a moment to think how you might help your friend work through his or her feelings surrounding the problem you just described.</p> <p>When you are ready, we would like you to help your friend work through their feelings in writing, using [THEIR NAME] and the second-person pronoun YOU as much as possible.</p> <p>Help them try to understand why they felt the way they did during the event. Help them try find closure.</p> <p>Remember, you are imagining that your problem happened to them. Write as if you are working through it with them at that moment, and when you write please try to refer to them with second-person pronouns or their name as much as possible.</p> <p>Take as much time as you need to do this.</p>

Appendix B: Self-Compassion Scale Short-form transformations

Transformed SCS-SF
(Originals in quotes and italics)

"When I fail at something important to me, I become consumed by feelings of inadequacy."
I feel inadequate because of my problem.

"I try to be understanding and patient towards those aspects of my personality I don't like "
I understand and/or accept why I reacted the way I did.

"When something painful happens I try to take a balanced view of the situation."
I have a balanced view of this situation.

"When I'm feeling down, I tend to feel like most other people are probably happier than I am."
I think most other people would have handled my problem better emotionally.

"I try to see my failings as part of the human condition."
Being partly to blame for my situation is just part of the human condition.

"When I'm going through a very hard time, I give myself the caring and tenderness I need."
I will take care of myself the way I need in this situation.

"When something upsets me, I try to keep my emotions in balance."
My emotions regarding this situation are in balance.

"When I fail at something that's important to me, I tend to feel alone in my failure."
Other people wouldn't have failed in this situation.

"When I'm feeling down I tend to obsess and fixate on everything that's wrong."
I am fixated on the things that are wrong in this situation.

"When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people."
My feeling inadequate or like I failed is something other people would feel too, in my shoes.

"I'm disapproving and judgmental about my own flaws and inadequacies."
What happened is unacceptable, and I should have done better.

"I'm intolerant and impatient towards those aspects of my personality I don't like."
I really should have reacted much better to the situation.

Appendix C: Whole sample descriptive statistics for unreported variables

Inauthentic Empathy Study 1

	Inclusion of the Other in the Self	How much better did the person you supported feel afterwards?	How much better did you feel afterwards?	Important to Listener (Participant Listener)	Important to Listener (Participant Speaker)	Important to Speaker (Participant Listener)	Important to Speaker (Participant Speaker)
Mean	4.23	5.07	5.03	5.03	4.88	6.37	6.20
N	200	99	101	99	101	99	101
Std. Deviation	1.898	1.197	1.682	1.693	1.596	.965	1.058

Inauthentic Empathy Study 2 Recipient Variables

	After talking about my problem today, I am feeling about it. (1 to 7)	Perceived Responsiveness (-3 to 3)	I think the other person truly felt sympathetic or compassionate about me or my problem. (-3 to 3)	I felt supported by the other person. (-3 to 3)	The other person was displaying more sympathy than they actually felt (-3 to 3)	The other person was only pretending to care about my problem. (-3 to 3)
Mean	5.10	1.7857	1.85	1.98	-.66	-1.53
N	140	140	140	140	140	140
Std. Deviation	1.013	.99163	1.163	1.063	1.437	1.322

Inauthentic Empathy Study 2 Provider Variables

	I have experienced a similar problem in my life before. (1 to 7)	I think the other person felt after talking today. (1 to 7)	I put in real effort to support the other person with her problem. (1 to 7)	How sympathetic or compassionate did you feel while talking today? (1 to 7)	I tried to convey more sympathy than I actually felt. (1 to 7)	I was only pretending to care about their problem. (1 to 7)	I really tried to convince the other person that I was feeling sympathetic (1 to 7)
Mean	5.67	4.76	5.84	5.61	2.94	1.61	3.82
N	138	139	139	139	139	139	139
Std. Deviation	1.744	.867	1.098	1.133	1.509	.967	1.621

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