Michael E. Bernard *Editor*

The Strength of Self-Acceptance

Theory, Practice and Research

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Albert Ellis, for his theory and professional practice spanning more than 50 years that has inspired so many people across the world to conquer self-depreciation (as much as humanely possible) and through self-acceptance to live less fearful and more self-actualized, fulfilled lives.

Christopher Peterson, for his seminal work in identifying universal positive human characteristics that contributes to well-being and for his recent support for self-acceptance as a character strength contributing to happiness and flourishing.

The Strength of Self-Acceptance

As [Jesus] went out into the street, a man came running up, greeted him with great reverence, and asked, “Good Teacher, what must I do to get eternal life?”
Jesus said, “Why are you calling me good? *No one is good*, only God.” (Mark 10:17,18)

The most terrifying thing is to accept oneself completely. (C.G. Jung)

At 30 a man should know himself like the palm of his hand, know the exact number of his defects and qualities, know how far he can go, foretell his failures—be what he is. And, above all, accept these things. (Albert Camus)

My definition of success is total self acceptance. We can obtain all of the material possessions we desire quite easily, however, attempting to change our deepest thoughts and learning to love ourselves is a monumental challenge. (Victor Frankl)

It’s not worth our while to let our imperfections disturb us always. (Henry David Thoreau)

Our healthy individuals find it possible to accept themselves and their own nature without chagrin or complaint or, for that matter, even without thinking about the matter very much. (Abraham Maslow)

When the individual perceives himself in such a way that no experience can be discriminated as more or less worthy of positive regard than any other, then he is experiencing unconditional positive self-regard. (Carl Rogers)

I do not have intrinsic worth or worthlessness, but merely aliveness. I’d better rate my traits and acts, but not my totality or ‘self.’ I fully accept myself, in the sense that I know I have aliveness and I choose to survive and live as happily as possible, and with minimum needless pain. I require only this knowledge and this choice—and no other kind of self-rating. (Albert Ellis)

We can never obtain peace in the outer world until we make peace with ourselves. (Dalai Lama XIV)

Because one believes in oneself, one doesn’t try to convince others. Because one is content with oneself, one doesn’t need others’ approval. When you accept yourself, the whole world accepts you. (Lao Tsu)

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Introduction to the Strength of Self-Acceptance: Theory, Theology and Therapy

The rationale for this book is the exploration of how different theologies (e.g., Christianity, Buddhism), psychological theories (humanistic, cognitive-behavioral), and therapies (e.g., REBT, CBT, ACT) view self-acceptance as a catalyst for the alleviation of emotional misery as well as an energizer supporting growth towards happiness and fulfillment. The idea that self-acceptance can be a stimulus for personal change and development has a long history in Eastern and Western religion and culture as well as in psychological literature as propounded by Maslow, Rogers, Ellis as well as by "third wave" cognitive-behavioral and self-regulation approaches (e.g., Hayes, Strosahl, & Wilson, 1999). Williams and Lynn (2010) have provided an in-depth historical and conceptual review of "acceptance" as Baumeister (1999) accomplished in his study of "self."

Self-acceptance as character strength has been left on the sidelines by some in the field of positive psychology who have delimited positive character traits associated with happiness and well-being (see Peterson and Seligman, 2004, listing of 24 *Character Strengths and Virtues*). At the Second World Congress on Positive Psychology held in August 2011, Christopher Peterson and Michael Bernard (Editor) discussed self-acceptance. Christopher Petersen agreed that self-acceptance was a universal character strength that had been overlooked. To demonstrate his interest, he was to write the foreword to this book which due to his recent death has not been possible. A rationale for this book is also a desire to see self-acceptance recognized as an important character strength. The theological, philosophical, and psychological discourse that is expansively presented by contributors to this book and the extensive research history that includes the development of many scales of measurement speak the importance of the construct of self-acceptance. Moreover, self-acceptance meets a majority of the criteria outlined by Peterson and Seligman (2004) by which a human quality or characteristic qualifies as a positive strength or virtue including: contributes to the individual's fulfillment, is morally valued, does not diminish other people in any way, occurs in a variety of situations and behaviors (trait), is distinct from other positive traits, is embodied in "consensual paragons" (stories, fables) and the extent of negative behavior when the quality is absent.

The term "self-acceptance" sounds simple but anyone trying to define it learns that it is not. Generally, self-acceptance is conceptualized as an affirmation or acceptance of self in spite of weaknesses or deficiencies. However, there is vast difference of opinion as to what is the "self" that is being accepted and the nature of acceptance.

While there is no scientific consensus concerning the defining attributes of "self," there is some agreement that the self is wholistic including one's characteristic traits, memories, thoughts, feelings, sensations, and behaviors and that the self is fluid over time. Baumeister and Bushman (2011) identify three components of self: (a) *self-knowledge* (self-awareness, self-concept, self-esteem, and self-deception), (b) *social-self* (relationships with others, social roles, group membership), and (c) *agent self/executive function* (decision making, self-management). The self has been described as a theory of our existence, an abstraction of who we are (e.g., Popper & Eccles, 1981). The issue of whether there is any benefit or disadvantage to the human tendency to provide an overall evaluation of the complex, ever-changing self on a good-bad continuum is widely discussed in the self-acceptance literature.

"Acceptance" is an equally challenging construct to define. Etymologically, acceptance means the act of taking or receiving something willingly or favorably (*Webster's Encyclopedic Unabridged Dictionary* 1994). Williams and Lynn (2010, pp. 8–10) have illuminated five different ways that acceptance has been described over the millennia: (a) *nonattachment*—accepting that objects of experience wax and wane, and that to allow them to come and go naturally is preferable to any attempts to control or retain them; (b) *non-avoidance*—refraining from pointless running away when no physical threat is present; (c) *nonjudgment*—a conscious abstention from the categorization of experience as good or bad, right or wrong, describing stimuli rather than evaluating stimuli; (d) *tolerance*—to be able to remain present and aware even when stimuli are frustrating or undesirable; (e) *willingness*—exercising a choice to have an experience. The acceptance literature has identified two domains of acceptance—"self-acceptance" and "acceptance of others"—with theory and research pointing to the positive association between the two (e.g., Sheerer, 1949).

In contemporary literature, self-acceptance involves a realistic, subjective, awareness of one's strengths and weaknesses. Self-acceptance can be achieved by stopping criticizing and solving the defects of one's self, and then accepting them to be existing within one's self; that is, tolerating oneself to be imperfect in some parts (Shepard, 1979, p. 140). According to Hayes, Strosahl, Bunting, Twohig, and Wilson (2004, p. 7) "acceptance involves taking a stance of non-judgmental awareness and actively embracing the experience of thoughts, feelings and bodily sensations as they occur." Self-acceptance shares some elements in common with Roger's (1951) positive self-regard and Neff's (2003) self-compassion and her discussion of kindness to self; however, the explicit absence of self-evaluation in self-acceptance distinguishes the constructs.

While self-esteem and self-acceptance are strongly correlated (e.g., Ryff, 1989), recent research and theorizing have suggested that it may be important to differentiate self-acceptance, as an aspect of psychological health, from high or favorable self-esteem. *Self-esteem* refers to how much one likes or values the self, is based on

congruence with personal standards or on comparisons with others (Coopersmith, 1967) and has been defined as a person's global sense of worthiness and goodness (Rosenberg, 1965). Deci and Ryan (2000) distinguished between stable or trait and contingent or unstable (state) self-esteem. Trait self-esteem represents an overall evaluation of self-worth lasting over time involving a person's attitudes towards themselves being self-determined and based on intrinsic motives. Contingent or state self-esteem refers to how good one feels about oneself at a particular moment in time based on temporarily meeting external, evaluative standards or conditions of worth. Crocker and Park (2004) argued that the pursuit of self-esteem is typically focused on state self-esteem instead of trait self-esteem. Individuals often try to experience positive affect by boosting their state self-esteem above trait levels and to avoid negative affect by not allowing their state self-esteem to fall below trait levels (Crocker & Park, 2011). Low levels of self-esteem (and self-acceptance) are associated with a variety of mental health problems (e.g., Crocker & Park, 2004; Swann, Chang-Schneider, & Larsen McClarty, 2007). High self-esteem, which can contribute to narcissism, a sense that one is great and more worthy than others, has been found to contribute to relationship problems and violent behavior (Baumeister, Campbell, Krueger, & Vohs, 2003). Self-acceptance has been argued as a healthier psychological attribute than self-esteem.

At the forefront of the psychotherapeutic community arguing for the importance of self-acceptance to mental health and the pernicious effects of self-esteem has been Albert Ellis (e.g., Bernard, 2011; Bernard, Froh, DiGiuseppe, Joyce, & Dryden, 2010; Ellis, 1962, 2005). In *The Myth of Self-Esteem,* Ellis (2005) stated that self-acceptance is a single idea that can make you radically different in many ways and that you can choose to have it or not have it. Here are some things Ellis (2005, p. 34) has written about self-acceptance. "People's estimation of their own value, or worth, is exceptionally important. If they seriously denigrate themselves or have a poor self-image, they will impair their normal functioning and make themselves miserable in many significant ways. When people do not value themselves very highly, innumerable problems arise. The individual's judgment of his own value or worth has such an impact on his thoughts, emotions and actions, how is it possible to help people consistently appraise himself so that, no matter what kind of performance he achieves and no matter how popular or unpopular he is in relations with others, he almost always accepts or respects himself." Here's how Ellis proposed how to help people feel worthwhile: (a) define yourself as a worthwhile person because you exist, because you are alive, and because of your individual character strengths and abilities that make up your uniqueness, accept yourself whether or not you achieve or people approve of you, accept yourself with your errors and do your best to correct your past behavior and (b) don't give any kind of global, generalized rating to yourself; you only evaluate what you think, feel, and do.

Of consequence to the study of self-acceptance is the distinction between *conditional* and *unconditional* self-acceptance. Rogers (e.g., 1957, 1995) described how children's developing sense of self-acceptance is determined by the extent to which the love and approval received from their parents is conditional or unconditional. When children are raised where love is conditional upon their living up to parental

expectations, they are more likely to judge themselves in terms of conditions of worth on which their self-valuation is contingent. That is, they are more likely to be self-evaluators basing their self-worth on the opinions of others or their achievements in different domains. In contrast, Ellis (1962) has argued that the tendency towards negative self-evaluation and depreciation has less to do with the environment children grow up in and more to do with the strength of their biological instinct towards irrationality.

Without question, self-acceptance is a scientifically valid construct. Over the past century, a variety of measurement scales of self-acceptance have been developed, the more recent ones meeting standards of validity and reliability (e.g., Berger's 1950 *Expressed Acceptance of Self and Others Scale*; Gough's 1957 *California Psychological Inventory, Self-Acceptance Subscale*; Shostrom's 1964 *Personal Orientation Inventory, Self-Acceptance subscale*; Ryff's 1989 *Scales of Psychological Well-Being, Self-Acceptance subscale;* Chamberlain & Haaga's 2001 *Unconditional Self-Acceptance Questionnaire*; Patterson and Joseph's 2006 *Scale of Unconditional Positive Regard*). The field has moved from measurement differentiation of self-acceptance from other-acceptance to an examination of the relationship to self-esteem and other related psychological constructs (e.g., self-compassion) associated with well-being. Recent scale development (e.g., Patterson & Joseph, 2006; see Bernard's *Child and Adolescent Survey of Positive Self-Acceptance* appearing in this book in Bernard, Vernon, Terjesen, & Kurasaki, 2013) has focused on the self-evaluative and self-regard aspects of the construct of self-acceptance as well as the relationship of self-acceptance to positive dimensions of happiness and fulfillment. Positive correlations of self-acceptance have been obtained with positive indicators of mental health and adjustment including leadership effectiveness (Denmark, 1973), happiness, life satisfaction, (Chamberlain & Haaga, 2001), and mindfulness (Thompson & Waltz, 2008).

There are two major historical streams of influence on modern-day practice of self-acceptance therapies; one theological, and the other psychological (see Part I of this volume). As an example of the theological stream of influence, Christian scripture is used in therapy to teach Christian clients self-acceptance through the example of God and the lessons of Jesus Christ including how sin does not reduce human worth. There are also direct links from Buddhism to contemporary psychotherapy. The Buddhist notion of *radical acceptance* consisting of a willingness to experience and accept whatever is taking place in the moment has been incorporated in the cognitive-behavioral treatment of borderline personality disorders (Linehan, 1993, 1995). The other stream of influence is humanistic psychology rooted in the work of Maslow (1943), Rogers (1951) and May (1983) that has addressed in theory and therapeutic practice the primacy of self-acceptance including necessary and sufficient conditions for change.

The human potential for self-acceptance can be developed in therapy as well as in education though the therapeutic and educational processes (e.g., explicit instruction; socratic/didactic disputing of self-depreciation; unconditional positive regard of therapist; mindfulness) varies depending on the prevailing conception of self-acceptance. Self-acceptance enhancement has become an essential ingredient to comprehensive programs for dealing with a variety of mental health issues that arise with children and adolescents, parenting, relationship difficulties, women's issues,

chronic illness, and aging (see chapters in Part II of this volume). It has been successfully taught in life skills, social and emotional learning, rational-emotive education, and psycho-educational curricula to young people as part of school-based prevention and promotion of mental health programs (e.g., Bernard, 2007; Knaus, 1974; Vernon, 2006).

An issue that remains to be resolved in the self-acceptance literature concerns the extent to which as Albert Ellis proposes self-acceptance is a cognitive process that due to its nonself-evaluative property is affectively neutral. That is, unconditional self-acceptance eliminates much emotional misery. However, the lack of any element of positive appreciation of aspects of self-inherent in Ellis' view of unconditional self-acceptance may not engender pleasurable and positive emotions that result from positive self-evaluation. However, it can be argued that positive judgments of one who is based on intrinsic characteristics (not based on conditions of worth) is compatible with the absence of negative, global, self-evaluative ratings, and contributes to stable, positive affectivity.

There is agreement among leading self-acceptance theorists from diverse backgrounds that self-acceptance needs to be accompanied by both individual determination to self-improve negative behavior that blocks individual goal attainment (happiness, long life) and a social conscience where one's action not only do not interfere with the rights and interests of others, but also contribute to the general welfare of the broader community.

Interesting questions remain to be answered in this field.

- Is the origin of self-acceptance biological or social?
- Can self-acceptance be developed before the age of 7?
- Is self-acceptance acquired as a result of aging?
- Can self-acceptance only be achieved after needs for love and accomplishment have been fulfilled?
- Does acceptance of all aspects of experience equate with unconditional acceptance of self?
- Is nonjudgment of self compatible with positive self-regard?
- Does achieving your potential bring about self-acceptance or does self-acceptance allow for one to achieve one's potential?
- Is self-acceptance a mediator or an outcome?
- How is self-acceptance best strengthened?
- Does strengthening self-acceptance in education or counseling lead to concomitant increases in positive mental health or does self-acceptance activate other psychosocial processes that themselves promote positive outcomes?

Finally, the authors of chapters in this book not only share in common an in-depth understanding of their field but they also communicate a passion for the importance of self-acceptance as a strength of character that is foundational to the journey towards self-actualization, happiness, fulfillment, enlightenment, and peace.

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Part I
Theory and Research

Humanistic Psychology and Self-Acceptance

Louis Hoffman, Abraham J. Lopez, and Michael Moats

Keywords Rogers • Maslow • May • Self-actualization • Self-acceptance and interpersonal relationships • Self-acceptance and creativity • Existentialism • Self-acceptance and self-awareness • Tillich • Therapeutic relationship • Humanistic therapy • Zhi mian

Humanistic psychology, it could be maintained, was the first psychological theory that gave serious consideration to the value and implications of self-acceptance in psychology, at least in its more explicit and positive constructions. As will be discussed, humanistic psychology began by advocating for radical self-acceptance that embraced a view of oneself, and human nature, as essentially good. Over time, the understanding of self-acceptance became more nuanced, particularly with the introduction of existential psychology as a school of thought within the humanistic tradition. In this chapter, we provide an overview of important humanistic views on self-acceptance, emphasizing how these emerge from a particular understanding of human nature as well as the implications for psychotherapy.

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History of Self-Acceptance in Humanistic Psychology

Carl Rogers, Abraham Maslow, Rollo May, and others developed humanistic psychology in response to the reductionist psychologies that dominated in the early twentieth century. This third force in psychology was part of a quest to give the human experience greater validity, which had been absent in psychoanalysis and behaviorism. It also provided an alternative conception of human nature. While behaviorism and psychoanalysis had a pessimistic view of human nature, humanistic psychology perceived human beings as being basically good. It is important to understand that it was never the intention of the early humanistic theorists to undermine the contributions of psychoanalysis and behaviorism. In fact, Maslow stated, "I interpret this third psychology to include the first and second psychologies… I am Freudian and I am behavioristic and I am humanistic" (Maslow, 1973). The intention of Maslow was to add a component of human consciousness to the two psychologies that had already been established. While behaviorism sought to control behavior through external stimuli, psychoanalysis sought to explore the inner self (Crain, 2005). Maslow believed that human potential was being ignored.

Maslow referred to the missing component as self-actualization, which is broader, but inclusive of, self-acceptance and self-worth. Attributes such as these give individuals a more authentic experience of life. Goldstein (1939/1963) defined actualization as one's potentials, capacities, and talents. Maslow agreed with this general definition but felt it was important to be clear that the full use of these characteristics be utilized in order to be truly self-actualized. Self-actualization is a term that Maslow considered to be high up within the hierarchy of a person's needs. Maslow created a pyramid of needs that were essential for a person's survival. At the bottom of the pyramid were physiological needs such as food and water. The next level was the safety needs, which referred to security and safety. Level three pertained to belongingness and love needs, such as relationships and friendships. The next level was the esteem needs. This level dealt with feelings of accomplishment. The final level and the one considered by Maslow to be the highest level included self-actualization needs. The final level refers to achieving one's true potential and it is at this level where Maslow believes one is able to achieve self-acceptance (Maslow, 1943).

Self-Acceptance in Humanistic Psychology

Self-acceptance is a concept that has been crucial in the development of humanistic psychology. Humanistic theorists have argued from its inception that human beings should be seen as a whole and therefore should not be broken into components. Areas such as self-acceptance and creativity cannot be broken down into smaller components to be modified by behavioral theory. According to Maslow, self-acceptance occurs through actualization of the self, which results from the discovery and development of the self (Goble, 1970). Maslow believed that self-acceptance

was a process or a journey of self-discovery. In aiming towards self-actualization, a person is required to have an understanding of oneself. As already has been mentioned, Maslow's hierarchical needs are organized in different levels and one rests upon the other. In other words, the lower level must be achieved in order to move on the next. It should then be noted that the highest level is about fulfilling one's full potential and through this achieving self-acceptance. The lower levels require interaction with other people. These are the issues that Maslow wanted to fully understand about self-acceptance and ultimately, self-actualization.

In his early studies, Maslow began to see how self-actualized people might be found or what characteristics they may posses. With this in mind, Maslow was intrigued by two professors that he had while working on his doctorate degree. The two professors were exceptionally interesting to him as they had personality characteristics that were distinct from other people (Goble, 1970). Through a comparison of characteristics and traits, Maslow found commonalities in both professors. He decided that he would extend his studies to include a wide range of people that included friends and public figures that were both alive and dead. As Maslow regarded self-actualized people as being in tune with the full use of talents and capacities, he found that very few could ever be regarded as reaching the pinnacle of the hierarchical pyramid. Maslow's conclusions confirmed that self-acceptance was more typically found in people around the age of 60 years of age (Goble). This finding is consistent with research in human development in which a person of this age range finds self-acceptance and is at peace with him or herself.

Carl Rogers and Abraham Maslow. Rogers placed great emphasis in his work on self-acceptance, which he saw as related to many variables. The basic premise for Roger's theories and that of humanistic psychology in general was to help people achieve their full potential as humans (Rogers, 1951). Rogers also believed that interrelationships with other people could be improved when a person finds self-acceptance within oneself. Client-centered therapy demonstrated that spontaneous insight and self-understanding was lacking in other types of therapies. While psychoanalysis did search for meaning and insight at the inner core of a person's unconsciousness level, Rogers had a different understanding of what insight should represent. Rogers's research findings concluded that insight involved four elements (Rogers). The first element was an acceptance of one's impulses and attitudes, which emerged in part through the influence of others. Negative impulses and attitudes in particular were often a result of prior negative experiences. The second element was being in tune with one's behavior and the perception of new relationships. The third element involved the renewed view of reality made possible by this acceptance and understanding of the self. The fourth element that Rogers proposed was the planning of new and more satisfying ways in which the self can adjust to reality.

Rogers (1940) believed that self-acceptance could be achieved through a type of relationship, particularly exemplified in the therapeutic relationship, and this would bring about positive results. For Rogers (1951), this scenario is not often achieved in the real world where society may not be able to provide this type of support. For this reason, Maslow saw that in order to achieve self-acceptance and eventually be

actualized as a person, one would have to satisfy lower level needs that included relationships with others. The theoretical perspectives on self-acceptance according to Maslow and Rogers must connect, to some degree, on interpersonal relationships with others.

Rollo May. May was another significant figure in the development of humanistic psychology that shared many of the same perspectives as Rogers and Maslow. May (1983) believed that humans could be seen as being *objects* that physically exist while also being *subjects* with the capacity to give meaning to their experiences. Freedom, then, is rooted in one's subjective experience, but also limited by many of the objective realities of being human, which he referred to as *destiny*. Destiny could be seen as accompanying many of the things focused on by behaviorism and psychoanalysis, such as one's biology, prior conditioning, and unconscious. Freedom, then, must always be understood in the context of destiny, or one's unfreedom. May believed that not accepting oneself as one is contributes to the restriction or elimination of freedom. Often, this occurs in the form of social conformity rather than self-expression and self-acceptance (Freiberg, 1999).

Similar to Rogers and Maslow, May saw the significance of interpersonal relationships and how the environment interacted with the person. While a balance with interdependence and independence is needed, May (1983) proposed that a lack of independence was a cause of neurosis. Self-acceptance becomes possible through freeing oneself from social dependence and allowing one to accept oneself as she or he is or wishes to be.

The common theme that can be seen with the early founders of humanistic psychology and has transcended into the present time is the importance of becoming an authentic adult through self-acceptance and creativity. The ultimate criticism by early humanistic psychologists, as stated by Erich Fromm, was that "man is not a thing" (Covin, 1974). There was a missing element of humanness in the current psychologies that excluded human experience and emotions. Furthermore, the paradigms of the times only saw the negative in people and tried to fix the problems. Humanistic psychology on the other hand sought to see the good in all people and exploit the goodness, creativity, and self-acceptance in each person. With the new proposed theories, people were now encouraged to seek fulfillment and accept every aspect of their person, even if there were areas that needed improvement. Positive attributes of the person, such as self-esteem, self-confidence, and capabilities, were the driving themes that gave humanistic psychology a different perspective than behaviorism and psychoanalysis.

Deepening Self-Acceptance and Self-Actualization

Reaching potential is not about summiting the pinnacle, which is a common interpretation of Maslow's (1998) hierarchy of needs. However, it is about striving to utilize the full use of one's potentials, which sometimes is best expressed in the acceptance of one's helplessness or limitations. This, too, is not a one-time

occurrence, but rather an ongoing process. Rogers (1980) maintained it takes facing an ever changing reality that demands risk. This risk comes through what Wang (2011) would call it *zhi mian*, which means to face life and oneself directly. Similarly, Xun (2000) wrote that hope for existence required one to face the potential for great suffering without the guarantee of existence beyond the moment. However, as Sittser (2004) noted, suffering can lead to a "wonderfully clarifying" life (p. 74).

In the struggle toward self-actualization one must first let go of what that looks like in order to succumb to the awe of the magnificent journey that it demands, a continuous rigor of accepting a task that cannot be completed. Self-actualization is not something to be achieved as some higher state or accomplishment, but rather a continual process. In many ways, it is preferable to talk about *the self-actualizing process* as opposed to the more commonly used *self-actualization*. Yet, for many in Western culture, this is hard to accept.

According to May (1983), this uncertainty is part of what drives individuals to cling to their myths (i.e., belief systems), because they provide a sense of structure and, with that, a sense of safety. Chah (2005) recognizes the discomfort and dissatisfaction with the impermanence of one's myths and aligns well with Rogers's (1980) beliefs that the continued process of change is one that must emerge from within to allow oneself to become "freer, more real, more deeply understanding" (p. 39). Chah (2005) spoke of this freedom in a perspective that was much larger than the intrapersonal. Beyond the philosophical conceptualization of one's aloneness in the world, few can truly lay claim to being in isolation, especially when considering one's connection to community, nature, or spiritual realms. The analogy of electrical power shows that potential energy is available but cannot be realized until it has a use, or something to be used by. Desmond Tutu described this stating that we can only realize our fullness of being human by engaging with one another (as cited in Battle, 1997).

To be human together requires vulnerability and risk, which also requires the courage to open oneself to the awareness of the negatives of life and in oneself in order to be more present and useful in one's own life as well as the lives of others (Hoffman, 2009; May, 1969; Tillich, 2000). Much like a young soldier that lies on a grenade during battle, the moment she or he has reached the ultimate potential of living for others was also the last moment of life. It is in the split second decision of accepting one's chosen role to sacrifice one's life for others that one has truly accepted one's destiny. She or he has accepted the paradoxical helplessness and power in one brief moment of self-determination (Frankl, 2006). Although it could be said that it was a shame that this individual died before realizing their true potential, one could question if one could have ever reached a greater symbolic pinnacle of self-actualization in the self and in connection to others. This action directly denied the first-level of safety. Thankfully, not all acts of intense self-actualizing through self-acceptance need result in physical death, but often one must face the symbolic death of who one was, to who one is, or is becoming.

This blurring of boundaries in hierarchical levels of self-actualization demonstrates that Maslow's pyramid was not as tidy as sometimes interpreted and can be better understood as paralleling Kübler-Ross's (1969) stages of grief and Attig's (1996) analogy of grief and the inner-connectivity of the spider web. Acceptance in

one domain is not in isolation to other domains. Laing (1967) adds to complexity of chasing actualization with recognizing the "metamorphoses that one man may go through in one day as he moves from one mode of sociality to another" (p. 97). It is difficult to accept not having the answers or a clear path when in the helping role, such as a therapist. Yet, to be an effective guide or healer one must recognize that potential is less about what one has to offer and more about offering one's presence while on the journey without fully knowing what the path looks like (Moats, Claypool, & Saxon, 2011).

Elkins (1998), speaking of the change in clients, stated, "The client knows that destruction will be associated with this process. Old ways of being, old patterns, unworkable structures and relationships may have to be relinquished" (p. 122). This change, the cycle of deconstruction and reconstruction, typically happens in an interpersonal context. To help others toward self-actualization, one must be able to accept oneself as a person in process. Bugental's (1990) believed that clinicians became good at helping others through change while being fearful of facing this process themselves.

Facing the unknown takes courage in the face of the anxiety that will be present (Tillich, 2000). May (1983) describes this as one's willingness to feel psychologically naked which could be compared to what Nietzsche (1878/1996) meant when writing, "Whoever reads dramatic poetry aloud makes discoveries about his own character" (p. 183). There is a continual revealing of oneself, whether aware of it or not. If one is open to this realization and recognizes that one cannot fully see oneself in isolation, then this vulnerability, along with the accompanying anxiety, can become part of the path of self-acceptance.

Humility in striving for self-awareness and self-acceptance is vitally important. Bugental (1987) writes of the continual process of self-actualization and warns of the clinician that believes she or he has attained the goal. For the therapist, the belief that one has reached such a level of competency may not be proof of such attainment, but rather may suggest one "has lost his artistry and become a technician and is probably dangerous to his clients" (p. 266).

Self-Actualization, Self-Acceptance, and Creativity

Maslow briefly referred to creativity in relationship to self-actualization in his early writing; however, it became more of a focus in his later writing. For Maslow, creativity was not limited to the work of artists, but instead focused on what Richards (2007) refers to as "everyday creativity" (p. 25). Maslow (1998) differentiated between *special talent creativeness* and *self-actualization creativeness*, with the latter being discussed as something that "sprang much more directly from the personality, and which showed itself widely in the ordinary affairs of life, for instance, in a certain kind of humor. It looked like a tendency to do *anything* creatively: e.g., housekeeping, teaching, etc." (p. 153).

Maslow (1998) connected this to a radical openness to experiencing life, an idea he attributed to Rogers. This willingness to deeply experience life, even the mundane in

life, was a key characteristic for self-actualizing people. Openness is a necessary starting point, but not sufficient. The openness to the experience must be connected to an acceptance of it, and to the ability to creatively respond to what life presents. Thus, the acceptance of one's experiences and oneself is a key component of self-actualization.

Self-Acceptance and Regard for Others

> And when I talk of therapy, I know what people think
> That it only makes you selfish and fall in love with your shrink
> But oh how I loved everybody else
> When I finally got to talk so much about myself (Dar Williams 1997)

This short quip from the lyrics of Dar Williams's song about psychotherapy has much wisdom and could be considered a highly succinct summary of humanistic psychology's view of self-acceptance and regard for others. According to Rogers (1961), "As a client moves toward being able to accept his own experiences he also moves toward the acceptance of the experience of others" (p. 174). Rogers (1951) believed a variety of factors, including self-acceptance, played a primary role in improved relationships with people after successful client-centered therapy.

For Rogers (1995), self-acceptance formed a basis for a number of important intrapersonal realities with interpersonal implications. As an individual accepts oneself, she or he is able to stay more open to the breadth of their experiences, thereby increasing their self-understanding. The increased self-acceptance also helps provide the confidence to speak from what one is experiencing, thereby increasing one's authenticity. Self-acceptance, too, helps one remain open to the experience of others, recognizing and experiencing them nonjudgmentally. Thus, self-acceptance can serve as the primary foundation for implementing the Rogers (1957) necessary and sufficient conditions for therapy.

Gonzalez (2002) approached the topic from a different angle, beginning with research suggesting that clients who are less accepting of others tend to have less favorable outcomes in therapy. He notes that this difficulty accepting others may be connected to deeply rooted self-rejection. This highlights the connection between acceptance of oneself and acceptance of others, and the importance of doing one's own work to accept oneself if the desire is to be able to be more unconditionally accepting of others.

Existential and Zhi Mian Perspectives

The existential branch of humanistic psychology in the United States has often been identified as beginning with the publication of *Existence* by Rollo May and colleagues in 1958. May's work was influenced by European existential

thinkers, particularly Binswanger; however, the existential psychology he helped develop in the United States had its own distinct flavor. From the beginning existential and humanistic psychology were closely related due to many shared values. The two most influential early existential voices from the United States—Rollo May and James F. T. Bugental—were important leaders in humanistic psychology that helped begin the early humanistic journals, associations, and educational programs.

Contrasting Views on Human Nature

While humanistic and existential psychology shared many core values, there were some important differences that have particular relevance for self-acceptance. Although both humanistic and existential perspectives objected to mainstream psychology's predominantly negative view of human nature and the tendency to pathologize individuals, humanistic psychology tended to take a more radical view of the nature of people as being primarily or wholly good. For the existentialists, it was still important to take seriously the potential for destructive acts and even the potential for evil (Hoffman, Warner, Gregory, & Fehl, 2011).

These contrasting views are most poignantly illustrated in a famous dialog between Rollo May and Carl Rogers in the *Journal of Humanistic Psychology* in 1982. In this exchange, Rogers (1982a, 1982b) asserts, again, that human nature is basically good and locates evil, including the human propensity toward engaging in hurtful acts, externally. It is the lack of acceptance, unjust systems, and negative influences from the world around the individual that lead individuals to engage in these negative acts.

For May (1982), it is dangerous to relegate these destructive human forces solely externally in the culture surrounding oneself. Furthermore, May aptly states that culture is made of up human beings, and if evil or destructive forces exist in culture it is because they are present in the human beings that make up culture. The key to understanding this propensity in human beings for May is the daimonic, which he defined as,

> any natural function which has the power to take over the whole person…. The daimonic can be either creative or destructive and is normally both…. The daimonic is the urge in every being to affirm itself, assert itself, perpetuate and increase itself (p. 123).

Similar to Jung's idea of the shadow, a constructive response to the daimonic begins with awareness. This awareness, then, can be integrated into one's self-understanding and directed or utilized in a creative manner. As noted by May, and further developed by Diamond (1996), the daimonic can be a source of creativity and vitality used in to help individuals achieve the height of their creative potential, but when one is not aware of the daimonic it can also be a source of destructiveness directed at oneself, others, and the world in general.

The Daimonic, Self-Awareness, and Zhi Mian

If, as May purports, awareness is essential in one's ability to channel the daimonic, which holds the potential for destructive or creative expression, then existential psychology ought rightly be positioned as a depth psychology. This suggests that there is a certain ethical as well as psychological necessity to be self-aware. When the daimonic is repressed, it becomes stronger and finds expression through other means, often outside of the individual's awareness (Diamond, 1996; Hoffman et al., 2011). Through bringing it into awareness, one is better able to direct or creatively utilize the daimonic.

Riker (1997) argued that most contemporary ethical systems were still basic upon the same assumptions from which they had been built prior to the "discovery" of the unconscious. If the unconscious has implications for one's attitude, behavior, and other actions, then this needs to be taken into account in our ethical systems. Similarly, if one accepts the unconscious, which can include the daimonic, then it is necessary to reformulate one's understanding of self-acceptance to include this recognition.

Recently, zhi mian therapy, developed by Xuefu Wang (2009, 2011), has been identified as an indigenous Chinese existential therapy. According to Wang (2011), zhi mian does not have an exact English translation, but could be understood as meaning "to face directly." However, this is best understood in a broad manner that includes facing oneself directly, facing life directly, and facing others directly.

Zhi mian at once broadens and unifies the concept of self-acceptance. It broadens through suggesting that self-acceptance should be done in the context of an honest facing of oneself and the realities of what it means to be human. It unifies theories of self-acceptance through demonstrating the necessity of self-acceptance occurring in the context of zhi mian: directly and honestly facing oneself, life, and others. To accept oneself through a distorted view of the self, or to accept oneself without honestly facing oneself, is not authentic self-acceptance; it is not an acceptance rooted in zhi mian.

Combining humanistic, existential, and zhi mian perspectives on self-acceptance, the necessity as well as complexity of this concept can be demonstrated. It is important to guard against overly simplistic conceptions of self-acceptance, as these do not guide nor sustain individuals successfully. As Diamond (1996) states,

> Integrity is unity of the personality; it implies being brutally honest with ourselves about our intentionality. Since intentionality is inextricably bound up with the daimonic, this is never an easy, nor always pleasant pursuit. But being willing to admit our daimonic tendencies—to know them consciously and to wisely oversee them—bring with it the invaluable blessing of freedom, vigor, inner strength, and self-acceptance (p. 233).

Self-Acceptance in Clinical Practice

One's view of human nature ought to influence the theoretical orientation a therapist chooses to employ. Unfortunately, in contemporary psychotherapy practice, these choices are more often made based upon the values of the mental health

system and insurance company instead of the values of the client and the therapist. Psychotherapy students are not encouraged to consider the implicit values of psychotherapy approaches or think of the value-laden implications of many of their therapeutic choices.

Humanistic therapy emerged from a theory of humans that rejected the primary premises in theories of human nature implicit in psychologies that dominated in the early twentieth century. These psychotherapies took a predominantly negative view of human nature and believed that human beings were something that needed to be controlled or contained. In these theories, to free people to express their deeper human nature would not make sense. Thus, the approach to therapy represented in Rogers's and other early humanistic psychologists necessitated a different theory of persons. The existentialists aligned with the values of humanistic psychology for the most part, including embracing the basic goodness of human nature, but took a more nuanced understanding to this goodness that recognized innate potential for evil or a more destructive aspect to human nature that co-existed with the basic goodness. This, too, has implications for psychotherapy.

In this section, we maintain that one's understanding of human nature has important implications for how psychotherapy is practiced. This is particularly true in relation to the manner in which self-acceptance is approached in humanistic therapy.

Humanistic Therapy and Self-Acceptance

According to Cain (2002),

> A fundamental value of humanistic therapists is their belief that people have the right, desire, and ability to determine what is best for them and how they will achieve it…. Humanistic therapists are, therefore, strongly inclined to engage in behaviors that are collaborative and provide optimal freedom for their clients. Conversely, they are disinclined to use methods that are directive, persuasive, or covert (p. 5).

Embedded in this therapeutic value system is a trust in the client that extends beyond the therapeutic relationship; it is a trust in the person of the client and their ability to contribute to and even direct the healing process.

Bohart and Tallman (1999) conceptualize therapy as largely enabling a self-healing process to occur. The therapist, in this perspective, is simply a participant in the healing process of the client. While some forms of therapy view the role of the therapist as having primary responsibility for change, humanistic therapy believes the clients have the primary role in the healing process. A significant amount of research supports this through the identification of client factors as being the primary predictors of successful therapeutic outcomes (Bohart & Tallman; Wampold, 2001).

According to Cain (2002), the self-actualizing tendency is the foundational premise of humanistic therapy. This is what forms the foundation for therapists to trust their clients' ability to heal themselves and make choices about the direction

of their treatment. It is not a naïve trust, but rather a trust rooted in a particular understanding of human nature.

This is the basis for Rogers's (1951, 1957) therapeutic approach. The necessary and sufficient conditions for therapy are those that help the client free their innate growth potential or self-actualizing tendency from what has been impeding this growth. The growth is inhibited by external factors, such as conditions of worth, by which individuals feel they need to meet certain criteria or conditions in order to be accepted or valued by others. Thus, for Rogers, the barriers to self-acceptance are often rooted in the perceived or actual lack of acceptance from important external figures, such as parents. For Rogers, most of what would be considered "pathology" by mainstream psychology is rooted in external sources and experiences with the surrounding world.

The journey to self-acceptance, then, is restoring what is natural for the individual. The failure of the external system to provide optimal conditions for self-acceptance is a primary root of pathology, therefore providing this acceptance, or unconditional positive regard, is critical in restoring an individual to psychological health.

Existential and Zhi Mian Therapy Approaches to Self-Acceptance

We have discussed that existential psychology can be considered a branch of humanistic psychology; however, there are some differences in the understanding of human nature. While there is agreement that human nature is basically good, existential psychology prefers to maintain a place within human nature for bad or evil. While Rogers located the source of this externally, May felt it was necessary to maintain an internal space for evil within the understanding of human beings.

We have also maintained that one's view of human nature ought to influence the way an individual conducts psychotherapy. Further, it makes sense that if May allows for a place for evil, or the daimonic, within the individual, then this should inform the therapeutic process. Indeed, this is the case. While once again the existential psychology is more similar than different from the humanistic approaches of Rogers and the client-centered therapists, much of the difference could be traced to the varied nuances in understanding human nature. At the same time, it is important to include the disclaimer that not all client-centered and existential therapists would be in agreement with Rogers and May, who we are drawing from heavily in this distinction.

May (1982) elucidates this distinction discussing research conducted by Rogers and colleagues in which several outside experts, of whom May was one, were asked to review recordings of client-centered therapists. He quotes the original study,

> Particularly striking was the observation by all the theorists that the client-centered process of therapy somehow avoids the expected and unusual patient expressions of negative, hostile, or aggressive feelings. The clear implications is that the client-centered therapist for some reason seems less open to receiving negative, hostile, or aggressive feelings (as cited in May, 1982, p. 15).

This reflection should not be surprising given the client-centered therapists view of human nature. If the positive is seen as more essential to who the person is, it is natural that the therapist will focus on reflecting these aspects of what emerges in therapy instead of the negative, hostile, or aggressive feelings. However, May notes that Rogers himself pondered if this may also be the therapist's own discomfort with the therapist's own negative, hostile, and aggressive feelings.

An illustration of these differences as related to the reflective listening process may help illuminate this distinction. A female client presents to a therapist in part to focus on anger at her husband, who she loves deeply. As the client discusses her relationship with her husband, including the feelings of love and appreciation as well as the feelings of anger and disappointment, the therapist's theory of persons is going to influence what they see and reflect. The therapist, in each moment, has many options on what could be focused on in the reflective listening process, and most likely will want to identify what is most primary to the person's core experience. If the therapist views love and appreciation as more primary, this will likely be noticed and focused on more by the therapist. However, if the therapist sees the anger and feelings of hostility as equally part of the human condition, she or he is more likely to provide reflections that include the paradoxical nature of different emotional experiences. Although this example oversimplifies the therapy process of both client-centered and existential approaches, and focuses on just one aspects of these therapies (i.e., reflective listening), it illustrates why a therapist may choose to focus on different aspects of the client's experience as more primary.

It could be argued from an existential perspective the therapist's acceptance of the client, and the client's self-acceptance, is deeper if it is inclusive of the negative, hostile, and aggressive feelings. It is easier to accept one's feeling of love and appreciation for others than to accept the more negative and conflicted aspects of the person. May (1982) goes even further to suggest that by being too nice, it may discourage clients from being more vulnerable in therapy relevant to their own feelings of hostility and aggression. He refers to a client-centered therapist from the previous study who later reflected that it was "difficult for people, because I was so nice, to tell me things that were not nice, and that it was hard for people to get angry at me" (as cited in May, p. 16).

Paradoxically, this illustration from May demonstrates that the therapist being too nice may interfere with the client being able to experience unconditional positive regard and full acceptance from the client. It may be necessary for the therapist to be nice, but also tough and open to conflict, to achieve deeper levels of interpersonal acceptance. This acceptance from the therapist, then, is key to the development of self-acceptance.

As an illustration, after a therapy demonstration with an insightful student, one of the authors (Hoffman) asked the student about their experience in the demonstration. The client/student responded saying, "It was tough, but that was okay because I could tell that you were right there with me emotionally; I could tell you cared." The client/student was able to reflect experiencing the toughness and the concern together, pushing into difficult places yet doing so with concern and empathy. It was the recognition of the therapist's acceptance that made it safe for him to push harder on the more difficult and painful issues, including providing tough feedback. The student/client stated that, in her view, this allowed a movement into greater depth.

Similarly, Tillich (1948), speaking from a religious perspective, describes acceptance without the acknowledgement of the potential for evil within the structures of one's being as a "graceless acceptance." Although Tillich was speaking from a religious perspective, this easily could be applied on the interpersonal level between human beings. As such, the acceptance of others with the provision of grace is more powerful than self-acceptance without grace. Similarly, self-acceptance that requires one to offer oneself grace or forgiveness is deeper than an acceptance of oneself rooted solely in one's basic goodness.

From a zhi mian perspective, it is necessary to face oneself, one's life, and one's relationships directly and honestly to attain authentic self-acceptance. One of the contributions of the zhi mian perspective is to recognize that each of these—facing oneself, facing one's life, and facing one's relationships—are interconnected. This encourages a holistic understanding of self-acceptance.

Contemporary Trends

In recent years, much has been written about the convergences of humanistic psychology and Eastern thought, including Buddhism (Chan, 2009; Hoffman, 2008; Hoffman, Yang, Kaklauskas, & Chan, 2009; Kaklauskas & Olson, 2009; Schneider & Tong, 2009; Yang & Hoffman, 2011). In part, these convergences emerge through awareness of the many shared ideas and values on various topics, including self-acceptance. For instance, self-compassion and self-acceptance bear similarity in their humanistic interpretations. The dialog between these ideas holds the potential to sharpen and deepening the understanding of each. Although these dialogs are beginning to occur, we only make brief reference to them here given that other chapters in the book are devoted to self-compassion and Buddhist views on self-acceptance.

Conclusion

Reading through the humanistic psychology literature, one might be surprised to find few direct references to self-acceptance. Yet, the concept is pervasively present at the implicit level and a key building block to much of humanistic theory. In particular, self-acceptance is critical in the ability to openly and empathetically engage with others. Additionally, accepting one's experiences and oneself is a critical part of the self-actualizing process. However, as we discussed, self-actualization is not a simple process. Authentic self-acceptance must entail facing life and oneself honestly (i.e., zhi mian). As life and the self are continually in flux, self-acceptance, like self-awareness, is an ongoing process. It is not something that one accomplishes, but rather it is an enduring way of living that inevitably comes with varying degrees of success at different points of one's life.

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Self-Acceptance in Buddhism and Psychotherapy

Daniel David, Steven Jay Lynn, and Lama Surya Das

Keywords REBT • Buddhism—Acceptance • Mindfulness • Meditation • Radical Acceptance • Self • Self-Acceptance and mental health • Self-esteem • Unconditional self-Acceptance • Beck's cognitive-behavior therapy • Self-evaluation

In this chapter, we will introduce the fundamentals of Buddhism to provide a framework for our discussion of the role of acceptance in conceptualizing the self, ameliorating psychopathology, and spurring new developments in the field of psychotherapy. We will use Albert Ellis's Rational Emotive Behavior Therapy (REBT) as an example of a Western psychological and psychotherapeutic approach to achieving unconditional self-acceptance, and we will examine this perspective from the vantage point of Buddhist views of the self. We focus mainly on REBT because it has advanced one of the oldest, original, most straightforward, and elaborated theories regarding the self and unconditional self-acceptance, as an alternative to self-rating (e.g., self-esteem). However, we will also describe how a growing number of psychotherapies are capitalizing on newfound interest in Buddhist approaches to cultivating acceptance and contending mindfully with maladaptive thoughts, feelings, and behaviors.

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About Buddhism

A Brief History

Buddhism emerged in the fifth century BC with the teaching of Siddhartha Gautama (563–483 BC), a prince of northern India in what is now western Nepal. The historical Buddha ("*the enlightened one*") renounced his Hindu kingdom and set forth on an extensive multi-year enlightenment quest. Visiting many of the leading teachers, sages, and masters of his day, over the years he eventually became enlightened through introspective meditation and awareness practices, leading to what he called nirvanic peace/liberation (e.g., bliss, acceptance, end of suffering). He claimed that any sentient being could become enlightened through such a path, including women, a radical point of view at that time. Thus, he was the first leader in history to educate women *en mass* and break rank with the Hindu caste system. Moreover, he was among the first leaders who advocated for protection of the earth's environment. At the age of 35, starting in the Deer Park at Sarnath outside modern Varanasi, the Buddha taught his new path—The Noble Eightfold Path—to freedom and spiritual enlightenment, which he called "The Middle Way," referring to a balanced and well-rounded, nonviolent spiritual path of gradual development and ultimate enlightenment.

Fundamentals

In this section, we briefly summarize the fundamentals of Buddhism (for more details see also Buswell, 2004; Coogan, 2003) to facilitate our analysis and discussion of Western psychology's concept of self-acceptance in relation to Buddhism. Taking into account substantial differences in Buddhist schools of thought, we will present a prototype description of Buddhism, acknowledging that it does not provide comprehensive coverage of the full range of Buddhist thinking and writings. Still, most authors would agree that there are three main branches or schools/approaches of Buddhism, which we review below, in which core concepts differ in emphasis (see also Buswell, 2004; Coogan, 2003):

1. **Theravada Buddhism** ("*the doctrine of the elders*") is the path of individual spiritual progress, purification, monasticism, renunciation and detachment, inner development, and eventual realization. It is the oldest Buddhism school arguing that each individual is responsible for his or her liberation. Known as the Southern School, it is based on the original Pali *sutras* (scriptures).
2. **The Mahayana Buddhism** ("*the great vehicle*") school is more community-oriented. It is based mainly on the Sanskrit scriptures (*sutras*) and places less emphasis, relative to the other schools, on individualism and monasticism, and more on impartiality, equanimity and compassion for all sentient beings, and

universal enlightenment. For example, Zen Buddhism, which is part of the Mahayana tradition, is well-know in the Western world for its combination between Taoism's principles (e.g., embracing life in a compassionate and a meditative way) and Buddhism's principles (e.g., path to enlightenment). Moreover, this tradition opens the door to female teachers and accommodates different pantheons of deities.

3. **The Vajrayana Buddhism** ("*the diamond vehicle*") school represents the tantric or non-dualistic approach, common in Tibet and the other Northern countries of Asia. This tradition is mainly related to Mahayana Buddhism in philosophy, but includes more practical techniques, often learned in an esoteric context from Guru-like masters, in order to provide an accelerated path to nirvana (e.g., tantric techniques, yoga practices, some shamanistic influences, enlightenment-now instructions).

Samsara ("*continuous flow*"), or the great round of becoming ("*cyclic existence*"), refers to the cycle of birth, life, death, and rebirth, which is basically seen as a cycle of suffering and dissatisfaction. Buddhism cosmology assumes various levels of existence. As related to the samsara cycle, Buddhism typically describes at least six realms of existence (or more levels in other versions—for various levels of existence see Buddhism cosmology): (1) god realm (characterized by wholesome actions, but also pride); (2) demi-god realm (characterized by generosity, but also envy/anger); (3) human realm (characterized by determined good conduct, but also desires/passion); (4) animal realm (characterized by ignorance and prejudice/stereotypes); (5) "hungry ghost" realm (characterized by lust/greed); and (6) "hell" realm (characterized by hate/aggression). These six realms of existence are also understood to represent the various states of consciousness within our own mind within this mortal life, not just substantial states or worlds of existence. Typically, the human realm is the most suitable to seek liberation because humans are not fully distracted by intense pleasures, pain, and/or ignorance, as is the case with respect to the other realms. **Karma** is the force that maintains the entire (vicious) cycle of samsara and conditioning, generated by our actions (e.g., what one does, thinks, and/or says), and perpetuating our unfulfilling habitual conditioning; although ultimately, the strongest cause of karma and negativity (suffering and delusion) is ignorance of the true state of reality, or not knowing and realizing enlightenment. From the Buddhist point of view, **Maya** is like an incomplete deity, goddess or archangel that creates and maintains the delusion by ignorance (**Mara**). **Rebirth** means that consciousness continues to evolve after death—or at least, to cycle and recycle, in the greater ecology of transpersonal being beyond any individual personal mortal existence—and becomes one of the contributing causes for the arising of a new being or incarnation; thus, the next life is not necessarily within the same realm as the previous life (e.g., human to human), due to karmic conditioning (the winds/forces of karma) and the vagaries of change and interdependence. Rebirth is different from the Hindu doctrine of reincarnation. **Reincarnation** refers to the fact that after our biological death, our self (soul) begins a new life in a new body (i.e., transmigration) that may be in various realms

of existence (e.g., gods, humans, animals—even plants in some Hindu schools, although most Buddhist and Hindu schools consider that rebirth and/or reincarnation involve only levels of existence for "conscious/sentient beings"), depending on the moral quality of the previous life's actions. In Buddhism, because there is no self (see below the **anatman** doctrine), we cannot talk about transmigration of a fixed self, and rebirth could happen, depending on karma, in any of the realms of existence described in Buddhist cosmology. Life is like a sequence of actions, reactions, and events, in which each act impacts and conditions the next while the ephemeral events following one upon another, though conditioned by what went before, are not exactly the same. Therefore, what is reborn is not a permanent individual self, but sequences of events known as "mental continuum, mental body" or "clear light mind" and karmic stream rather than personality, separate permanent soul, a solid self, memory or intellect, and so forth. Precisely in what form and how these karmically conditioned events or *samskaras* (imprints) are carried from life to life is a much-debated question even within Buddhism, as far as underlying continuum or other continuity is concerned. Lama Surya creatively speculates that the sages' intuitions regarding these immaterial but impactful *samskaras* (karmic imprints) presage by millennia the modern scientific discovery of genes and chromosomes, suggestive of significant determinants of some kind actually carried over from life to life in an evanescent world.

Thus, Buddhism asserts that our aim should be to stop the samsara cycle of endless wandering, birth after birth, and enter into the freedom and liberation of enlightenment or **nirvana**. **Nirvana** refers to what Buddha himself termed "the heart's sure release," the end of suffering and confused wandering, a boundless and unending peace of heart-mind—the heaven-like divine-ish soteriological goal of many human beings. In order to appreciate how to achieve nirvana, we should first understand the **four noble truths**.

The four noble truths of Buddhism are:

1. **Life as we know it is dissatisfying and rife with suffering**. From birth to death, life is inevitably replete with suffering, pain, grief, despair, and emotional turmoil. Suffering is not related only to earthly, day by day suffering (which might be less present and/or even absent for many people), but mainly to (1) aspects of the basic human cycle (i.e., relating birth, illness, aging, and death) and (2) to a more subtle (even implicit) and soteriological suffering resulting from failure to achieve nirvana because of our ignorance of the "way things truly are," including the fact that clinging to fleeting cravings or desires provides no lasting fulfillment.
2. **Suffering stems from craving-desires**. Suffering and dissatisfaction are the product of ignorant craving and attachment to particular thoughts, people, sensory objects, and habitual ways of acting in the world. If such attachments and desires are not satisfied, we experience suffering (e.g., pain, distress). However, if our desires are satisfied, we still suffer in the sense that we continue to strive to satisfy ignorant and non-ceasing cravings and pleasurable experiences that do not truly lead to enlightenment, allowing us to live in delusion while preventing achievement of the nirvanic state. Constantly striving for ever-more goods,

sexual pleasures, and so forth establishes a sense of loss, inferiority, and lack of acceptance of the moment and the self, whenever what is sought is not attained.

3. **The need to conquer craving-desires**. To escape suffering one must conquer ignorant craving and not cling to attachments, many of which are culturally created and reinforced (e.g., wealth, social prestige). Because all people and possessions are created and ultimately destroyed or die, any attempt to hold onto what is impermanent or evanescent will surely lead to suffering. Accepting that objects of experience wax and wane, and allowing them to come and go naturally are viable means to achieve nonattachment and ultimate liberation.
4. **Follow the path (marga)**. Following the Buddha's Noble Eightfold Path (i.e., the marga) is a reliable means to conquer insatiable desires and achieve Nirvana. This is said to happen often during many lives and experiences in various realms of existence described in Buddhist cosmology.

The EightFold Path to Enlightenment (i.e., marga) to nirvana (and enlightened living) is represented by the following three sections and eight components.

Section I is a moral one—referring to ethical self-discipline, compassion, and character development—and it comprises three components:

1. Wise speech (e.g., to not lie/tell the truth, to not use verbal abuse/speak amiably, to speak only when necessary)
2. Wise action (e.g., to not harm sentient beings/act compassionately, to not steal, to avoid sexual misconduct)
3. Wise livelihood (e.g., avoid actions and/or professions involving using weapons, prostitution, slaves, etc.)

These three components of Buddhism are similar in salient respects to the ethical and moral prescriptions promulgated by other major philosophies and/or religions (e.g., Christianity).

Section II refers to mental control—meditation and mindfulness awareness, or mind training—and it contains three components:

1. Wise effort (e.g., to use our mental resources to attain our liberation aims)
2. Wise mindfulness (e.g., moment by moment awareness and acceptance of the entirety of present reality to see things as they are; mindfulness meditation is helpful in developing this ability)
3. Wise concentration (e.g., awareness and experience of a specific aspect of reality to see the whole reality/things as they are and promote acceptance; concentrative meditation on an object or thought is helpful in developing this ability)

Acceptance in this context implies purposeful nonjudgmental awareness of moment-to-moment experience and the ability to allow experiences and cravings to come and go without clinging and attachment or aversion and resistance. Acceptance also implies tolerance of ever-changing experiences (see Williams & Lynn, 2010), whereas "mindfulness is relaxed, open, lucid, moment-to-moment present awareness. It is like a bright mirror: nonclinging, nongrasping, nonaversive, nonreactive, undistorting" (Lama Surya Das, 1997, p. 300). Traditional Buddhist meditation manuals

describe mindfulness as paying attention to what we experience, not what we would like to experience. In short, mindfulness implies friendly acceptance of the totality of our changing experience rather than avoidance or manipulation of experience.

Mindfulness is an integral part of classical Buddhist meditation practice. Lama Surya Das (1997) defines meditation as "mental discipline, an effort to train the mind through the cultivation of mindful awareness and attention to the present moment" (p. 260). Specific meditation practices to develop compassion cultivate the capacity to hold with kindness painful or intense experiences that are arising within us. Cultivating radical acceptance and equanimity, for example, in mindfulness meditative awareness practice—as an inner experimental laboratory for mind training and attitude transformation—can help us to be more mindful, objective, detached, and aware of the fact that it's not what happens to us in life, but what we make of it, that makes all the difference. Understanding and accepting this fact through inquiry and experience leads us to become master rather than victim of circumstances and conditions. Acceptance is therefore an essential aspect of mindfulness and classic Buddhist meditation practice.

Modern social scientists, neuroscientists, and therapists have documented the value of acceptance and equanimity as well as mindfulness and meditation practices. Clinicians have used meditation to treat anxiety (Roemer, Orsillo, & Salters-Pedneault, 2008), depression (Teasdale et al., 2000), chronic pain (Grossman, Tiefenthaler-Gilmer, Raysz, & Kesper, 2007), and substance abuse (Bowen et al., 2006), as well as to enhance overall health and quality of life (Grossman, Niemann, Schmidt, & Walach, 2004). Moreover, meta-analyses (Baer, 2003; Hofmann, Sawyer, Witt, & Oh, 2010) have provided support for mindfulness techniques in the treatment of a variety of problems and medical conditions.

Section III refers to wisdom—insightful wisdom and self-knowledge realization training—and has two components:

1. Wise view/right understanding, which basically means to realize and understand the Four Noble Truths, being the beginning and the end of the path to nirvana.
2. Right intention refers to the volitional aspect for our commitment to the *marga* (the path). Simply put, we can make choices in life that count. Our lives can be driven by important values that, when acted upon, represent the manifestation of our understanding of the Four Noble Truths and lead directly to inner peace, balance, and harmony, both individually and collectively.

Arhat ("*worthy one*") in *Buddhism*, in general, signifies a spiritual practitioner who has realized certain high stages of liberation/attainment. If the spiritual practitioner fails to reach the final stage in this lifetime, then he or she will, according to this doctrine, be born again, as human or nonhuman, depending on the stage of liberation the practitioner reached. Buddhism thus recognizes the inherent difficulty of achieving liberation and provides incentive for striving to the utmost to achieve a nirvanic state, while acknowledging that the process may continue for eons. The implications of the term Arhat, however, vary based on schools and traditions. In Theravada tradition Arhat means anyone who attained Nirvana, following the **bodhisattva-like path** of an enlightened existence conducive to liberation

from samsara. In the Mahayana and Vajrayana traditions, for a full liberation, an Arhat (who liberated himself/herself from various aspects—e.g., prejudice, lust, and hate—but not of the delusion) should follow the **bodhisattva path** defined differently, meaning an Arhat motivated by great compassion has postponed his or her own liberation and helps others to attain liberation (e.g., embracing the current life as an expression of the Buddha-nature, as in Zen Buddhism). In this way, the Arhat progresses even further on the path himself. Therefore, the concept of **bodhisattva** is understood differently in Theravada (i.e., enlightened existence to attain nirvana individually) and Mahayana/Vajrayana Buddhism (enlightened existence to attain nirvana together with all human beings). In Theravada Buddhism there are three types of Arhats: (1) who discovers the truth by himself and teaches others (called Buddha); (2) who discovers the truth by himself, but does not teach others (i.e., lacks the skills, does not have the necessary karma, etc.) (Paccekabuddha); and (3) who received the truth directly or indirectly from a Buddha. In Mahayana/Vajrayana Buddhism, Arhat means a spiritual practitioner liberated only partially (e.g., from prejudice, lust, and hate), but still in delusion because he or she did not follow the bodhisattva paths as defined in this school: (1) aim to become a Buddha as soon as possible and then help others to do to the same; (2) aim to become a Buddha together with other salient beings; and/or (3) aim to delay being a Buddha until all sentient beings achieve liberation. Such an Arhat will be reborn, when ready to follow the bodhisattva path, as described in Mahayana Buddhism tradition.

About Self and Self-Acceptance in Buddhism and Western Psychology

Fundamentals

According to Buddhism, an individual is a combination of five aggregates of existence, also called the **five skandhas**. These are: (1) form; (2) sensation/feelings; (3) perception/understanding; (4) mental formations and volition; and (5) consciousness. In Buddhism (like Hinduism) the word **atman** refers to self (soul). According to Buddhism, self is an illusory (**maya**) by-product of **skandhas**. A deity-like force or negative energy (ignorance) called **Mara** helped to create and maintain the self, by blessing and encouraging all self-creations (e.g., self-ratings). In aggregate and separately, the five skandhas are empty (illusory). That is, they are not inherently existing qualities of a self (**atman**)—a soul or an *ens*—because there is no separate independent self possessing them to be found (i.e., **anatman** doctrine). Although our sense organs clearly operate to form perceptions of the world and ourselves that we come to think of as "reality," our "self" is a construction based largely on our upbringing and totality of learnings from birth to the present, sculpted by interpersonally and culturally based understandings of the world and our personal existence. Because all aspects of the self, including inferences and attitudes regarding any genuine physical limitations,

are constructed by the skandhas, the self is viewed as illusory, essenceless, impermanent, contingent, and interdependent rather than as permanent, independent, or eternal. This understanding of anatman (no-permanent separate self-entity) is one of the main reforms Buddha the Teacher brought to the Indic Vedic world and culture of his time, and to this day distinguishes a nontheistic Buddhism from Hinduism and other theistic traditions

An attitude of radical acceptance and absorption in moment-to-moment experience, including the negative as well as positive ideas that flow through our minds, can promote greater flexibility and freedom from the sense of a fixed self that responds mechanically to whatever stimuli are present. A negative thought that skirts our consciousness, such as "I am bad," in this context can be seen as nothing more than a thought, rather than a permanent and indelible marker of our character. Additionally, with mindfulness practice, often in the context of meditation, meditators can achieve a breakdown of the boundary between the "self" and "other," and the "self" and the object of attention, experiencing more or less a sense of union and integration with what is perceived and felt in the moment.

Contrary to the Buddhist notion of self, the concept of self, in Western terms, refers to an organized and consistent set of beliefs ascribed to oneself, encompassing both a distinction and an integration between the self as "I"—*the subjective knower*—and the self as "Me"—*the known object* (Passer & Smith, 2009). The following terms are typically related to the concept of self (see for details Passer & Smith, 2009): *self-esteem*, which refers to the general feeling of self-worth and/or self-value; *self-efficacy* (i.e., general or task specific), which refers to the belief in one's capacity to perform various tasks; *self-confidence* referring to beliefs in one's personal worth and perceptions of the general probability of success, regardless of the task or specific to a task; and *self-concept*, referring to an individual's perception of self in relation to various domains (e.g., academic, work, family, social, physical, moral, etc.).

In Western terms, no matter how we operationalize the self-construct, it involves evaluation and a rating process. Self-evaluation (i.e., the self) appears to be strongly related to mental health and disorders (e.g., see also McCrae & Costa, 1996). Indeed, if evaluation is in the low range (e.g., low self-esteem, low self-efficacy, low self-confidence, less organized, and/or rigid self-concept), it is likely that we will experience various psychological problems (Chamberlain & Haaga, 2001a, 2001b). This link between the concept of self and psychological maladjustment supports the development of programs aiming to enhance various self-related components (e.g., self-esteem, self-confidence, self-efficacy, self-concept). However, an excessively high level of these components is also associated with various psychological problems (e.g., mania, perfectionism, vulnerability to criticisms, narcissism, high aggressiveness; Chamberlain & Haaga, 2001a, 2001b).

Thus, conceptualizing mental health, in Western terms, in relation to an immutable or mostly fixed self is risky business, because the self-rating process itself seems to relate to, if not create, vulnerability to mental disorders (e.g., if one habitually makes positive ratings, when experiencing the so-called positive events, the same person will make negative ratings, when facing the so-called negative events). According to

a Buddhist perspective, the simple act of labeling an event "positive" or "negative" can take away from direct contact with and immersion in the experience of the event. Thus Buddhists consider everything as relative, and subject to conceptual limitations superimposed upon (so-called) reality itself—all lacking in ultimate essence or fixed entityness, being found to be, under careful examination and continuous scrutiny, interdependent, impermanent, contingent upon other factors, and so forth.

Experiences construed as negative (e.g., being near a dog if a person is phobic) may promote knee-jerk avoidance, thereby promoting psychological and behavioral rigidity and negative reinforcement of feared yet harmless situations (e.g., being attacked by a tame dog). Whether avoiding a harmless animal or a specific location due to baseless worry about a terrorist attack, the universal experience of avoiding experiences we label as negative or harmful to the self (i.e., experiential avoidance) is both the antithesis of acceptance and a "core psychological diathesis underlying the development and maintenance of several forms of psychopathology… and human suffering in general" (Karekla, Forsyth, & Kelly, 2004, p. 725–726). Scientists have determined that inhibiting thoughts, feelings, memories, and other internal events, including negative or distressing contents of consciousness, increases the probability that the suppressed events will recur (Dalgleish & Yiend, 2006; Hayes & Wilson, 2003; Polivy & Herman, 1987; Strauss, Doyle, & Kreipe, 1994; Wegner, Schneider, Carter, & White, 1987). Indeed, avoidance and suppression of experiences construed as negative contribute to depression (see Ellis & Robb, 1994; MacLeod, Bjork, & Bjork, 2003; Teasdale, Segal, & Williams, 1995), anxiety (Amir, Coles, Brigidi, & Foa, 2001), a poorer quality of life (see Hayes & Wilson, 2003), and alexithymia, neuroticism, and absent-mindedness (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006). If we fear many situations with no ability to harm us, expend energy in the unsuccessful attempt to completely expunge unwelcome thoughts that lack the capacity to hurt others or ourselves, and avoid any and all risks, we have little chance of living a rich or enlightened life, as per the EightFold Way. Moreover, the ability to accept and tolerate all thoughts and feelings, regardless of their emotional valence, permits a more objective assessment of how to respond in a variety of potentially threatening and nonthreatening situations. Surya Das puts forward the notion that "…until we accept a diagnose of a problem, for example, or one of our own shortcomings and limitations—we cannot begin an effective therapeutical cure. Therefore, acceptance should not be confused with mere complacence or indifference. Acceptance has its own powerful transformational magic" (Das: New Dharma Talks, 2011—unpublished).

Rational Emotive Behavior Therapy Approach to the "Self" and Self-acceptance

Some psychological models and research pertaining to the self reify what Buddhists consider to be an illusory construction. Indeed, many psychotherapies, including some cognitive-behavioral ones (e.g., Beck's cognitive therapy; Beck, 1995), still

promote the idea of enhancing self-esteem, which inherently involves the danger of self-rating and evoking cognitive vulnerability and avoiding situations in which self-esteem is under threat. Moreover, the data about the effect of such programs for improving self-esteem is mixed (see Dawes, 1996).

We now turn our attention to Rational Emotive Behavior Therapy (REBT)—the first form of cognitive-behavioral therapies—as a specific example of an influential approach geared toward diminishing pervasive and oppressive self-evaluation. REBT (see Ellis, 2005) adopts an innovative and somewhat atypical approach to the self and emphasizes unconditional self-acceptance as an antidote to self-esteem (i.e., self-rating) more so than many other psychological perspectives and interventions. Indeed, although unconditional self-acceptance was also discussed in other major theories (see also Rogers, 1953), it was not conceptualized as an antidote to self-esteem. REBT's solution to the problem of self-rating—the core constituent of self—is pragmatic and strives to cultivate *unconditional self-acceptance* (USA), meaning that "the individual fully and unconditionally accepts himself whether or not he behaves intelligently, correctly, or competently and whether or not other people approve, respect, or love him" (Ellis, 1977, p. 101). Ellis and Robb (1994) contend, "unconditional self-acceptance is crucial to solid emotional and behavioral health" (p. 91), namely "getting" and "staying better," rather than only "feeling better."

Ellis and Robb's (1994) claim regarding the virtues of acceptance is entirely consistent with a slew of studies (see Williams & Lynn, 2010) that provide evidence for the positive effects of acceptance related to: (a) an expanded range of available experiences (McCurry & Schmidt, 1994); (b) an increased potential for productive action (Cordova & Kohlenberg, 1994); (c) increased compassion and reduced blaming of others (Greenberg, 1994); (d) increased compliance, serenity, and reasonableness, and decreased negative emotions (McCurry & Schmidt, 1994); (e) reduced posttraumatic stress symptoms following the terrorism attacks of 9/11 (Silver, Holman, McIntosh, Poulin, & Gil-Rivas, 2002); (f) reduced depression among mothers of children subject to bone marrow transplantation (Manne et al., 2003), and (e) a variety of positive therapeutic outcomes (Greenberg & Safran, 1989).

REBT's construct of unconditional self-acceptance is a part of a more complex acceptance construct, as conceptualized by REBT (see for details David, Lynn, & Ellis, 2010). Indeed, REBT considers that at the core of our mental health lies the rational formulation of our desires. Rational formulation of our desires/goals involves three components: flexible (i.e., nondemanding and non-absolutist) preference, motivational relevance, and acceptance (e.g.,"I would prefer to get a good grade and I will do my best to get it, but I can accept that sometimes things do not happen the way I want them to happen"). If various activating events (e.g., getting a good grade) fit (motivational congruence) our desires formulated rationally, we experience functional positive feelings. If activating events (e.g., getting a bad grade) do not fit (motivational incongruence) our desires formulated rationally, a second wave of informational processing (i.e., rational cognitions/beliefs) follows: (1) frustration tolerance (e.g., "I can stand getting a bad grade, even if I do not like it"); (2) badness (e.g., "It is very bad getting a bad grade and I do not like it, but this is not awful, the end of the word"); and/or (3) unconditional acceptance (e.g., "Getting a

bad grade does not make me a bad person; I can work to improve my performance"), generating functional negative consequences (e.g., unhealthy feelings, maladaptive behaviors). At the core of mental problems lies an irrational formulation of our desires. An irrational formulation of our desires/goals involves three components: demandingness (rigid/absolutistic thinking), motivational relevance, and nonacceptance (e.g., "I must get a good grade, I do my best to get it, and I cannot conceive not getting it"); thus, if one eliminates demandingness, the acceptance of self, others, and world comes naturally. If activating events (e.g., getting a good grade) fit our desires formulated irrationally (motivational congruence), we will experience dysfunctional positive feelings: they are dysfunctional, because they reinforce their underlying irrational beliefs. If activating events (e.g., getting a bad grade) do not fit (motivational incongruence) our desires formulated irrationally, a second wave of information processing follows (i.e., irrational cognition/beliefs): (1) frustration intolerance (e.g., "I can't stand getting a bad grade"); (2) awfulizing/catastrophizing (e.g., "It is awful getting a bad grade, the worst thing that could happen to me"); and/or (3) global evaluation (e.g., "I am a stupid person, because I got a bad grade"), generating dysfunctional consequences (e.g., unhealthy feelings, maladaptive behaviors).

We believe that REBT has a place in the larger contemporary movement within the field of psychotherapy, described as the "third wave" of behavioral and cognitive approaches (Hayes, 2004; Hayes, Follette, & Linehan, 2004). This third wave of acceptance and mindfulness-based approaches, inspired, in part by Buddhism, has expanded in the past two decades or so and include Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999), Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2002), Dialectical Behavior Therapy (Linehan, 1993), and Mindfulness-Based Stress Reduction (Kabat-Zinn, 1990/2005; Kabat-Zinn, 2003).

Indeed, REBT techniques encompass mindfulness in the form of Mindfulness-Based REBT (see Whitfield, 2006). However, in REBT mindfulness can be conceptualized either as a technique for symptom relief (e.g., reducing anxious symptoms without changing their underlying cognitions) engendering "feeling better," and/or as a cognitive restructuring technique (e.g., changing irrational beliefs into rational beliefs with the ultimate aim of changing dysfunctional consequences into functional consequences), generating "feeling better," "getting better," and "staying better." Additionally, acceptance is part of REBT's core construct of psychological flexibility (i.e., flexible preferences/flexible thinking), as discussed above.

Differences in potential mechanisms aside, all of the third-wave approaches valorize acceptance and eschew avoidance of distressing thoughts and emotions. For example, mindfulness-based cognitive therapy (MBCT; Segal et al., 2002), which teaches acceptance and distancing of negative thoughts from the self (i.e., a negative self-judgment is just a thought and not a valid marker of self-worth), produces reductions in the average rate of relapse in depression on the order of 50 % (Hofmann et al., 2010; Piet & Hougaard, 2011). According to Davis and Hayes 's (2011) review, acceptance and mindfulness can elicit positive emotions, promote greater response flexibility, decrease reactivity to thoughts and emotions, and minimize negative affect and rumination.

Similarly, according to REBT, it is most advantageous to accept the self unconditionally and to not evaluate the self (the idea is also applicable and extends to the self of others and to life in general). Indeed, "self" is a complex reality/construct that is too difficult, if not impossible, to evaluate globally. Lama Suryas Das says that "…self is a mere congeries of impermanent, evanescent, ownerless whirling forces, and therefore need not be reified or over-valorized as the true center of our existence, significant, as the fully functioning individuated healthy adult self is ('relative self,' as we call it in Buddhist psychology)" (Das: New Dharma Talks, 2011—unpublished). A global evaluation of the self is an irrational belief that is based on the logical error of overgeneralization. Whereas we can better evaluate specific behaviors, emotions, and cognitions (and even self-concept domains), we cannot evaluate our total or global "self," without committing overgeneralizations and then reifying as an object what is more akin to a contingent process.

Recently, we (DD) have proposed a distinction between philosophical unconditional self-acceptance (phiUSA) and psychological unconditional self-acceptance (psyUSA). Whereas philosophical self-acceptance is related to Ellis's classical proposal described above (Ellis, 1994), psychological self-acceptance is related more to specific domains of self-concept and specific behaviors that people typically rate or evaluate, rather than to the global construal or construction of the self. For example, globally evaluating your "motherhood self-concept" (e.g., "I am a bad mother"), but still accepting yourself (e.g., "I accept myself even though I can be a bad mother at times and not meet all my child's needs, and I can work to improve my behaviors"), would be an example of psychological unconditional self-acceptance. Indeed, Albert Ellis originally proposed philosophical unconditional self-acceptance (e.g., "I accept myself as a person and do not evaluate my personal worth, and I can work to improve my behaviors") as an antidote to global ratings of self-esteem (e.g., "I am a bad/worthless person"). In a parallel way, psychological unconditional self-acceptance (e.g., "I accept myself even though I can be a bad mother at times and not meet all my child's needs, and I can work to improve my behaviors") is proposed as an antidote to self-esteem related to a specific domain (e.g., "I am a bad mother").

This distinction is in line with both the REBT idea of accepting, rather than challenging, distorted inferences/descriptions (e.g., "bad mother") and with similar provisos of Acceptance and Commitment Therapy (see for details, Ellis, 2005). Of course, someone could argue that philosophical unconditional acceptance (e.g., "I accept myself as a person and do not evaluate my personal worth, and I can work to improve my behaviors") could also counteract specific self-esteem concerns (e.g., "I am a bad mother"). We believe this is an empirical issue at the present time, and that future research and theory should take into account the following three observations:

1. *Ecological criterion*: People have a natural tendency to evaluate themselves, even if they are sometimes illogical and overgeneralize the negative in doing so. Allowing in psychotherapy evaluations in the form of self-concept domains and behaviors (e.g., psychological unconditional self-evaluation) would conform to this natural tendency.

2. *Pragmatical criterion*: Because self-rating is a seemingly automatic, natural activity of human beings, in clinical practice it can be difficult to teach clients philosophical unconditional self-acceptance. An alternative is to accept largely inevitable self-rating in relation to various self-concept domains, even if it still involves errors of overgeneralization, and then teach clients psychological unconditional self-acceptance.
3. *Progressive research criterion*: Whereas positive changes in global self-esteem account for positive outcomes in psychotherapy, accounting for self-esteem in specific domains adds to the prediction of various psychological outcomes, beyond global self-esteem (see Dutton & Brown, 1997; Marsh, 1990; Roberts & Gotlib, 1997).

Several studies using measures of phiUSA, as defined in REBT, support REBT's perspective. For example, in a nonclinical adult sample, phiUSA was positively correlated with state mood after imaginal exposure to negative activated events and negatively correlated with anxiety symptoms and with narcissism (Chamberlain & Haaga, 2001a, 2001b). Moreover, participants with high phiUSA displayed low proneness to depression and low self-esteem lability; they also were more objective in evaluating their performance (i.e., public speaking) and were less predisposed to denigrate people who provided negative feedback related to their speech performance (Chamberlain & Haaga, 2001a, 2001b).

Relationship Between Buddhist and REBT's View of Unconditional Self-Acceptance

As we mentioned before, REBT (see Ellis, 2005) has advanced one of the most elaborated theories regarding the self and unconditional self-acceptance, as an alternative to self-rating (e.g., self-esteem). However, the connection between REBT theory focusing on unconditional self-acceptance and the Buddhist tradition has not been well elucidated to date (but see Christopher, 2003).

According to the Buddhist perspective, the illusion (*maya*) of self created by *skandas* based on ignorance, craving (for existence-security, for example), and confusion can be considered a vulnerability factor or precondition to attachment and desires. More precisely, "I" and "Me" are conceptualized as not real, integral entities (self), but rather illusory constructions (*maya*) that carry forward personal narratives, memories, roles, and a sense of identity. As we mentioned earlier, the concept of no-self or illusory self is called *anatman* in the Buddhist tradition. Thus, Buddhism proposes a radical doctrine, as an alternative to self-evaluation, in which we recognize that self is just an illusion; therefore, we can theoretically renounce the tendency to evaluate and then over-valorize the self.

Indeed, according to the Buddhist perspective, it is possible to transcend self-evaluation and experiential avoidance entirely by practicing radical acceptance. Lama Surya Das argues that (unconditional) acceptance has its own transformational magic.

It is not at all identical to, nor synonymous with, complacence and indifference (see also Lama Surya Das, 1997). Much like Albert Ellis, Buddhist mindfulness teacher and therapist Tara Brach (see Brach, 2000) observes that self-aversion (and unworthiness) is one of the most difficult challenges to Westerners today because it causes severe suffering. Therefore, Tara Brach argues in her teachings that radical self-acceptance is the main path to break and escape out of this "emotional prison," so we can discover and experience the freedom that comes with unconditional acceptance (i.e., true appreciation) of both ourselves and others. Radical acceptance is thus viewed by Tara Brach as the gateway to healing sufferings and for spiritual transformation. If we are able to face our experience with radical acceptance, Tara Brach claims it is possible to discover the wholeness, wisdom, joy, and love that are our deepest nature (see also Linehan, 1994; Robins, Schmidt, & Linehan, 2004). Lao Tsu of China, whom Confucius said was like a phoenix, said it ages ago, in his classic wisdom tome known as *Tao Te Ching* (The Way and its Power): "When you accept yourself, the whole world accepts you."

It is, perhaps, important to note here that a healthy and individuated self is neither denied nor controverted by Buddha's teachings; rather, it is the illusory (*maya*) notion of the permanence of the self that the *anatman* teaching is directed at. Selfishness, self-centeredness, and the co-emergent insatiable craving and clingings based on habitual ignorance and conditioning—for example, about where true happiness, fulfillment, and contentment actually reside—is the vital issue to be addressed, according to Buddhism. The Arhat's pure values and virtues—qualities to be developed by aspiring awakeners or enlightenment seekers on the path to liberation—include spiritual detachment, nonattachment (nonclinging), renunciation, equanimity, acceptance, patient forbearance, and impartial altruistic treatment of all beings without exception. Additionally, in the *Bodhisattva doctrine* of the Mahayana School we presented above, personal values and the individuated self should be accompanied by a strong sense of "warm empathic compassion" for others and socially oriented actions (i.e., caritas, self-giving, "self-renunciation" and its natural concomitant unstinting generosity), expressed in community engagement motivated by the goal of attaining nirvana together with all human beings in this world and in the next.

Compared with Buddhist teachings, the Rational Emotive Behavioral Therapy (REBT) model of self is both similar and different yet complementary. Let us examine this model at various levels, as follows. Indeed, any scientific model can be analyzed at three levels: (1) paradigmatic (i.e., philosophical assumptions); (2) theory; and (3) technical implications.

At the paradigmatic level, there are various philosophical positions regarding self. A realism position (e.g., objectivity) would hold that self refers and/or corresponds to a psychological ontological reality. In contrast, an anti-realism position would assume that self does not refer and/or correspond to a psychological ontological reality; rather, it contends that (1) psychological ontological reality of self does not exist independently of our language/concepts (e.g., a constructivism position) and/or (2) our language/concepts cannot capture the psychological

ontological really of "self" as it truly is (e.g., various forms of idealism). A middle way position is represented by pragmatism, which argues that self has a psychological ontological reality, but it is constructed and emerges as a by-product of interactions among a community of people; thus, the community conspires to create a constructed psychological ontological reality of the self. A more atypical position (see functional contextualism) is that we should ignore the issue of ontology (e.g., here the ontology of self) altogether and focus, instead, on the development of scientifically and empirically based theories and models to facilitate understanding the self.

Concerning self at the philosophical level, the REBT position is distinctly mixed. Some clinicians and researchers would embrace realism and/or a pragmatic approach. Others, more behaviorally oriented—and REBT could be seen as a part of behavioral tradition—would say that REBT should put the philosophical issue of the "self" in parentheses and not explore it in detail. Finally, some clinicians and researchers could embrace an anti-realism approach. At this level, the Buddhism perspective on "self" is not in opposition to REBT, unless REBT assumes a realism position.

At the theoretical level, the REBT theory of self proposes that self is part and parcel of our psychological reality that can be investigated scientifically (e.g., hypothesis testing). However, according to REBT, the best way to deal with self in clinical practice is to accept it unconditionally (philosophically and/or psychologically) and to not evaluate it at all. Rather, as we have noted, we can evaluate specific behaviors, emotions, cognitions, and even domains of self-concept, but not our total self. If we do not focus on self in clinical contexts, in REBT terms it could mean that (1) we accept its psychological ontological existence (be it objective and/or constructed), but do not rate it; (2) we accept its existence only as an illusionary construction and therefore, it makes no sense to rate it; and/or (3) we consider the problem of its existence as an unimportant one. Positions 1 and 3 would support a weak connection between REBT and Buddhism, with practices common to Buddhism and REBT (e.g., ignoring/avoiding the self-rating process), but not common theories (e.g., the philosophical/theoretical status of self). However, position 2 could support a strong connection between REBT and Buddhism, with both shared practices and theories. Thus, REBT is not in opposition to Buddhist tradition, although their connection may vary in terms of strong vs. weak, as specified above.

Note that unlike REBT, other cognitive-behavioral therapies (CBTs) (e.g., Beck's cognitive therapy; Beck, 1995) promote the importance of self-esteem, which involves self-evaluation. Thus, according to cognitive therapy, positive self-esteem could enhance mental health, whereas negative self-esteem could be detrimental to mental health. However, if a client evaluates the "self"—be it positive and/or negative—it means the client assumes its existence (ontologically and/or constructed) and works within this framework. Even if its existence is considered to be a constructed one, because clients jump into or reify this construction (i.e., illusion—in Buddhism terms), this perspective is clearly in opposition to Buddhist tradition.

At the technical/pragmatic level, REBT is interested in developing techniques that could help people to renounce self-evaluation (i.e., self-esteem) and focus on unconditional self-acceptance. At this level, Buddhist techniques could be and are already easily assimilated into classical REBT (e.g., concentrative and/or mindfulness meditation), even if the correspondence between REBT and Buddhism is not one-to-one at a paradigmatic and/or theoretical level. Moreover, mindfulness-based REBT (see Whitfield, 2006) is already a common practice among REBT therapists, paralleling the development of other mindfulness-based approaches, such as MBCT. Practically, many techniques included in the Buddhism's *marga* (the path) could be integrated in REBT intervention packages, once they are adapted to the cultural background of each client. Having said that, we think that the reverse could also be true. For example, the REBT distinction between desires formulated rigidly (e.g., "I must absolutely get the position I want, otherwise I can not conceive of living") and desires formulated flexibly (e.g., "I would like to get the position and I do my best, but I accept that sometimes things do not happen the way I want") (see for details David et al., 2010) could be related to the third noble truth of Buddhism. More precisely, rather than renouncing craving-desires completely, which could be very difficult to accomplish, we can establish first a more rational formulation of them, in terms of flexible and nonattaching preferences (accompanied by the acceptance of not meeting your desires formulated rationally), as an intermediate, perhaps more pragmatic, step before complete renunciation.

Conclusions

An interesting article by Christopher (2003), "Albert Ellis and the Buddha: Rational Soul Mates? A Comparison of Rational Emotive Behavior Therapy (REBT) and Zen Buddhism" explored the relations between REBT and Buddhism at a general level (see for details Christopher, 2003). In this chapter, we have focused mainly only on one core component of REBT (and other psychotherapies), namely unconditional self-acceptance.

Both REBT and Buddhism consider judgmental self-evaluation to be detrimental. According to REBT, self-evaluation negatively impacts mental health. Whereas improved self-esteem could support "feeling better," it does not support "getting and staying better," because self-evaluation is a vulnerability factor for poor mental health. According to the tenets of Buddhism, self-evaluation is detrimental in terms of liberation from *samsara* because "self" and self-evaluation encourage attachment and desires; in fact, they are themselves forms of attachment.

The conceptualization of self and self-evaluation is slightly different in Buddhism and REBT. In Buddhism "self" is an illusion, and we can liberate ourselves from this illusion by understanding the Four Noble Truths and following the *marga* (the path). In REBT the nature of self cannot be narrowly or operationally defined easily, because it possesses components related to both behavioral and cognitive traditions (e.g., by-product of our mind—as per the behavioral tradition, versus a construct

referring to a real psychological phenomenon—as per the cognitive tradition); therefore, the REBT theoretical and practical solution is to avoid self-evaluation by focusing on the specific evaluation of our behaviors, cognitions, emotions, and self-concept domains. Whereas avoiding self-rating in REBT is a goal compatible with Buddhism, the evaluation of specific domains of self in REBT is clearly not in accordance with Buddhist teachings (for Buddhism, these specifics are like illusions themselves, merely concepts and/or projections and interpretations further binding and attaching us to the illusionary world conditioning of samsara). Despite these conceptual differences, the techniques used in Buddhism to circumvent self-evaluation and self-clinging (e.g., meditation) could be and often are fully assimilated in REBT procedures (e.g., mindfulness techniques).

To conclude, both REBT and Buddhism agree that self-evaluation is detrimental. However, they propose alternative conceptualizations to contend with self-evaluation that are potentially complimentary. In the case of Buddhism, self is thought to be an illusion, whereas in the case of REBT, unconditional self-acceptance replaces self-evaluation at the global level. For practical reasons, the techniques proposed by Buddhism's *marga* (the path) and REBT (e.g., cognitive restructuring, behavioral modification, emotive techniques) to contend with self-evaluation could be easily incorporated in both traditions. For example, in REBT, mindfulness meditation is conceptualized as an emotive technique (e.g., using experiential techniques to change irrational/dysfunctional cognitions), and in Buddhist practice, flexible formulation of desires could be used to reduce the attachment/craving component of desires, as an intermediate step before complete renunciation of desires and freedom from attachments to cravings. Clearly, both perspectives, alone and in tandem, can enrich people who seek self-acceptance, love and self-compassion, inner pace, and vibrant living.

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Self-Acceptance and Christian Theology

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In this chapter we explore *self-acceptance* in Christianity and rational emotive behavior therapy (REBT). Our thesis is that *the self* and self-acceptance as evident in fundamental tenets of Christianity and as conceptualized in REBT overlap or parallel one another sufficiently that they resonate. We will show that this resonance allows use of Christian scripture in therapy to help people attain greater self-acceptance. We chose REBT's approach to self-acceptance because REBT theory is specific about the nature of the self and self-acceptance, because REBT theory is clear about the function of self-acceptance in emotion and behavior, and because REBT offers a well-defined method for helping clients deal with emotional problems that arise because of conditional self-acceptance (CSA). Helping clients attain unconditional self-acceptance (USA) is one of REBT's fundamental goals.

Our chapter has three main divisions. First, we provide a brief, historical overview of Christianity to establish the breadth of Christianity's influence and provide a beginning point for learning more about Christian belief systems and traditions. We believe that understanding client religious beliefs can facilitate therapy. Secondly, we address the self and self-acceptance. We present our definitions and conceptualizations of the self and of self-acceptance and present a sampling of how the self and self-acceptance have been addressed in Christian theology. Finally, we illustrate how we believe CSA and USA affect emotion and behavior and provide examples using Christian scripture to challenge CSA and encourage USA.

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Mixing REBT and Christianity may seem ironic, given that REBT was developed by Albert Ellis, one of psychology's most notorious atheists (see, Ellis, 1983; Johnson, 1994). Despite this atheistic genesis, the benefits of integrating religion with REBT have been reported for at least 25 years (Ellis, 1994a, 2004; Johnson, 1992, 1993, 1994, 2001; Nielsen, 1994, 2001, 2004; Nielsen & Ellis, 1994; Nielsen, Johnson, & Ellis, 2001; Young, 1988). Controlled outcome studies demonstrate that integrating Christian scripture with REBT and other forms of cognitive behavior therapy can support and improve treatment outcomes (Johnson, DeVries, Ridley, Pettorini, & Peterson, 1994; Johnson & Ridley, 1992; Propst, 1980a, 1980b; Propst, Ostrom, Watkins, Dean, & Mashburn, 1992).

Christianity

Christianity is the world's predominant religion; 33 % of the world's population are Christians (Association of Religion Data Archives, 2012; Pew Research Center, 2011). Christians are a distinct majority in North and South America (86 %), Europe (76.2 %), and sub-Saharan Africa (62.7 %), but a distinct minority in Asia (7 %) and the Middle East and North Africa (3.8 %). The 10 largest Christian populations are in the USA (247 million, 79.5 % of the population), Brazil (176 million, 90.2 %), Mexico (108 million, 95 %), Russia (105 million, 73.6 %), the Philippines (87 million, 93.1 %), Nigeria (81 million, 50.8 %), China (67 million, 5 %), the Democratic Republic of the Congo (63 million, 95.7 %), Germany (58 million, 70.8 %), and Ethiopia (53 million, 63.4 %). A majority of Christians are Roman Catholics (50.1 %), next Protestants (37 %), then Orthodox Catholics (11.9 %), followed by relatively small numbers of adherents in other Christian denominations, including Restorationists such as the Church of Jesus Christ of Latter-day Saints, Jehovah's Witnesses, and Seventh-Day Adventists. Though relatively small, the Church of Jesus Christ of Latter-day Saints and Jehovah's Witnesses are the fastest growing Christian denominations (Pew Research Center, 2011).

Catholicism

Catholic comes from καθολικός, "catolikos," for universal. Catholic history begins with Jesus Christ giving priesthood authority to the apostles. Roman Catholics believe that Peter was the first of its 265 popes (see Matt 16:18,19). Tradition recounts establishment of Orthodox Catholic patriarchies by other of the original apostles; for example, the Russian Orthodox Church by the apostle Andrew during his proselyting along the Black Sea and Caspian Sea, the Malankara Orthodox Syrian Church by Thomas when he proselyted in India, the Armenian Apostolic Church by Bartholomew and Thaddeus in Armenia.

Christians worshiped with and proselyted Jews until Peter was told to also share the Gospel with Gentiles (see Acts 10 & 11). Roman civil order supported this proselyting, and the Church grew most rapidly among Gentiles in Roman cities. Christians fled Jerusalem and separated themselves from Jews during three Jewish-Roman rebellions in 66–73 CE, 115–117 CE, and 132–135 CE. Authority passed from the apostles to successor bishops in larger Imperial cities. By tradition, Peter's successor was Linus, Bishop of Rome, and the second pope.

Christians refused to join in the pagan festivals of Rome and in emperor worship, triggering periodic, but inconsistent persecutions, including spontaneous, popular attacks by angered Roman citizens, persecutions organized by local magistrates, and periodic Imperial proscriptions. Christianity continued to grow, sometimes in secret, sometimes openly, and its political importance increased with its growth.

In 312, guided by a dream, Constantine had the overlapping Greek letters χ, chi and ρ, rho—a symbol of Christ—placed on his troops', shields as a battle standard. He subsequently won military victory over his rival, Maxentius, gaining control of Rome. Though he did not accept Christian baptism until just before his death, 24 years later, Constantine liberalized laws about religious worship, returned confiscated Christian property, and took an immediate role in Christian affairs, including working to resolve doctrinal disputes. He organized the First Council of Nicaea, an ecumenical (οίκουμένη, "the entire world") council of bishops which produced the Nicene Creed, the foundation of the current creeds of Catholicism and mainline Protestantism. Below is a current, widely endorsed ecumenical version of the Creed:

> We believe in one God, the Father, the Almighty, maker of heaven and earth, of all that is, seen and unseen. We believe in one Lord, Jesus Christ, the only Son of God, eternally begotten of the Father, God from God, Light from Light, true God from true God, begotten, not made, of one Being with the Father; through him all things were made. For us and for our salvation he came down from heaven, was incarnate of the Holy Spirit and the Virgin Mary and became truly human. For our sake he was crucified under Pontius Pilate; he suffered death and was buried. On the third day he rose again in accordance with the Scriptures; he ascended into heaven and is seated at the right hand of the Father. He will come again in glory to judge the living and the dead, and his kingdom will have no end. We believe in the Holy Spirit, the Lord, the giver of life, who proceeds from the Father and the Son, who with the Father and the Son is worshiped and glorified, who has spoken through the prophets. We believe in one holy catholic and apostolic Church. We acknowledge one baptism for the forgiveness of sins. We look for the resurrection of the dead, and the life of the world to come. Amen (English Language Liturgical Consultation, 1988).

Emperors, not bishops, organized the next six ecumenical councils that were called to resolve theological questions, stabilize doctrine, and unify Christianity. Oriental Orthodoxy recognizes the first two or three of these councils, Greek Orthodoxy recognizes the first seven, the Roman Catholic Church recognizes 21 councils, the last convened in 1962 (Allison & Grudem, 2011).

Christians regard many of their behaviors as sinful, making the creedal statement about "baptism for the forgiveness of sins," an important element in self-acceptance. CSA is often associated with an exaggerated sense of sinfulness. A lack of self-acceptance and the ensuing sense of sinfulness often interact. CSA may create feelings of shame and these feelings can suggest that sins have not been forgiven.

Christianity became increasingly integrated in Imperial politics. When it became Rome's official religion, disputes about ecclesiastical authority, theology, and political conflict were integral in both the division of Catholicism into Eastern and Oriental Orthodox, Greek Orthodox, and Roman Catholic Churches, and in the Empire's ultimate disintegration. European politics and the Protestant Reformation were also intertwined. The entanglement of religious and political conflict certainly continue to the present, though the rise of modern democratic governments, including constitutional monarchies in Europe, dramatically decreased the political importance of religion by the last half of the twentieth century (see Grant, 1970; Urban, 1986).

Roman Catholicism. The decline of the Roman Empire is generally considered to have begun when the Empire grew too large to be governed by one emperor. The Empire split into Eastern and Western halves, then the Western Empire was overrun by warring Central European tribes. Rome's governing and administrative structures failed and its territories passed into the hands of opponents and successor countries. The ecclesiastical structure of the Roman Church in the west, including the Church's distributed priesthood, remained largely intact. Catholic priesthood and holy orders, especially abbots, became influential in preserving the learning of Greece and Rome and in maintaining a religious presence in former Roman territories. The educational schools associated with abbeys, convents, and cathedrals establish a pattern of learning, often emphasizing scholasticism, which grew into Europe's universities wherein learning and writing proceeded in Latin through the end of the seventeenth century. Isaac Newton, for example, wrote his scientific works in Latin.

The kings that replaced Roman rule often adopted Christian belief as their official religion. The most important of these subsequent realms was the Holy Roman Empire, whose first king, Charlemagne, was crowned emperor of Rome in 800, by Pope Leo III. Conquest and colonization of Central and South America and parts of Asia by Spain and Portugal, whose kings counted themselves descendants of the Holy Roman Emperor, created new realms for the Roman Catholic Church, making it the largest Christian Church.

Fundamental in Roman Catholic theology are the Ten Commandments, the infallibility of the Pope when speaking ex cathedra ("from the chair," meaning for the Church), the Seven Sacraments of the Church, and the Apostolic Creed, an extension of the Nicene Creed printed above. The seven sacraments are baptism, confirmation, holy communion, penance, anointing of the sick, holy orders or priesthood, and marriage. The sacraments are seen as a means by which mankind receives God's blessings, allowing spiritual communion with God. Roman Catholic canon law includes 1,752 separate rules, revealing the Church's theological specificity and administrative complexity.

Compliance with commandments and sacraments, especially baptism and penance, keep humans in communion with God, until eventually, at death, communion with God can continue. To continue to commune with God is heaven. A life ending in noncompliance yields separation from God, which becomes permanent with death and Jesus Christ's judgment; separation from God is hell. Those whose sins

are forgiven, but who need further penance, meaning purifying punishment, spend time in purgatory, from which they may eventually enter heaven. An active, structured approach to psychotherapeutic change may seem straight-forward and natural to a Roman Catholic, given the Church's detailed, precise theology and canon law.

Oriental Orthodoxy. Orthodox comes from ορθος, orthos, for right, and δοχα, doxa, for belief: right belief or right thinking. A dispute about the relationship between Jesus Christ's human and divine natures created Catholicism's first permanent division. By 451, African, Syrian, and Armenian bishops rejected and separated themselves from the larger Catholic Church because of the Ecumenical Council of Chalcedon's declaration that Jesus Christ had two distinct natures, human and divine. These churches, now called Oriental Catholic Orthodoxy, held and now hold that the divine and human nature of Jesus Christ are united in one, without any separation. Oriental Orthodoxy has approximately 82 million adherents, centered in six autocephalous churches (αύτοκέφαλος, literally self-headed or self-governing), each led by a patriarch: Ethiopian, Alexandrian (Egyptian), Armenian, Syrian, Eritrean, and Malankara (Indian) Syrian Orthodox Churches. Most Oriental Orthodox Catholics reside in their home countries, though these six autocephalous Churches are also represented around the world, especially in the USA and the UK.

Greek Orthodoxy. Greek speaking bishops had rejected both the primacy of the Roman Pope and the addition of the *filoque* to the Nicene Creed by 1054. Filoque is Latin for, "and the Son." The Greek version of the Creed affirms, "And I believe in the Holy Spirit, the Lord and Giver of Life, Who proceeds from the Father" (Orthodox Christian Information Center, 2012). In the ecumenical creed (presented above) the wording is, "We believe in the Holy Spirit, the Lord, the giver of life, who proceeds from the Father and the Son." This created theological implications about the nature of Jesus Christ, the Holy Ghost, and the Trinity that were deemed unacceptable for Greek Orthodoxy.

The rift between Greek Orthodoxy and Roman Catholicism became violent. As many as 60,000 Roman Catholics in Constantinople were killed by rioting Greek-Orthodox Catholics in 1184. In 1204, Roman Catholics of the Fourth Crusade sacked Constantinople, killing thousands of Orthodox Catholics, looting the city, destroying churches, and establishing a Roman Catholic kingdom in Constantinople. In 2004, Pope John Paul II expressed sorrow for the sack of Constantinople. The apology was officially accepted by Bartholomew I, Patriarch of Constantinople, that same year (British Broadcasting Corporation News, 2004).

Pinched between Roman Catholicism in the west and Oriental Orthodoxy in the east, Greek Orthodoxy moved northward, eventually leading to the strengthening and growth of Orthodox Catholicism in Russia and other Slavic countries. Today Greek Orthodox Catholicism is organized as 15 autocephalous Orthodox Churches, each directed by a Patriarch: Constantinople, Antioch, Alexandria, Jerusalem, Romania, Russia, Cyprus, Serbia, Georgia, Bulgaria, Greece, Czech and Slovakia, Albania, Poland, and the USA. The Patriarch of Constantinople is considered first among equals, but the highest authority in solving doctrinal disputes is not the

Ecumenical Patriarch, but the Ecumenical Council of the sister-churches. Twelve autonomous churches are dependent on the Ecumenical Patriarch or another autocephalous Patriarch. Greek Orthodoxy is more widely dispersed than Oriental Orthodoxy, with at least 300 million adherents, including many outside the home countries (see Cunningham & Theokritoff, 2009; McGuckin, 2008).

What many religions call a sacrament, Orthodoxy calls μυστήριον, mysterion, "a thing to be silent about" (McGuckin, 2008). Ordinances were hidden or kept mysterious during early, post-apostolic years to avoid ridicule and persecution. Orthodox mysteries are not numbered, but there are at least seven: baptism, Chrismation, communion in the Holy Eucharist, ordination, confession, marriage, and unction. Orthodoxy is known for monasticism which began in the fourth century and for icons, symbols meant for aesthetic and didactic functions, by which Christians experience the reality of the Heavenly Kingdom on earth.

The culmination of Orthodox theology and spirituality and the purpose of human life is theosis, meaning glorification, union with God, and diefication. Theosis occurs through ascesis, meaning disciplined steps toward God (Chryssavgis, 2009; Ready, 2001). The Orthodox view is that God created us expressly to share His divine life, and to participate fully in all His divine attributes, including holiness, love, beauty, glory, and immortality–self-actualization. Theosis would seem to accentuate human potential, which could enhance self-acceptance.

Protestantism

Protestantism is the third major manifestation of Christianity. Protestantism began in Europe, but is now a global phenomenon, accounting for approximately 37 % of Christian believers. Protestantism emerged as a lasting phenomenon in the sixteenth century Reformation, initiated by Luther and Melanchthon in Germany, by Zwingli and Calvin, in Switzerland, and by Henry VIII and Cramner, in England. Luther and Calvin, reacting against an emphasis on works in Roman Catholicism, developed a Christocentric or Christologic doctrine, focused on justification by faith (*sola fide*) and the authority of the Bible (*sola scriptura*). They argued that salvation was God's gift, through Jesus Christ as sole mediator between God and humanity. Many Protestant denominations argue for the priesthood of believers, meaning that by virtue of baptism, members become priests in the church of God. Protestant denominations have emerged emphasizing different features of Biblical Christianity, including charismatic gifts of the Holy Spirit, especially the gift of tongues (see Hillerbrand, 2004; McGrath & Marks, 2004).

Finding ultimate authority in the Bible, often rejecting centralized organization, yielded great cultural, theological, and ecclesiastical diversity, thousands of denominations, and no essence of Protestantism. Protestant denominations can be classified along at least three dimensions, including historicity, liberality versus fundamentalism, and ecumenism versus exclusivity. The four main historical groupings are (a) Classical Reformation Protestants from the sixteenth century, including Lutheran,

Reformed, and Anglican churches. (b) Radical Reformation Protestants from the sixteenth century, including Mennonites and Baptists. (c) Revivalists from the eighteenth to nineteenth centuries, self-defined as seeking to revive original Reformation principles, including Methodists and Presbyterians. (d) Twentieth century Charismatic and Pentecostal groups, including the Apostolic Church and the Assemblies of God.

Liberality versus fundamentalism and ecumenism versus exclusivity overlap with the historical development of denominations. Liberal Protestants are generally characterized by open-mindedness, respect for science, confidence in human reason, freedom from traditional dogmas and creedal formulations, and tolerance for doctrinal differences. Fundamentalists construct their identity around the authority and inerrancy of the Bible, adhere to strict Biblical moral codes, and oppose liberalizing of dogma and creeds. Ecumenical Protestants are flexible regarding salvation outside particular denominations; exclusivists insist on adherence to denominational doctrines and ordinances for salvation. Protestants across these dimensions may adhere strictly to or reject elements of the Nicene Creed and may or may not accept a Trinitarian view of God. Moving away from central authority can tend to enhance the importance of the individual, which may also enhance self-awareness and the potential for self-acceptance.

Restorationists

Christians preparing for Christ's promised return, Christians seeking to restore New Testament Christianity, and Christians trying to unify believers formed new denominations in the nineteenth century. In 1823, William Miller concluded that numerological signs in the Book of Daniel showed that Jesus Christ would return before 1845. This did not happen (it was called The Great Disappointment), but a focus on Jesus Christ's return remained influential for the Seventh-Day Adventist Church and for Jehovah's Witnesses. Jehovah's Witnesses believe that Christ returned in 1914, beginning his spiritual reign in heaven, while, except for Jehovah's Witnesses, the world remains under the devil's control (See Penton, 1997; Weber, 2012). Barton Stone and brothers Thomas and Alexander Campbell worked to unify Christians under apostolic leadership like the original Christianity of the New Testament. This contributed to formation of the United Church of Christ, the Church of Christ, the Church of Christ (Christian Churches), and the Disciples of Christ in the 1830s (see Disciples of Christ, 2012; Lambert, 2012; Marini, 2012).

Joseph Smith said that in 1820, frontier revivals led him to pray for guidance about which church he should join. He said that God the Father and Jesus Christ came to him and told him no denomination was correct. Peter, James, and John later came to him as resurrected, angelic beings, and ordained him an apostle, the first of an ongoing group of modern apostles that now lead the restored Church of Jesus Christ of Latter-day Saints. Smith said he was directed to record as scripture the most important of the revelations he received and, inspired by God, translate from

ancient metal records *The Book of Mormon*: *Another Testament of Jesus Christ*, from which the cognomen Mormons comes (Nielsen, Judd, & Nielsen, 2006).

The Self and Self-Acceptance

The word self appears frequently and in many contexts and forms in English. Varied psychological constructs contribute to confusion about the nature, role, and meaning of the self. Leary and Tangney (2003a, b), editors of the *Handbook of Self and Identity*, found 66 distinct selfconstructs used in psychological scholarship and research, self-acceptance among them. They group these 66 constructs into five categories, the self as (a) the total person, (b) personality, (c) the experienced subject of consciousness, (d) beliefs about oneself, and (e) the executive agent of consciousness. To avoid confusion about what we mean when we refer to the self and self-acceptance, we define these terms below.

The Self

The self is the subject and object of self-awareness; it is the total, personal conception of self, most often experienced and described as "me" or as the "I" of I am. The self is usually experienced as both the observer of events, including the observer of thoughts, and the executor of decisions and actions (Leary & Tangney, 2003a, 2003b). The self is also an abstract summary of our existence and a theory about our experience, observed from its own reference point in the past, present, and anticipated future (Popper & Eccles, 1981). The self is likely the most common and important abstraction, present as subject, object, and referent for almost all cognition, including most of our perceptions, thoughts, emotions, behavior, and memories. Most people experience the self as a perceptual point midway between and just behind the eyes (Barbeito & Ono, 1979; Mitson, Ono, & Barbeito, 1976). The congenitally blind experience the self as a perceptual point located midway between the ears (Sukemiya, Nakamizo, & Ono, 2008). The self usually develops at approximately 2 years of age, increasing in complexity and sophistication with age (Harter, 2003).

Self-Acceptance

Self-acceptance is synonymous with self-rating, self-acceptance is our evaluative examination of the self as defined above. Self-acceptance is both a mental process and the product of self-rating.

Unconditional self-acceptance (**USA**). Unconditional acceptance of the self is unqualified, unreserved valuing of the self. USA implies that the value of the self is an indivisible, irreducible constant. Parallel to USA is unconditional acceptance of others; all humans have the same, constant value. This is the constant: Each person has the indivisible, unchanging value of one person. This value is a constant because there is no clear scientific, legal, logical, or pragmatic way to rate or modify the value of a human or the value of the self. Any evaluation less than accepting the self as having a constant value is conditional acceptance.

Conditional self-acceptance (**CSA**). CSA is probably the normative and modal belief system that people have about the self. This is easily demonstrated in a simple thought experiment. Imagine saying to almost any group of adults, "Raise your hand if you want to be a better person." Most will raise a hand. Each person who raises a hand believes in some change that will better the self. This bettered self would be more acceptable. Each who raises a hand views the self as conditionally acceptable because it would be more acceptable or fully acceptable only on condition of this imagined, bettering change.

USA does not mean that all human skills, habits, and behaviors are acceptable. It is often quite reasonable to rate behaviors, attitudes, skills, and traits as more or less acceptable in a particular context. Physical strength is, for example, an appropriate criterion for rating and recruiting players for an athletic team, but an illegal criterion for recruiting staff at a counseling center. There is, however, no clear logical, scientific, legal, or practical way to aggregate traits, skills, and behaviors, no accounting method for finding an overall value, rating, quality, or level of acceptability for the self. We will show below that there are Christian scriptures that clearly dispute the idea or belief that the self is less than unconditionally acceptable.

The ABC Model and ABCD Method

Our definitions are drawn primarily from REBT theory and from our experience using Albert Ellis's *ABC model of emotion* (Ellis, 1994b) during REBT. The ABC model of emotion is a simple model for explaining and demonstrating the sources of healthy and self-defeating emotional processes; the *ABCD method* is a basic REBT approach to helping clients.

The ABC model. The ABC model of emotion states that a *C*, a self-defeating emotional *C*onsequence, is caused not by a particular *A*, *A*dversity or other *A*, *A*ctivating event, but by a *B*, *B*elief, about *A*.

The ABCD method. The ABCD method focuses on changing self-defeating emotional consequences by *D*, *D*isputing problem *B*eliefs. In this context disputation means use of argument, persuasion, behavioral homework, emotionally evocative

experiences, and other methods for teaching and reinforcing healthy alternative beliefs. The fundamental goal of disputation is to replace problem beliefs with healthy beliefs.

Belief in REBT and Christianity

We define belief in the ABC model as an attitude, action, or habit of accepting and holding something to be true. Belief is, of course, fundamentally important in Christianity. Paul's Letter to the Hebrews includes this statement, "It's impossible to please God apart from faith. And why? Because anyone who wants to approach God *must believe* both that he exists and that he cares enough to respond to those who seek him" (Hebrews 11:6, The Message translation, italics added). This is quite specific: Believe that God exists and cares. REBT likewise focuses on specific beliefs, proposing that absolutistic beliefs, often called irrational beliefs, create self-defeating emotions. Though there are many absolutistic beliefs, the worst trouble makers can be classified in four categories:

Demands. Demanding beliefs are often seen in absolutistic statements, including words and phrases such as, *you must*, *I should*, *we have to*, *they ought to*, *I'm supposed to*, and so forth.

Catastrophizing. Catastrophizing, awfulizing or terrible-izing are often evident in absolutistic statements including words and phrases such as, *I need it*, *it's horrible*, *that's awful*, *how terrible*, *I can't stand it*, *it's unbelievable*, and so forth.

Frustration intolerance. Frustration intolerance can be a bit more subtle, as it can seem less extreme than demands or catastrophizing. Frustration intolerance is like a blend of demanding and awfulizing. Frustration intolerance often appears in absolutisms such as, *I can't do it*, or *this is too hard*.

Human rating. Human rating will often show up in absolutistic phrases and words such as, *I want to be a winner*, *what a loser I am*, *she's a saint*, *what a jerk*, and so forth. Human rating is conditional acceptance of the self or of others.

The absolutism of CSA. Conditional acceptance of the self or of others is absolutistic because it is generalizing from discrete evaluations to the abstract totality of the self. As noted above, it is possible and reasonable to evaluate a skill or trait in a particular context. For example, on condition of completing a qualifying examination, a trainee may move from a lower to a higher level in a training program. Acceptance to the next training level is conditional on successful performance. Acceptance to the next training level does not mean that the person is now more acceptable, only that the skills, based on the examination, appear to be acceptable. There is no indisputably reasonable way to extend evaluation of particular element of a person to the abstract, total self.

CSA is arbitrary because it is capricious, occurring at the discretion or whim of the rater, without resort to logic, law, science, practical consequence, or clear religious principles. It is the contention of REBT theory that there are no logical, legal, scientific, pragmatic, or broadly held religious principles that allow for rating individual worth or adequacy. Christian scripture, in particular, includes no accepted way to rate the value of souls, either conditionally or by comparison of one soul with another soul.

Comparing Conditional and Unconditional Self-Accepting Beliefs

Imagine identical twins, alike in all ways except their beliefs. They are enrolled at a seminary, studying for the same, very important, very difficult, theological examination. Both are unsure they understand the material and doubt that they will do well. One says, "This may show God that I am weak, sloppy, and lazy." The other says, "This may show God that I haven't used my abilities as I could have." The examination is *A*, the *A*ctivating event. The twins self-talk reveals what each *B*, *B*elieves, about the examination. What are the emotional *C*s, the *C*onsequences of their *B*eliefs?

"This may show God that I'm weak, sloppy, and lazy," reveals very strong CSA. The emotional consequence could easily be test anxiety before and during the test, avoidance of studying and distraction before the test, and distraction and blocking of memory during the test.

"This may show God that I haven't used my abilities as I could have," focuses on poor effort. The self is observer of what is happening, not the focus. Effort, not the self, is evaluated. The emotional consequence for this twin would be concern. Concern is unpleasant, but more likely to motivate studying before the test and efficient use of time during the test.

Now imagine that the twins fail the test with identical low scores. One says, "God can see that I am a weakling, a slob, a lazy failure!" The other says, "God will surely be disappointed that I haven't used my abilities as I could have!"

"God can see that I am a weakling, a slob, a lazy failure!" generalizes from performance to the self. This self-damning is likely to yield self-defeating emotional consequences such as shame, reduced motivation to study, and general discouragement.

"God will surely be disappointed that I haven't used my abilities as I could have!" is an observation that God will dislike poor effort, but not an evaluation of the self. This belief will likely create unpleasant emotions such as regret and annoyance. These emotions could motivate this twin to study more in the future and perhaps to assertively refuse social alternatives to studying.

Finally, imagine the twins earn perfect scores on the test, scores 20 percentage points higher than the next highest score on the test. One says, "This score shows I am one of God's elect!" The other says, "This score shows God that I worked hard

enough to understand!" Who is most likely to feel arrogance? "I am one of God's elect!" is a possible consequence of CSA, conditional valuing of self over others. Such a thought could lead to self-aggrandizement, pride, and arrogance.

The Self and Self-Acceptance in Christian Theology

The Oxford English Dictionary (2012) defines theology as, "the study or science which treats of God, His nature and attributes, and *His relations with man* and the universe; 'the science of things divine'; divinity" (italics added). Human nature is, thus, central to theology, though theology is not necessarily clear in defining self-constructs or about self-acceptance.

Christian Scripture

Bible comes from βιβλια, biblia, for books; the Bible is a collection of ancient texts; the originals are no longer available. There is no evidence that Jesus Christ wrote anything beyond tracings in the dirt (John 8:8). We have no original copies of the Gospels or Apostolic letters. The first documented texts recording Christ's life, ministry, death, and resurrection come from about 160 CE. When and by whom the earliest copies of Biblical texts were written is debated. Collections of Greek, Latin, Syriac, and Coptic texts were in broad use by the late third and early fourth centuries, but again without documentation of authorship. Texts in the current Protestant and Roman Catholic Bibles were assembled in 380 CE. The Protestant Bible includes 66 texts; the Roman Catholic Bible, 73; the Eastern Orthodox Bible, 76; the Ethiopian Orthodox Bible, 81 texts (See Barrera, 1998; McGrath, 1998).

The Bible comes to us through translators attempting to provide modern renderings that are faithful to ancient texts. This is semantically and theologically complex. Self constructs must often be inferred from inexplicit references to the self, a concept that has developed over time. The word *self* appears six times in 1611's King James Version, 53 times in 1999's Contemporary English Bible, and 65 times in 2002's The Message. We could not, with repeated electronic text searches, find *self-acceptance* in any Bible translation. Consider how self constructs vary in The Message, the Contemporary English, and the King James Version translations:

Self-focus. This reference to thinking in the King James Version sounds like it is addressing sexuality, "For to be *carnally minded* is death; but *to be spiritually minded* is life and peace" (Rom 8:6; italics added). The Contemporary English Version sounds like it is more broadly addressing desires, "If *our minds are ruled by our desires*, we will die. But *if our minds are ruled by the Spirit*, we will have life and peace" (italics added). The Message introduces self-focus as the object of the verse, "*Obsession with self* in these matters is a dead end; *attention to God* leads us out into the open, into a spacious, free life" (italics added).

Perfectionism. The King James translation of Jesus Christ's Sermon on the Mount includes a command that sounds perfectionistic, "*Be ye therefore perfect*, even as your Father which is in heaven is perfect" (Matt 5:48; italics added). The Contemporary English Version is more about behavior change, "But you must always *act like your Father in heaven*" (italics added). The Message version changes the focus to behavior change and identity, "In a word, what I'm saying is, *Grow up*. You're kingdom subjects. Now live like it. *Live out your God-created identity*. *Live generously* and graciously toward others, *the way God lives* toward you" (italics added).

Conversion. Paul's discussion of conversion (Eph 4:22–24) seems to discuss identity change in the King James Version:

> … *put off* concerning the former conversation *the old man*, *which is corrupt* according to the deceitful lusts; and be renewed in the spirit of your mind; and that ye *put on the new man*, which after God is created in righteousness and true holiness (italics added).

The Contemporary English translation adds a description of life style change:

> … your foolish desires will destroy you and that *you must give up your old way of life* with all its bad habits. *Let the Spirit change your way of thinking and make you into a new person*. You were created to be like God, and so you must please him and be truly holy (italics added).

The Message translation drops identity change, focusing on behavior and trait change:

> … we do not have the excuse of ignorance, *everything–and I do mean everything–connected with the old way of life has to go*. It's rotten through and through. Get rid of it! And then *take on an entirely new way of life*–a God-fashioned life, a *life renewed from the inside and working itself into your conduct as God accurately reproduces his character in you* (italics added).

Christian Theology

Surveys have documented the denominational affiliation of about 50 % of US Christians through membership in congregations associated with 219 denominations (Grammich et al., 2012). These are 219 diverse theologies. Christians whose membership is not documented in one of these 219 distinct denominations represent further doctrinal variety, revealing a potential welter of theologies. Cataloguing such theological variation is well beyond this chapter. We offer a sampling of how the self and self-acceptance appear in Christian theology.

Jesus Christ's human nature. Early Christian theology became more stable as Christian authorities attempted to resolve disputes about the nature of Jesus Christ's humanity (Dumont, 1985). *Against Heresies*, written by Irenaeus in 180 CE, refuted the gnostic notion that the physical Jesus was inferior to the spiritual Christ. At about this time Tertullian first used the Trinitarian phrase, three persons, one

substance. Doctrine about the humanity of Jesus Christ stabilized somewhat with adoption of the Nicene Creed in 325 (McPartlan, 2005).

Human equality. Lactantius, a third century convert to Chrisitianity, did not refer to the self, but he wrote about the acceptability of humans. He wrote, "For God, who produces and gives breath to men, willed that all should be equal, that is, equally matched" (Lactantius, trans., 1886; p, 151). His statement alludes to equal, nondiffering acceptability

The self. The first reference in Western thought to an inner self appears not in Greek philosophy, but in Augustine's *Confessions*. He wrote that he could not escape sensual sins and understand God until he turned his attention inward. The light of God could then shine to his inner man (see Cary, 2000; McPartlan, 2005). In *The City of God*, he examined awareness of self, highlighting the difference between love of self and love of God as the difference between the earthly city and the heavenly city. In the earthly city, self-love is the source of sin.

Self-regard and self-love. In 1274, Thomas Aquinas referenced Augustine in discussing the role of self-love in sin, concluding that inordinate self-love is the root of all sin, while love that desires the good of God, good for others, and good for self is acceptable. He redefined human love as having a motive beyond love of self, including love of the object of the love above the benefit to the self. Self-love keeps one from loving God, but loving the self for the love of God solves the problem. Bernard of Clairvaux held that the sinner does not really love the self, because he mistakes what is truly for his own good (see Harder, 2005).

Individualism. Luther and Calvin referred to Augustine in their arguments against the Roman Church (Tillich, 1967). The Reformation asserted priority of the individual (Weaver, 2002). Religious individualism emphasized independent capacity to understand the Bible, creating an unmediated, personal relationship with God, and a foundation for modern approaches to the self expressed by Descartes, Locke, Hume, Kant, and Hegel (see Weaver, 2002) and the Christian existentialism expressed by Kierkegaard (McPartlan, 2005).

Self-acceptance. Paul Tillich offers one of the most convincing Christian arguments for USA. Ironically, his view was influenced by readings and discussions with influential psychotherapists, including Carl Rogers. He credited psychotherapy with a rediscovery of acceptance (Cooper, 2006). Albert Ellis, in turn, credited Tillich with influencing his development of REBT (Ellis, 1973; McMahon, 2003). Tillich said "acceptance of acceptance" is a cornerstone of the Christian experience. He believed understanding that God accepts us unconditionally is the essence of the Reformation and one of the most important of all Protestant messages. He accentuated this by saying, "he who is unacceptable is accepted" (Tillich, 1952, p. 167), meaning that sinful man is still acceptable to God.

Like Augustine, Tillich viewed sin as estrangement from God and the self. Estrangement from God was a necessary experience for understanding grace. "Grace occurs 'in spite of' something … in spite of separation and estrangement.

Grace is the reconciliation of the self with itself" (Tillich, 1952, p. 156). Tillich believed that accepting grace leads to self-acceptance, self-affirmation, and an antidote to meaninglessness, despair, guilt and anxiety (Tillich, 1952, 1953).

Self-Acceptance Errors in Christian Theology

Individuals have difficulty understanding the self and USA, errors characteristic of this inherent human confusion arise in theological treatments of the self. At least two errors are common: overgeneralizing to the self and absolutistic, dichotomous reasoning about selflessness and selfishness.

Overgeneralizing about the self in the form of self-improvement. Some theologians insist that to change behavior, humans must change who they are (see Leary, 2004; Shulman & Stroumsa, 2002). This is evident in the article, "Self-theory and Theology," from *The Journal of Theology*:

> The way one feels (emotively) about oneself is known as one's self-regard. This appears to be negatively related to the level of aspiration, that is, to the discrepancy between self-image and self-ideal. … Though a negative self-regard often interferes with a happy, adjusted life, complete self-acceptance as here defined would be the end of human culture with its norms and ideals (Buss, 1965, p. 47).

Two misunderstandings about self-acceptance are evident here: (1) We are fundamentally motivated by differences we see between the perceived self and an ideal self and hence by a desire for self-improvement. This is integral to many humanistic views of self-acceptance. (2) USA may ease distress, but will reduce motivation for self-improvement. Without a desire for self-improvement the organizing goals of society would decline and perhaps disintegrate.

It is probably true that most people are motivated by self-improvement goals. This is not necessarily a fundamental motivation and can be demonstrated to be psychologically risky. If a particular change, say stopping a bad habit, equals self-improvement, then a worsening of the habit can seem like deterioration of the self. Seeing the self as regressing could create shame, discouragement, and other self-defeating, *de*-motivating emotions.

Furthermore, self-improvement motivation is obviously *not* a necessary motivation. It is obvious that people study to satisfy curiosity, play because it is fun, earn to provide for present and future needs, work to help others, and so forth. Note that motivation to study, to play, to earn, and to help others can be described without reference to self-improvement; similarly, self-improvement need not be present in motivation.

Finally, self-improvement motivation can easily complicate motivational thinking and interfere with performance. To be sure, attaining USA can greatly reduce anxiety, shame, discouragement, and other self-defeating emotions, but it can also simplify motivation. The thought, "Those people need help," is motivating. The thought, "If I help those people who need help, I will be improving myself,"

complicates the motivational process. Extra thoughts about self-improvement can easily distract one from trying to help others. Attaining USA frees one from any goal of improving one's self and from any risk that one might sense in performing badly when trying to help; this allows unfettered, undistracted focus on helping others.

Absolutistic, **dichotomous reasoning about selflessness and selfishness**. The distinction between USA and selfishness raises subtle, tricky problems when selflessness is made an absolute virtue. For example, the famous theologian Reinhold Niebuhr wrote about sins of the flesh, "Whether in drunkenness, gluttony, sexual license, love of luxury or any inordinate devotion, … sensuality is always an extension of self-love" (pp. 239–240). Niebuhr extended this principle to the story of the rich man who asked Jesus what he should do to inherit eternal life (in Matt 19:26–36; Mark 10:17–27; & Luke 18:27). Jesus told the man to sell his possessions, give the proceeds to the poor, and join him. The man was unwilling to give up his wealth and sadly went away. Niebuhr explained that, "What is demanded is an action in which *regard for the self is completely eliminated*" (Neibuhr, 1941, p. 287, italics added).

Niebuhr's analysis of the story of the rich man suggests that only utter selflessness will satisfy God. A balanced approach to self care and service is often hindered when either selflessness is treated as an absolute good or selfishness is treated as an absolute evil. Insistence on selflessness or demanding that self-regard be eliminated leads to unassertiveness and confusion. It is not uncommon for psychotherapy clients to think that having wants is an unacceptable sign of selfishness. Such extreme views of selfishness and selflessness contradict Christ's statement about the two most important commandments:

> And thou shalt love the Lord thy God with all thy heart, and with all thy soul, and with all thy mind, and with all thy strength: this is the first commandment. And the second is like, namely this, Thou shalt love thy neighbor as thyself. There is none other commandment greater than these (Mark 12: 30, 31, King James Version).

The first commandment is to love God. The second commandment, love your neighbor, is like the first; that is, they are essentially equal. But Christ's explanation of the second commandment shows that love of others has a foundation in love of self. Love of God, love of others, and love of self have at worst commonality and are perhaps of equal importance. Christ's explanation shows that love of self is a necessary standard by which love of others should be judged. His formulation does not show that self-regard–a less intense state than love of self–must be completely eliminated to please God. In the absence of absolutism about selfishness and selflessness it is possible to explore the ramifications of self-regard and self-interest:

Unethical, *illegal behavior*. Behavior that ignores or violates the rights and safety of others is badly selfish. Those rightfully convicted of felonies have behaved in badly selfish ways. A want that, if fulfilled, would result in a felony, is a badly selfish want.

Ethical and legally pursued wants. Wanting something that is ethical and legal, and seeking it in a way that attends to the rights and safety of others is appropriately self-interested. This could be called appropriately selfish—though the word selfish is extreme in its pejorative quality. For example, using a truthful resume with

authentic references in a competitive job application process could be called appropriately selfish. Obtaining a job using such an application does deprive at least one other person who will not be hired. It is bad for the person not hired, but good for the company doing the hiring as well as good for the person hired. Not applying for a job because others could lose out in the competitive job application process would seem quite unselfish, but if the best applicant does not apply for a position because some other candidate might lose out, then the employer will not get the best employee, the best applicant will not be hired, the best match between employer and employee will be lost, and all who might be benefitted by this good match will lose out. This would be bad selflessness.

Jesus Christ's self-regard. Christians believe that Jesus Christ suffered and died for humanity. He did this willingly, though he was fully capable of preventing his own death, either by using his divine power or by calling forth "more than twelve legions of angels" (Matt 26:53) to protect him from those who wanted to harm him. His atoning sacrifice was, thus, quite selfless. But scripture seems to show that Jesus Christ was keenly aware of his own desires. He expressed his personal desires. The night before his capture, trial, torture, and crucifixion, while praying, Christ is recorded as saying, "Father, remove this cup from me. But please, not what I want. What do you want?" (Luke 22:42, The Message). Jesus Christ did not want to suffer. This was a personal desire that was not, at least at that moment, completely selfless. He gave up this desire, which was unselfish. The balance between concern for himself and his suffering and concern for others was decided in mankind's favor, but the balance was more nuanced than can be captured by calling his decisions completely selfless.

Using Christian Scripture to Challenge Conditional Self-Acceptance

Using the most basic theological material available, Christian scripture, provides a simple method for disputing CSA among believing Christians. As we state above, CSA is an absolutistic belief process, because it is a generalization about the abstract, total self. Scripture provides powerful, authoritative evidence for self-acceptance, including evidence that human worth is a constant or an absolute. A therapist can, thus, use scripture to compare absolute with absolute: Authoritative, unconditional acceptance of humans in scripture can be pitted against a client's conditional acceptance of the self.

Working Within the Client's Thinking

Working to change a client's beliefs is facilitated by working within client's thinking patterns, thinking style, and preferred thought topics. For example, if a client who rates himself down were trained in electrical engineering, the scientific

orientation of engineering provides a bridge to demonstrating the arbitrariness of CSA. Asking, "What is a voltmeter? How is it used?" alludes to a validated, scientific measurement process. Asking, "Why don't we have humanometers?" emphasizes that the abstract self is not measurable.

Using Client Religious Beliefs

A voltmeter is an empirically validated scientific device. A humanometer could not be empirically validated, so the notion is a slightly humorous, metaphorical tool for emphasizing that there is no good empirical evidence that we can rate humans; this use of empiricism as an antidote to human rating is an evidentiary strategy for invalidating CSA. Christian scripture provides authoritative evidence to Christians about many important principles. Using scriptural authority to challenge CSA is also an evidentiary strategy.

Clients are likely to be religious, especially in the USA. Indeed, clients in the USA are more likely to be religious than their psychotherapists by a ratio of approximately 8 to 5; that is, 80 % of the US population endorses Christian belief, while fewer than 50 % of psychotherapists endorse any kind of religious belief (Bergin, 1980; Richards & Bergin, 2005). Developing greater fluency in addressing client religious beliefs can help therapists help their clients attain USA.

I (Nielsen) once counseled an observant Muslim who was condemning herself because of her sexual behavior. She was quite anxious and depressed. She believed that the Qur'an is God's word. I asked her to help me understand what God said in the Qur'an about the worth of repentant sinners. Her own research and her teaching me what she found in the Qur'an about her worth provided her with proof that God accepted her, moving her toward USA (Nielsen, 2004).

A simple, reasonable sequence would be to ask a client: (1) Are you a religious believer? (2) Do you believe in the Bible? (3) Do you believe in the New Testament? (4) Do you believe in other scriptures? If the answer to the first question is no, scripture would not be useful for helping the client attain USA. Subsequent answers would help fine tune the use of scripture in therapy. Scriptures that are useful for disputing CSA and encouraging USA might be grouped in five main categories:

1. **We are the children of God**. The word *father* appears 381 times in the King James New Testament; the majority of these uses of the word are references to God as our Father in Heaven. Paul's Letter to the Romans says this clearly, "The Spirit itself beareth witness with our spirit, that we are the children of God" (Rom 8:16; King James Version). Jesus Christ's instructions to Mary Magdalene just after his resurrection highlight this relationship, "Go to my brothers and tell them, 'I ascend to my Father and your Father, my God and your God.'" (John 20:17; The Message). During *D*isputation of CSA the client might be asked something like this, "What are you telling yourself about you? What is Paul saying about you here in his letter to the Romans? Is there some way that you don't qualify as a child of God?"

2. **We are all sinners**. Paul, referring to Psalms 53:3, in the Old Testament, wrote, "As it is written, There is none righteous, no, not one" (Rom 3:10; King James Version). The scriptural statement that none are righteous provides forceful, absolutistic evidence that may be an antidote to CSA. This doctrine is, however, an absolute in the same way that USA or unconditional acceptance of others is an absolute, as it provides evidence that human value is a constant: No one is righteous.

A potentially persuasive piece of scriptural evidence that we have the same value is this important story:

> As [Jesus] went out into the street, a man came running up, greeted him with great reverence, and asked, "Good Teacher, what must I do to get eternal life?" Jesus said, "Why are you calling me good? *No one is good*, only God." (Mark 10:17,18; The Message, italics added).

After stating that no one is good, Jesus tells the man to keep the commandments. The story of Jesus Christ's encounter with this man is repeated in Matthew 19:16,17 and Luke 18:18,19, with very little variation in wording and with Jesus making the same declaration that no one is good. To a client who is quite practiced at CSA, the notion that no one is good might seem discouraging. But the disputation is strengthened by suggesting that if no one is all good, it perhaps follows that no one is all bad. That actions may be good or bad is clear from Jesus saying to the rich man, "You know the commandments" (Mark 10:19; all translations). But if doing good does not make us good, then logically, neither does doing bad make us bad, though good or bad consequences may come from doing good or bad things.

Clients can sometimes experience immediate relief with a question like, "How would it feel if you believed that *no one* is good *or bad*? Including you? You don't believe it, but how would it feel if you *did* believe it?" Many clients will say that it would be a relief. This question may engage clients in momentary USA.

3. **God forgives sin**. The Parable of the Prodigal Son (Luke 15:11–32) may be a useful way to show Christians who are condemning themselves that God is quick to forgive His children, slow to abandon them, and that He values them equally after they have sinned. The parable tells of a son who asked his father for his inheritance, spent the inheritance in debauchery, fell on very hard times, then decided to return home. He said to his father,

> "Father, I've sinned against God, I've sinned before you; I don't deserve to be called your son ever again." But the father wasn't listening. He was calling to the servants, "Quick. Bring a clean set of clothes and dress him. Put the family ring on his finger and sandals on his feet. Then get a grain-fed heifer and roast it. We're going to feast! We're going to have a wonderful time! My son is here—given up for dead and now alive! Given up for lost and now found!" And they began to have a wonderful time (Luke 15:21–24, The Message translation).

It is often important to point out that the parable, which was told by Jesus Christ, includes references to the egregious sin of hiring prostitutes (Luke 15:28–30). The parable can be quite emotionally evocative for one who views himself or herself as an unforgivable sinner. An important set of questions focuses on the symbol and the

message, “Is this about a particular father and son or does it have a larger, symbolic meaning?” The parable is, of course, about all sinners. “What does it say about the father–child relationship of sinners to God?”

The message in these verses is that the parent–child relationship between God and sinners is close, loving, and not easily broken, and that God wants to forgive us.

4. **Sin does not reduce human worth**. There are many New Testament verses wherein Jesus Christ emphasizes that sin does not lower human worth. The Parable of the Prodigal Son is found in Luke, Chapter 15. This chapter begins with Pharisees and scribes criticized Jesus for allowing sinners to be among his listeners. The Parables of The Lost Sheep, The Lost Coin, and The Prodigal Son were his response to their criticism. It can be useful to have Christian clients struggling with CSA read and reread Luke 15.

All three parables show God to be loving toward sinners. The Parable of the Lost Sheep is quite famous for comparing each sinner to a lost sheep, helping establish Jesus Christ as the Good Shepherd. The Parable of the Lost Coin can be particularly useful because it emphasizes equality of worth, “What will a woman do if she has ten silver coins and loses one of them? Won’t she light a lamp, sweep the floor, and look carefully until she finds it?” (Luke 15:8; Contemporary English Version). Many translators include in footnote that “silver coins” is the English translation for δραχμάς, drachmas. At that time a drachma was a laborer’s daily wage.

After reading this part of the parable to a client and showing the client the footnote about the value of each coin, it’s useful to ask what a laborer currently earns for a full day’s work. It would be between $50 and $100 in the USA. A simple question then follows, “So if you were at home and had ten, $100 bills one minute, then the next minute discovered you can find only nine, would you say to yourself, “It doesn’t matter, I still have nine?” Or would you look hard for the missing money? Would you be happy when you found it? Well Jesus said that when the woman found the missing coin she was so happy that she called her friends and had a party. And he said that in the same way, the angels are happy when anyone turns to him (Luke 15:9,10). Any evidence in these verses that one person is worth more or less than any other person?”

Latter-day Saint clients may be persuaded by any these verses or by verses from one of their modern scriptures. For example, Joseph Smith said that Jesus said to him, “Remember, the worth of souls is great in the sight of God; For behold, the Lord your Redeemer suffered death in the flesh; wherefore he suffered the pain of all men, that all men might repent and come unto him” (Doctrine & Covenants 18:10,11). This makes clear that Christ suffered for all because of their great worth, or perhaps that Christ’s suffering for all shows that all have great worth.

5. **Jesus Christ values all equally**. Jesus Christ compares himself to people in prison in the Parable of the Sheep and the Goats, providing a clear, striking example of unconditional acceptance of humans. He says he will give the blessings of heaven to some, explaining that,

> I was hungry and you fed me, I was thirsty and you gave me a drink, I was homeless and you gave me a room, I was shivering and you gave me clothes, I was sick and you stopped to visit, *I was in prison* and you came to me (Matt 25:35,36; The Message; italics added).

Surprised by this, those who are to be blessed in heaven will ask Jesus when they did these things for him. His answer makes clear how he values those in prison, "I'm telling the solemn truth: Whenever you did one of these things to someone overlooked or ignored, that was me–you did it to me" (Matt 25:40, The Message).

"Who goes to prison?" is an important question to ask. The hoped for answer is, "Bad people," for this parable highlights the paradox inherent in calling people good or bad, since Jesus Christ has equated himself with those that most people would think of as bad. If the client does not answer as expected, it's good to give the point directly, "Wouldn't most people say that people who go to prison are bad people? Especially people who are rightfully convicted of a crime. Notice that the parable does not say that those in prison were wrongfully convicted. But how does Jesus seem to view those in prison? He says here that he values them as he values himself. If he values people in prison that much, how then would he feel about you?" The goal is to show the client that viewing the self as inferior contradicts the scriptural evidence for how Jesus Christ views people, including people in prison.

Members of the Church of Jesus Christ of Latter-day Saints have received the cognomen Mormons because of their belief that *The Book of Mormon*: *Another Testament of Jesus Christ* is scripture. Mormons may be persuaded toward believing that all have equal worth by reading a simple statement recorded in *The Book of Mormon*. The speaker, a King named Benjamin, was revered by his people as a prophet. He told his people, "And I, even I, whom ye call your king, am no better than ye yourselves are; for I am also of the dust" (Mosiah 2:26). I (Nielsen) find it helpful to ask, "Now would you have believed him had you heard him? If the current prophet of the Church were to say this, would you believe him?" Most of my clients say that they would not, which allows for a discussion focused on giving up CSA.

Contradictory Scripture and Disagreements About the Meaning of Scripture

As noted above, Biblical manuscripts are separated from the events they report by 160 or more years. Meaning may change across translations and across generations. More importantly, people may select one scripture over another, perhaps choosing to believe scriptures that appear to support CSA.

For example, I (Nielsen) have had more than one client read or allude to Matthew 5:48 from the King James Version and use this verse to berate himself or herself. It reads, "Be ye therefore perfect, even as your Father which is in heaven is perfect." They will say something like, "I'm just not good enough! I'm commanded to be perfect and I am so imperfect!" Such use of scripture reveals the

moment-by-moment, dynamic nature of a client's evaluative thinking. It reveals a need to dynamically explore self-acceptance during the session. The client is providing the therapist with signs of the decision making process that leads to CSA. The client's selection of a scripture that seems to support CSA provides an opportunity for examining and engaging with the client's self-rating process as well as clues about client willingness to work at changing beliefs. Here are a few strategies for dealing with disagreement about scripture:

Ask about awareness of other scripture. Is the client aware of scriptures that reinforce USA. "What the Savior said there seems quite important to you. Are you familiar with the parable in which he compares himself to people in prison? Would people in prison be perfect?" Or, "Are you familiar with what he said about the acceptability of sinners? Here's what he said about the acceptability of sinners," then read the Parables of the Lost Sheep, the Lost Coin, and the Prodigal Son. Sin is not being accepted in these scriptures, but introducing these examples of Jesus accepting sinners might be sufficient to encourage the client to work toward an attitude of USA. Or, "Do you know what Jesus Christ said about good people? No? You may be surprised." Then read Mark 10:18. Having it pointed out that no one is good may powerfully dispute the client's insistence on CSA.

Choice. If a client is already aware of scriptures that support USA or if the client considers and reflects on scriptures pointed out by the therapist that support USA and elevates scriptures that seem to support CSA over scripture that seems to support USA, ask why the client has chosen one verse of scripture over others. "That seems like an important scripture for you. I wonder why that verse is more important or more believable to you than these other verses?" Understanding a client's reasons for preferring scripture that supports CSA over scripture that supports USA will likely reveal beliefs that require more finely tuned disputation strategies.

Emotional effects. Ask the client to compare the emotional effects of different scriptures. In this strategy the therapist might say, "You have decided that you have to be perfect to be an acceptable human being. Here's a place where Jesus said that *no* human being is good (Mark 10:18). That sounds like we are all *equally unacceptable*. Try saying it, 'No one is good. We are all equally *bad* and *equally unacceptable*.' How did that feel?" Or the therapist might say, "We just read the Parable of the Prodigal Son, how would it feel if you believed that God is as willing to accept you as that father was willing to accept his son?"

As noted above, asking how it would feel if a particular thing were believed invites the client to experiment with believing the alternative belief. Many clients will also feel a lifting of mood when the therapist utters a rational alternative to an absolutistic, irrational belief. After reading a verse that supports USA, it is sometimes useful to ask, "Could you feel a difference when I read those verses?" If the answer is, "Yes, I felt better," the client may feel hope that treatment can make a difference. If, more rarely, the answer is, "No, I find it upsetting," then the therapist knows to explore or adopt a different stance or approach.

Summary

The self is a subtle, abstract, omnipresent element of human cognition, emotion, behavior, perception, and memory. REBT theory holds that many if not most clients experience self-defeating emotional distress and behave in self-defeating ways because they rate or conditionally accept the self and others. Because the self is an abstraction, rating the acceptability of the abstract self is inherently arbitrary and problematic. It may not be possible to ignore the self, but it is possible to resist the tendency to rate the self.

Christianity's core doctrine is that God is the patient, loving, parent of mankind, who gave His beloved Son, Jesus Christ, to willingly sacrifice himself for mankind; this provides an antidote to CSA. Many Christian scriptures show God as an unconditionally accepting parent, though not a parent who unconditionally accepts misbehavior. Christian scripture can provide therapists with powerful evidence to help convince Christian clients that while all humans are sinful, they are equally accepted and loved by Jesus Christ.

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The Value of a Human Being

Albert Ellis (deceased)

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A basic tenet for rational living is that people do not rate themselves in terms of any of their performances, but instead fully accept themselves in terms of their being, their existence. Otherwise, they tend to be severely self-deprecating and insecure, and as a consequence they function ineffectively.

Why should this be so? To value oneself in terms of any deeds or acts will work only as long as one is performing rather well. Even if such deeds or acts are excellent at the moment, it will probably be only a matter of time when they will become less praiseworthy. Among other things, the individual grows older with the passing years—and consequently does worse eventually at various feats at which he may do well in his youth. Besides, no one is perfect, and being fallible, all of us will sooner or later fail in many respects. Where will they be, then, who insist on rating themselves by performances?

Knowing, moreover, that the chances of ultimately failing at some prized goal are normally high, people tend to work overtime at worrying about the possibility of such failure; and in the process will frequently interfere with their chances of success. For worrying is distracting and time consuming and hardly enables one to cope with any kind of problem solving; on the contrary, it almost always sabotages.

The investment of personal value, or worth as a human being, in any performance, makes it very "dangerous" to attempt to do that thing. A man would be loath to risk the game at all, if he is prepared to define himself as a failure should his performance fail. He therefore tends to make up excuses and avoids trying; or if he

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pushes himself ahead and compels himself to make an effort, he does so while worrying, "Will I do well?" or "Is it going to be good enough?" Frequently he enjoys the action so little, and finds such difficulty in keeping at it, that he finally concludes with something like, "Hell! It's not really worth all this trouble. Who wants to do *that* sort of thing, anyway?" The result is often a withdrawal from the activity, a conviction that, in spite of a dearth of objective evidence to judge by, it is not really worth doing.

Thus, the artist who *wanted* to be a painter of fine murals would have a delightful goal to strive for and would probably have a very fine time trying for it. But if he absolutely *had* to be a great muralist, and was convinced that he must be a marvelous painter, or else he is a person without worth, a nonperson, an inhuman, he would then soon find it too risky to paint—for who wants to prove what a worthless being he is? And rather than take that risk, the would-be artist will probably end up with excuses or rationalizations: "I don't have the time or money for painting," or "The lumbago in my arm is too painful for me to do any amount of painting," or "Nobody wants murals these days, anyway, so what's the use of trying to paint any?"

If a person must rate his self, his "personal worth," or "self-esteem," he had better do it in terms of some quite safe standard, such as his aliveness or his being. He can then, in accordance with this standard, quite justifiably conclude, "I am good, not because I do very well at anything, and not because certain people tend to approve of me, but just because I am alive, because I exist," For when he accepts his goodness as a human being in terms of being or aliveness, he obviously can accept himself under virtually all conditions that he may possibly face during a lifetime. By this standard, he would only fail to have goodness when dead.

Valuing oneself in relation to being or existence is the logical solution to the problem of self-worth. It is derived from the works of Paul Tillich, of Robert S. Hartman, and various other existentialist philosophers. Hartman has had a profound influence on the development of rational-emotive psychotherapy; for psychotherapy, as Perry London and various other practicing therapists have shown, is really largely concerned with morals and values, even when the therapist does not fully consciously recognize this fact. And the effective therapist would better have a good philosophy of life himself and be well prepared to discuss deeply philosophic questions with his clients if he wants to get very far with many of them.

Unfortunately, the more I used a modification of the Tillich-Hartman approach with my clients, and the more I tried to show them that they never really had to denigrate themselves as human beings no matter how poor their performances might be and no matter how little certain significant others cared for them, the more I began to encounter some very bright individuals who would not quite buy this line or who at least had serious philosophic objections to it. For these clients would object: "You say that the individual is good just because he's alive, and that he needs no other requisites for self-worth. I can see how this may work. If someone really believes this idea, he cannot very well devalue himself in any serious way, even though he may fully admit that many of his actions are less than good or are even reprehensible. But how can you positively state that a person *is* good merely because he exists? How can *you prove* this hypothesis? He's alive, all right; you can definitely, empirically prove that. But what makes him good *because* he's alive? You might just as

sensibly say, 'He's bad because he's alive.' For both these statements, that he's good or that he's bad because he exists, are definitions or tautologies, and neither of them is really provable."

"Well," I could only agree, when I listened to the arguments of these clients, "they're right! How *can* I prove that the individual's aliveness equals his worthiness? I can, of course, disprove any client's assumption that because he exists and because he behaves poorly, he is indubitably worthless (i.e., of no value to himself and deserving of being dead). For his assumption, too, is tautological, and there is no empirical data by which he can uphold it. But how can I prove to him that he really *is* intrinsically worthwhile?"

There really *is* no answer to the question, "What am I worth?" or "How do I prove that I am a good person?" since the question is rather meaningless and foolish in the first place. If I ask myself, "What do I do?" "What are my traits?" or "What is the value of this performance of mine?" such a question is meaningful, since it inquires about a trait, characteristic, or performance which (1) can be observed and (2) can to some degree be measured or rated. Thus, I play tennis, I possess a good backhand swing in this game, and my particular performance at tennis today was good, since I won all the matches I engaged in with competitors. But if I ask myself, "Who am 1?" how am I going to answer this question *except* in the light of my traits, characteristics, and performances? How am I to give a meaningful answer to such a vague, undefinable, rather meaningless question?

I *am*, as David Bourland has noted, nothing very observable or measurable. For whenever we use any form of the verb *to be*, we tend to overgeneralize about ourselves. Thus, I really am not, although I may erroneously label myself as, "a tennis player." Instead, I am a person, an individual, who among many other things *sometimes plays tennis*. Nor am I a "good backhander at tennis." For I am an organism, a human who has several usual (and some unusual) tennis characteristics—including the one that I often hit the ball back at my opponent with a good backhand stroke *and* I often also do several other things while playing tennis, such as usually serve badly and retrieve the ball quickly, or hit it with a mean twist. Nor am I a great tennis player because my game today was particularly good. Rather, I am a man, a creature who today played very well, and who tomorrow may play very badly, the next day well again, and so on. If I *am* anything, then, I am very complex; and it is rather foolish and false to refer to me as simplistically *being* a tennis player, a psychologist, a writer, or almost anything else. I am, much more accurately, *a person who* does various kinds of things. So "Who am I?" is a silly question to ask about me. "What are my traits and how, at various times, do I perform them?" is much more sensible to ask.

Similarly, "What is my identity?" is a fairly meaningless question, despite the efforts of Erik Erikson to answer it. For the only conceivable answer to a question like this is, "I am a male," or "I am an American teenager," or "I am a writer of books on psychology." And all these are false overgeneralizations. I am really a human being, and I do innumerable things, some well and some badly. 1 cannot be legitimately characterized as a "leftwinger," a "rational-emotive therapist," a "musician," or by any similar over-inclusive or under-inclusive term. When 1 use these kinds of appellations to describe myself, I am using shorthand—and very inaccurate

shorthand at that—which probably far more obscures than reveals what/*and my traits* truly are.

When I ask, moreover, "What is my identity?" what I really mean, when I am honest, is, "How do I shape up against you? Am I not a member of a group (such as the group of liberal middle-aged Americans), which is at least equal to, and preferably superior to, the group of which you are a member? Isn't my identity, as compared to yours, real, honest, true, and good? Don't I, because of my identity, deserve to live and prosper, while you (for all I care) can easily shrivel up and die?" The questions, "Who am 1?" and "What is my identity?" could technically mean, as Erikson sometimes seems to imply, that I merely want to know what my traits are and what my real thing is, so that I may, with the use of this knowledge, enjoy myself during my 75 years or so of existence. But they truly, for the most part, are one of the main ways in which I play ego games—by which I devoutly hope to "prove" that I am great and you are not, that the world will justly honor me and damn you, and that I shall sooner or later get to heaven while you ignobly fry in hell.

That, in fact, is the basic reason for what we call self-esteem, feelings of worthwhileness, or ego strength: to show that I am good and you (i.e., the entire rest of the world) are not; that because I am good, I deserve to go on living and to enjoy myself; and that because I am good and deserve to go on living and enjoy myself, I shall ultimately attain some kind of salvation. When I have a good ego, I don't merely want to live and enjoy—I want to undevilify and to deify myself.

"Well," you may observe, "that may all be true. But as the sages have noted for centuries, isn't it also necessary that things be so? Can a human really live satisfactorily *without* ego, self-esteem, pride, feelings of worth, or whatever you want to call it?"

Why can he not? "Certainly," I started to tell a client when I saw that it would not be easy to convince him that he was good just because he was alive, "I can't prove to you that you're really worthwhile, just as you can't prove to me that you're really not. For whatever standards or measures we seem to use in these arguments, we're being tautological. I say, 'You're good just because you exist,' and you rightly show me that that's merely *my definition* of goodness or worth. And you say, 'I'm worthless because I perform badly,' and I rightly show you that that's merely your *definition* of badness. We both get nowhere with such arguments, because they don't have, nor can they ever have, any empirical referent. But why do we even have to think about or label your worth or value at all? Why do we *need* such a concept?"

"Well, *don't* we? I just can't even think of a human being not rating himself at all—not liking or hating himself."

"Why not? Why does he *have* to invent *any* kind or type of self-evaluation?"

"So that he can efficiently live, I guess."

"Efficiently?" I ask. "Nonsense! The more he evaluates or rates himself, the less efficient he is likely to be. First of all, he spends much, or even most, of his time and energy doing this evaluating. Secondly, he never comes up with a very accurate or consistent answer. Thirdly, he ultimately—because he is immensely error-prone and demandingly perfectionistic—evaluates himself rather negatively and thereby seriously *interferes* with many of his own performances. How does all *that* help?"

"I see what you mean. But I still can't see how he could avoid evaluating himself completely."

"Well, let me show you how he can," I confidently retort. Then I go on to show the client that all he really has to do is to keep entirely within the empirical realm and view his life in this manner:

1. He obviously exists or is alive—which can fairly easily be observably determined (and checked with others' observations).
2. He can either choose to remain alive or to let himself die—another empirically observable choice.
3. He can, if he chooses to remain alive, either strive for more pleasure than pain or for more pain than pleasure—a third empirically determinable choice.
4. He can decide in favor of living and of pleasure on the basis of the hypothesis, "*It* is good for me to live and to enjoy myself," or on the basis of the hypothesis, "*I* am good and therefore I deserve to live and enjoy myself." If he decides on the former basis, he avoids rating or evaluating himself, although he does rate or evaluate his performances (i.e., living and enjoying). If he decides on the latter basis, he brings in ego and evaluates himself.
5. Without any self-evaluation and ego-rating, he can decide to continue to live and to have as much enjoyment in life as he can find. His major questions to himself then do not become, "Who am I?" "What is my identity?," or "What is my worth?" They become, rather: "What are my traits?" "What sort of things do I enjoy and not enjoy doing?" "How can I improve some of my traits and find more things to experience—so that I will continue to live and to have a maximally satisfying existence?"

This is the main line that I now take with my clients. "Look," I tell them. "If *you must* rate or value yourself, or wallow around in what is ordinarily called ego and ego games—and I strongly advise you against it—you have a simple solution to the problem of worth. Just define yourself as good, in terms of your existence, your aliveness. Dogmatically tell yourself, 'I am alive, and I am good because I am alive.' This simple formula, if you really believe it, will work, and will be virtually unassailable. For, believing it, you will never feel terribly anxious or self-deprecating as long as you are alive. And when you are dead, you still won't have much to worry about."

"But if you want a preferable solution to the problem of human worth—and I strongly suggest that you strive for this solution—then you'd better avoid rating yourself at all. You are not *good* and you are not *bad*—you are merely *you*. You possess many traits, most of which you may (and often would better) rate: your abilities to read, to talk, to write, to run, to jump, to drive, just to name a few. But you never have to jump, as if by magic, from rating these traits to rating *you*. You can, if you wish, give your various facets, your characteristics, your talents, a report card; but you'd better not give *you* a similar report card. Then, minus such a self-rating, and minus playing the ego game and the power struggle of vying for 'goodness' with other human beings, you can ask yourself 'What do 1 really want in life?' and can try to find those things and enjoy them."

No therapist will have an easy time inducing clients to give up rating themselves and to stick more rigorously, at most, to assessing, measuring, and evaluating their traits. Humans, unfortunately, seem to be almost universally born and reared to give themselves self-evaluations. They use, to be sure, different trait ratings for these self-rating standards. In the United States, for example, they rate themselves as "good" if they have lots of money, education, or artistic talent; while in many more primitive parts of the world they rate themselves as "good" if they have a considerable amount of physical strength, child-begetting ability, or perhaps head-hunting proclivity. But wherever they are, they are not prone merely to accept themselves, with whatever traits and talents they happen to have, and to look for enjoyments that *they* happen to like (rather than those other people think that they *should* like).

Is this self-rating tendency of human beings more or less inborn? I think so—for if people all over the world, no matter how they are raised, tend to deify themselves and denigrate others, or vice versa, and to depress themselves horribly when they do not succeed in whatever aspects of life their culture tells them that they *should*, there is some reason to suspect that they naturally and easily fall into a self-assessing and ultimately self-condemning pattern. Love, it is often said, makes the world go round. Yes: self-love, mainly, or the frantic striving on the part of the great majority of humans to achieve such love.

Although man has unique powers of observation and logic and is consequently the one animal primarily born to be a scientist, he also has unique tendencies toward religiosity, magical thinking, anti-intellectualism, and non-empiricism. Rollo May thinks that man is innately predisposed toward what he calls the daimonic. But while May gives up and thinks that man had better make peace with his demon-creating tendencies and deeply imbedded roots in irrationality, I take a much more optimistic view. I contend that man *can* think more rationally, even though he rarely does; that he *is* able to give up superstition and magic; and that he can teach himself and fairly consistently stick with the logico-empirical method of confronting not only the external world but also himself and his own functioning. Further, if he really does this much of the time, he can stop his absurd ego games and self-rating and can tolerantly accept both himself and others and look for a much saner goal in life: to enjoy the experience of living.

So I say, again, to my clients: "All right, face it: you have screwed up very badly much of your existence. You failed to do as well as you could have done in your work; you married the wrong girl and then endlessly goofed on making the most of a bad deal or getting out of it as quickly and gracefully as possible; and you have been far worse a father to your children than you probably could have been, and have consequently helped them cause themselves a lot of needless trouble. O.K. So you did all this with your deadly little hatchet and there's no point in trying to excuse your acts or say that they were right. They weren't right: they were stupid and wrong. *Now*, why are you blaming yourself and denying your worth for acting in these execrable ways?"

"Well, *should* I have done those wrong things, and thereby hurt myself and others?"

"Of course you *should*—because you *did*. *It would have been desirable*, of course, had you not acted in those ways; but because a thing is desirable never

means that it *should* exist. Only some unalterable, godlike law of the universe could ever say that you should, you must, do what is desirable. And where is there such a law? Can you demonstrate that that kind of law ever has existed, or ever will?" "No, I see what you mean. And if there's no invariable law of the universe that says that I *should* not have done what I did, then I guess you also mean that there's no supplementary law which says that I should be punished for breaking that law."

"Right! You are intrinsically penalized, of course, for many of/your wrong acts. If you fail to do as well as you could have done at work, you lose out on some of the rewards of succeeding. If you stay with a wife who is incompatible, and you make conditions of living with her even worse than they had to be, you then lead something of a miserable married life. So acting poorly or inefficiently usually (though not always) has its intrinsic penalties. But when you think that you're a rotter and that you *should* be punished, you really mean that some magical, overlooking super-being in the universe is spying on you, is noting your errors, and is determining to punish you for them. Well—is it likely that there really is such an overlooking super-being who is so sadistically inclined that he's going to deliberately add *extra* punishment to your lot, when you have already seriously penalized yourself by your stupid behavior?"

"No, I guess it doesn't look like that. I guess I really do believe in some kind of devil when I think that I *deserve* to be punished when I have acted badly."

"You certainly do. And how about the hereafter business? Do you really believe that if you lead an error-prone, screwed-up life on this earth, you will be reincarnated somewhere else and made to suffer there for your earthman inadequacies?"

"Well, hardly! But my actions, admittedly, imply that on some level I do believe that kind of drivel, for I certainly often *feel* as if I'm going to be eternally damned when I don't do the right thing in this terrestrial existence."

"Yes. So you do keep damning yourself in various ways, and you do feel that you should be temporarily or eternally punished. The point is: you, as a human, are not rateable in any way, though your deeds may well be. Now, every time you do feel like a louse or a worm, you'd better fully admit that you are rating yourself negatively and then vigorously dispute this rating. You will not thereby necessarily solve the practical problems that beset you—such as the problems of how to work better, how to get along with your wife, or how to be a good father to your children—but you will solve your emotional problem. You will continually, unconditionally accept *yourself*, even though you will continue to dislike and refuse to accept a good deal of your behavior. You will keep rating your *traits*, but stop rating *you."*

"Can people really consistently do this?"

"Not perfectly, not always, not to the *n*th degree. But if they keep working at it, they can do it pretty well, and rarely have ego problems while otherwise remaining exceptionally human. In fact, to have an ego problem really means that you are striving to be *superhuman* and just will not fully accept your humanity, your fallibility. If you follow the rational-emotive procedure, which is one of the most humanistic methods of personal problem solving ever invented, you will unconditionally accept yourself and others *as human*. This kind of tolerance is, I contend, the essence of emotional wellbeing. Why not try it and see for yourself?"

The rational-emotive approach to psychotherapy is not only unusually effective clinically, but is now backed by a considerable amount of experimental evidence

which almost consistently supports its phenomenological tenets and indicates that human emotions and behavior are enormously influenced by cognitions. Besides being successfully practiced today by a number of clinicians who attest to its usefulness, it also has significant applications in education, in industry, and in other important aspects of human living. There is clinical, experimental, and other support for rational-emotive therapy.

All psychotherapy is, at bottom, a value system. The individual who is disturbed decides that he would rather be less anxious, depressed, hostile, or ineffective, and he thinks that he can be helped through talking with a therapist. On his part, the therapist agrees with the client that it is unnecessary for him to be so troubled and that he can somehow help him to feel and to behave better. Both the client and the therapist could agree, theoretically, that severe anxiety, depression, and hostility are beneficial—in which case the therapist could, as a social scientist, help the client to become more rather than less disturbed. But they both have similar prejudices or belief systems about what we tend to call emotional problems, and they agree to collaborate to minimize rather than to maximize such problems when the client feels that he is over-afflicted with them.

It has been clinically observed that most of the time when the client is beset with anxiety, withdrawal, inhibition, and depression, he values himself very poorly and thinks of himself as worthless, inadequate, or bad. As long as he has this picture of himself, or appraises his being in this manner, it seems almost impossible to help him very much with his basic emotional problems (although it may be possible palliatively to divert him from them in various ways). Consequently, the main goal of intensive, depth-centered psychotherapy usually becomes that of helping the client to stop devaluing himself and to gain what is usually called "self-confidence," "self-esteem," or "ego strength."

The rational-emotive approach to psychotherapy hypothesizes that there are two main approaches to helping the client gain self-acceptance, one inelegant and one elegant. The inelegant approach is to have him believe that he is "good" or "worthwhile" as a person, not because he does anything well or is approved by others, but simply because he exists. The more elegant approach is to show the individual that he does not have to rate, assess, or value himself at all; that he can merely accept the fact that he exists; that it is better for him to live and enjoy than for him to die or be in pain; and that he can take more delight in living by only measuring and valuing his traits, characteristics, and performances than by superfluously bothering to value his so-called *self*. Once the client is helped to be fully tolerant of all humans, including himself, and to stop giving them any global report cards, he has a philosophic solution to the problem of personal worth and can truly be self-accepting rather than self-evaluating. He will then consider himself neither a good nor a bad human being, but a person with fortunate and unfortunate traits. He will truly accept his humanity and stop demanding super-humanness from anyone.

Psychologically Flexible Self-Acceptance

Tami Jeffcoat and Steven C. Hayes

The term "self-acceptance" sounds simple but anyone trying to define it quickly realizes that it is not. What does "acceptance" mean? What is being "accepted?" Who is the "self" we are speaking of? Is the "self" doing the acceptance? Or is the "self" being accepted?

It is not as important to come to a consensus on these questions and answers as it is to be clear about them within a particular clinical and empirical approach. The present chapter is being written within the "contextual behavioral science" (CBS) tradition that includes Acceptance and Commitment Therapy (ACT, said as a word, not initials; Hayes, Strosahl, & Wilson, 2012) and its underlying research program in language and cognition, Relational Frame Theory (RFT; Hayes, Barnes-Holmes, & Roche, 2001). The core focus of ACT is "psychological flexibility", which we will use as the intellectual touchstone for the present chapter.

Brief Overview of Psychological Flexibility and Act

Psychological flexibility is a way of speaking about behavioral variability that is sensitive to contextual control, not overly limited by cognitive rules, and guided by what matters most to a person. Said another way, it involves "contacting the present moment as a conscious human being, fully and without defense, as it is and not as what the mind says it is, and persisting with or changing behavior in the service of chosen values" (Hayes, Strosahl, & Wilson, 2012). Broadly viewed, psychological flexibility has become a target for a number of modern empirical interventions (Hayes, Villatte, Levin, & Hildebrandt, 2011) but the precise approach and model

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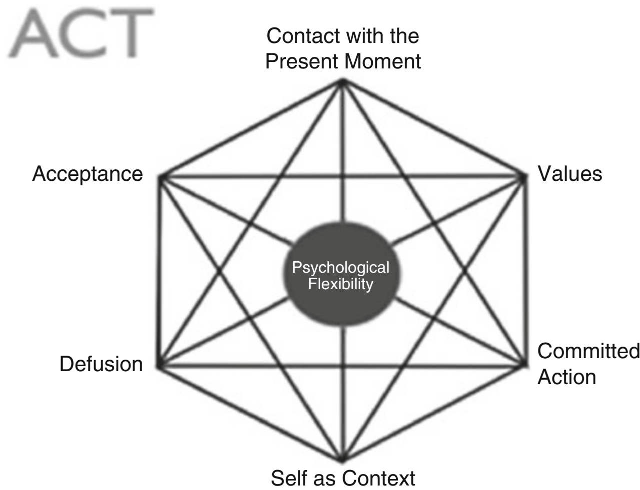

Fig. 1 Psychological flexibility model

vary. In ACT, psychological flexibility is said to be defined by six core processes (see Fig. 1), *acceptance, defusion, self-as-context, present moment focus, valuing, and committed action* (Hayes, Villatte, et al., 2011). Briefly, each of the interactive component processes of psychological flexibility can be described as follows:

- Acceptance involves both behavioral willingness and psychological (experiential) acceptance. Willingness is the values-based choice to contact private experiences or their environmental antecedents; psychological/experiential acceptance is an open, nonjudgmental posture with respect to those experiences (Hayes et al., 2012, p. 77).
- Cognitive defusion involves reducing the literal meaning of language sufficiently so that the process of thinking can be viewed, not just the products of thinking (Hayes, Strosahl, Bunting, Twohig, & Wilson, 2004, p. 8). It involves the conscious act of distinguishing between the content thoughts and the awareness of them.
- Contact with the present moment is flexible, fluid, and voluntary attention to the external and internal world in the present.
- Self-as-context is the awareness of a perspective taking sense of self from which to view internal and external experiences (Hayes et al., 2004, p. 9). This sense of self is argued in RFT to emerge from deictic cognitive relations such as I–You, here–there, and now–then and emerges when “I/here/now” comes together as a distinct perspective.
- Values are chosen qualities of ongoing patterns of action that establish meaning and purpose in the present. They are different from goals in that they cannot be achieved as concrete results; rather they are instantiated moment by moment in action itself (Hayes, Muto, et al., 2011).

- Committed action involves the construction of larger and larger patterns of values-based action (Hayes, Villatte, et al., 2011).

ACT has been shown to be effective in treating a wide variety of clinical issues (for a recent review see Ruiz, 2010) and to do so by altering psychological flexibility (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). The various aspects of psychological flexibility contribute to positive outcomes when they are specifically targeted by intervention components (Levin, Hildebrandt, Lillis, & Hayes, 2012). Psychological flexibility also predicts psychopathology, cross-sectionally and longitudinally (Hayes et al., 2006). Thus it appears to be a clinically and theoretically useful concept.

In this chapter, we will examine self-acceptance from the point of view of the psychological flexibility model that informs ACT. We will use the term *psychologically flexible self-acceptance* as a way of speaking about self-acceptance considered in this way. In what follows we will walk through each element of the psychological flexibility model and work up to a definition of psychologically flexible self-acceptance. We will then also discuss a psychologically flexible approach to the therapeutic relationship with emphasis on therapist self-acceptance.

Accepting Self Across Components of the Model

There are six core psychological flexibility processes. We will begin with issues of acceptance and issues of self because they are primary in this case, and then will proceed to the other processes. Accepting selfhood involves saying "yes" to each of these human processes.

Experiential Acceptance and Self-Acceptance

Saying "Yes" to Willingness to Feel, Think, Sense, and Remember Without Needless Defense

Experiential acceptance is an active embrace of the moment, taking an open and curious posture toward experiences, without attempts to change them when doing so is costly to valued living. From the perspective of the psychological flexibility model *acceptance* is viewed as an ability or skill set that encompasses both acceptance and change. It is not a prescription to hold onto what is as a permanent given; it is not a belief or a rule. Acceptance is not hostile or submissive tolerance, which in fact fails to relate to positive health outcomes (Cook & Hayes, 2010). Etymologically, *acceptance* means to take what is offered (Hayes et al., 2004). It is also sometimes just called *willingness* in the literature which fits well provided willingness entails experiential openness.

The reverse, *experiential avoidance,* occurs when a person is unwilling to stay in contact with some private experiences (e.g., emotions, thoughts, memories, urges,

sensations) and works to change the form, frequency, or situational sensitivity with these experiences, even when doing so is unnecessary or harmful (Hayes & Wilson, 1994; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). There is a lot of evidence that unwillingness to consciously contact difficult thoughts, feelings, or other experiences can lead, paradoxically, to even more of these experiences, greater reactivity to them, and fewer positive experiences (Chawla & Ostafin, 2007; Hayes et al., 2006; Sloan, 2004). Acceptance in this sense does not refer to acceptance of situations or actions that are changeable and whose modification serves valued living (Follette & Pistorello, 2007). The abused need not accept continued abuse; the on-fire house may be escaped; the job may be let go; the significant other may be asked to change behavior and rewarded for doing so. Follette and Pistorello (2007, p. 89) clarify this point for trauma survivors. "The challenge is to notice when control will work and when it won't…You can clear dangerous substances out of your house."

An analogy for experiential acceptance and willingness involves a story about having family as guests at a party (Hayes & Smith, 2005, pp. 125–6). Imagine many of your favorite family members are in your home and you are feeling pleased and so are the other guests. Then Aunt Ida, your least favorite Aunt, pulls up. Your heart sinks remembering each time she has arrived in the past, unkempt and a little smelly, critical and hostile to the rest of the family and especially to you, unappreciative of your hospitality. You don't *want* her at the party, but she has come to the door. You have a choice to welcome her or to try to keep her out. In welcoming her, she is still likely to be Aunt Ida. Trying to change her hasn't worked in the past and probably won't now. You can choose to keep her out, only to be distracted further by her anger and continued attempts to enter. This may even disappoint other guests who are open to welcoming the obnoxious aunt. You won't get to enjoy any of the party or guests if you focus your efforts on rejecting her. It may not even be possible to keep her out since she always knows how to get into the side door. The choice to welcome the unwanted guest is exactly that. It comes neither with ignorance nor with over focus on appeasing or expelling the "guest" but rather it a choice, guided by values.

In the psychological flexibility model, self-acceptance is not passive or avoidant. It is about consciously approaching what matters. High experiential avoidance leads to less behavioral flexibility and less contact with what is worthy in valued moments and worthy in accepting self. On the other hand, self-acceptance does not ask people to say "yes" to experiencing pain for its own sake—rather it asks that pain be carried in the interests of valued action.

Consider this analogy: To reach a beloved other person, you must cross a chilly pond of water with a small child in your arms. As you step into the shallows the tiny body you hold tenses and shakes with fear. The babe clutches you, legs squeezing your ribs, little arms so tight around your neck, little head wedged against your jaw, little shoulder pressed against your throat making it hard to breathe. It even hurts. You walk deeper into the water, up to your shoulders, and the pond feels colder and seems even larger than you predicted. The babe begins to fight, scream, and struggle. Here is a moment of choice. You can try to make the child stop screaming. Or you can turn back and abandon your journey and its purpose. You can drown yourself to end the pain. Or you can say "yes" to a supportive relationship with this child. You may put your arms around the babe in fear and with kindness, feel the pressure

around your rib, breathe through the tight pain in your throat, and feel the cold together. It is not merely the tolerant, partial "Yes, I guess I will drag this @#$% kid across this $#@! pond because I HAVE TO!" Experiential acceptance is enacted in the moment of embracing, from your core, the present moment child of your own self-process. This move is healing to a degree in and of itself (in the etymological sense of the term, meaning "to make whole"), but there is a larger purpose: to move toward what you care about.

Self-as-Context and Self-Acceptance

Saying "Yes" to Taking Perspective from the Core Self, Distinct from Experiences I Have

Work in Relational Frame Theory (Hayes et al., 2001) has established three major senses of self (Barnes-Holmes, Hayes, & Dymond, 2001; Foody, Barnes-Holmes, & Barnes-Holmes, 2012; Hayes, 1995), each of which has relevance to self-acceptance. They have been commonly called *self-as-content* (or the self as concept)*, self-as-process* (ongoing awareness or experience)*, and self-as-context or the transcendent self* (involving perspective taking).

Self-as-content consists of statements, stories, evaluations, and concepts about the self. In some contexts (e.g., contexts of literality; reason-giving), there can be a tendency to believe the literal truth of psychological content and to identify the self with mental descriptions and evaluations (Foody et al., 2012). The conceptualized self is the direct by-product of training in naming, categorization, and evaluation. It is the type of self-relatedness that we are most likely to be fused with (attached to). "We humans do not merely live in the world; we interact with it verbally and cognitively. We interpret it, build narratives about it, and evaluate it" (Hayes et al., 2012, p. 81), and we do so with respect to ourselves.

Self-as-process is ongoing personal experience including stream of thought, emotional and physiological behavior, and perceptions of the world as it continues to present itself. Among the differences between *self-as-content* and *self-as-process* are the tendencies to summarize, integrate, and evaluate self-concepts. When identifying with *self-as-content* we tend to attach to these conceptualization at the content level. This is different from open awareness of the flow and change experienced at the process level (Foody et al., 2012). *Self-as-process* involves experiencing all events in the moment including the verbal events that occur in that moment.

Self-as-context is the internal personal setting in which an aware *observer* of self-process is identified; it involves the self that is aware of awareness itself. The behavioral tradition has long held that responding to one's own responding is a key to self-awareness: "A person becomes conscious in a different sense when a verbal community arranges contingencies under which he not only sees an object, but sees that he is seeing" (Skinner, 1974, p. 220). Relational Frame Theory holds that this perspective-taking self develops from experiencing a consistent perspective or point of view (I/here/now) that is furthermore identified and related through verbal

processes (Hayes, 1984). A body of experimental work demonstrates how these processes work (McHugh & Stewart, 2012).

This center or observer of self refers to the "fromness" of awareness in which there is a differentiation between thought content and the sense of "I/here/nowness" of perspective taking (Foody et al., 2012). Akin to "wise mind" (Linehan, 1995), and theory of mind (see Doherty, 2012) in other approaches, it is a useful vantage point from which to appreciate whole selfhood. To appreciate our whole selves is to do so from this position of open awareness. Saying "yes" to a perspective-taking sense of self requires letting go of attachment to the conceptualized self in favor of a sense of self that is beyond categorization and evaluation. We don't have to define its properties to be aware of the observer. This self-perspective is not defined by content, and so it is not threatened by difficult material or apparent conceptual contradiction. For this reason it seems especially likely to facilitate psychologically flexible self-acceptance.

Clinically, contact with this sense of self is fostered by all mindfulness processes. It is present in all moments of awareness. A person asked to feel the sensations in the soles of his feet, and asked to be aware of who is noticing, will notice an observing person. RFT researchers have shown that this sense emerges from learning the deictic relations of "I—You," and "Here—There," and "Now—Then." As these cognitive/verbal relations (which are "deictic" meaning that they must be learned by demonstration) come together, "I" begins to refer to the I/here/now "experience of continuity and selfsameness, a 'central something" (Tsai et al., 2009). Saying "yes" to it allows action from this center.

Acting from this center can undermine avoidance. Otherwise, avoidance patterns are hard to extinguish (Luciano et al., 2008) because they tend to be automatically reinforced by relief from uncomfortable emotions. To move beyond avoidance we need to view our regularly aversive or appetitive feelings and related urges with open awareness, but forward on the basis of choice rather than impulse. Choice is not used here as a word that indicates an internal independent wellspring of will. From a contextualistic stance, choosing is itself learned behavior and in any literal sense, conscious will, free from environmental selection, is an illusion (see Wegner, 2002 for a volume-length discussion). To shape the behavior of *choosing* from the self-as-context perspective is to balance and broaden the influence of contextual variables. Instead of automatic avoidance or escape, one can choose, with broader awareness, to be open and to consciously apply flexible values-based rules in a situation. This perspective is also a central self from which to say "yes" to other component questions in the psychological flexibility model.

Defusion and Self-Acceptance

Saying "Yes" to Noticing Experiences as Distinct from What My Mind Says

Cognitive fusion is a process by which symbolic events dominate over other sources of behavioral regulation (Blackledge, 2007; Hayes et al., 2012). All complex

organisms can acquire relational responses based on formal properties (e.g., learning to pick the smaller of two things), but humans appear to be unique in their ability to bring that action under arbitrary contextual control (e.g., learning to treat this as smaller than that, regardless of their actual size—as occurs when a dime is said to be larger than a nickel). RFT argues that relational responses of this kind (those that are free to be under arbitrary stimulus control) underlie all symbolic behavior and calls their specific forms "relational frames." The meanings of a single word have been shown to be based on "frames of coordination" between a sound or sequence of letters, and an object or event, for example (Hayes et al., 2001). This becomes psychologically relevant because the functions of events change when they participate in such relations. This process is demonstrated in several studies in which functions of one event in a relational network alter the functions of other events in the network (i.e., *transformation of stimulus function*). Changes in functions are based on the derived relation between stimuli. For example, if event B has been paired with shock and is supposedly "greater than" event C, event C can be more aversive than B even without any shocks even having been paired with it (for an empirical demonstration, see Dougher, Hamilton, Fink, & Harrington, 2007).

Fusion technically refers to the domination of automatic-derived stimulus functions over other processes, such as direct experience, and values-based choices (see Blackledge, 2003 for article-length discussion or Hayes et al., 2001 for a book-long treatment). For example, a person who has framed sadness or anxiety with "weakness," and weakness with being unlovable, might avoid feeling or expressing such emotions because they threaten social rejection, based not on the direct experience of rejection but on this set of derived relations. Frames of opposition may lead such a person into forcing our displays of "happiness," regardless of internal experience (e.g., if difficult emotions = unlovable then perhaps lovable = constant displays of happiness).

Fusion with such verbal products can function as part of the context in which we reject our own emotional experience. This can happen without our conscious awareness and is only a tiny example of an expansively generative system. Verbal thinking processes can take on lives of their own with little environmental support. Many of the contexts that reinforce them are pervasive, such as sense-making, problem solving, and coherent storytelling; and the end result can be a diminished sensitivity to natural contingencies (Hayes et al., 2012, pp. 51–2).

Fortunately, because the transformation of stimulus functions is under contextual control (where it not, we would eat the words "ice cream"), we can create contexts that reduce the needless dominance of verbal stimulus control in given situations. The goal in each case, however, is not to rearrange the content of thoughts directly, but to provide a context in which the *function* of thought content can be altered. These "cognitive defusion" techniques are commonly used in ACT, but increasingly can be found in other contextual therapies where their aim is to increase psychological flexibility (Hayes, Villatte, et al., 2011). Examples include watching thoughts come and go as one might watch clouds; distilling thoughts to a single word and saying them aloud, repeatedly, for 30s; singing difficult thoughts to the tune of "happy birthday"; imagining that thoughts were physical objects and examining their attributes; and so on. Literally hundreds of such methods have been created over the last several years.

With respect to self-acceptance, cognitive defusion techniques help reduce fusion with self-stories and self-judgments (Blackledge, 2007), allowing broader and less rule-governed forms of self-awareness. This provides a greater ability to notice and observe the effects of one's history as one learns not to struggle with the content of consciousness.

Cognitive defusion facilitates, and in turn is facilitated by, other processes that interact with it in the model. For example, defusion helps the person say "yes" to the *distinction* between thought on one hand, and full awareness on the other. Thus, defusion supports perspective taking/self-as-context. Defusion can undermine the impact of self-limiting concepts or negative self-evaluations (Healy et al., 2008). Healy et al. (2008) point out that fusion often involves believing, without perspective, that thoughts say something very important (and seemingly true and permanent) about who we are. As a result, relevant experiences that contradict self-stories are ignored. Defusion helps individuals experience themselves as more than simply their concepts and personal evaluations. It undermines overidentification with our thoughts about ourselves and supports a broader and more flexible form of self-acceptance.

Contacting the Present Moment and Self-Acceptance

Saying "Yes" to Direct Experience of the Present

Life occurs in the present; it has nowhere else to be. But the degree to which attention can be allocated to what is present in a flexible, fluid, and voluntary way varies. Self-acceptance is fostered by the ability to attend to the present moment inside and outside the self and is one of the four mindfulness skills within the psychological flexibility model. Mindfulness is generally understood as awareness at the level of direct and immediate experience, separate from judgments, concepts, categories, and expectations (Dimidjian & Linehan, 2009). Mindfulness in the psychological flexibility model is the skill of being both *open* and *centered*. Openness is viewed as a combination of acceptance and defusion skills; centeredness means contacting the present from the self-as-context perspective. It involves the ability to attend to the internal and external world in a flexible, fluid, and voluntary way (Fletcher & Hayes, 2005). Contacting direct experience from a centered perspective facilitates openness to the whole of experience; at the same time being open facilities conscious and flexible attention to the present moment.

The evidence is clear that focused, voluntary, and flexible attentional processes can be learned (Baer, 2003). Practice at intentionally attending here/now is a task involving a perspective that does not change when the content of thoughts, feelings, and experiences does (Wilson, 2012). In this way the observing "I" is differentiated from what "I" observe about myself. This differentiation strengthens centering processes. In a sense, centering processes (contacting the present moment from a perspective-taking sense of self) are like hinges that can allow emphasis to move from

rigid self-concept confirmation toward the creation of life patterns: "Conscious and flexible attention to the now empowers the person to activate defusion and acceptance skills when they are called for or to engage in value-based actions when they are needed … and it is empowered by centering processes" (Hayes et al., 2012, p. 78).

Coming into the moment does not mean ignoring the past. For example, when we remember, we do so now. Memories are *present* when they are, and trying to shut them out can generalize to ignoring many other features of ongoing experience. This is a form of self-rejection and also a loss because we learn from our experiences. Coming into the present is an implicit form of self-acceptance. It helps one to "turn around and embrace one's immediate experience in a nonjudgmental way and without struggle. This very act many gradually alter emotional response, but in an inclusive and open way in which all aspects of one's history are welcome to come along for the ride (Hayes et al., 2012, p. 77)."

Values and Self-Acceptance: Saying "Yes" to Choosing Directions I Truly Value

Values are "freely chosen, verbally construed consequences of ongoing, dynamic, evolving patterns of activity, which establish pre-dominant reinforcers for that activity that are intrinsic in engagement in the valued behavioral pattern itself" Wilson and Dufrene (2008, p. 66). In other words, values are chosen qualities of action that are here and now. They are more than reinforcers (Skinner, 1971); they require verbal knowledge and choice (Yadavaia & Hayes, 2009). From an RFT perspective, values are verbal establishing operations (Plumb, Stewart, Dahl, & Lundgren, 2009). Choosing a value such as "I want to be more loving in my relationships" is the verbal equivalent to depriving food to a lab animal for the purpose of raising the reinforcing value of food. The statement draws attention to what can sometimes be missing.

Valuing in a psychologically flexible way involves embracing what matters by choice, not being trained in what "should" matter; or merely complying with others. Values thus involve all of the other processes of psychological flexibility. For example, values choices require defusion skills—otherwise choices are merely fused, analytical decisions. Similarly, values require acceptance skills because the behavioral implications of values choices are often difficult. Valuing requires present moment skills because experiences in the present inform us about what brings meaning and purpose to our lives. As such, saying "yes" to choosing life directions means saying "yes" to the other components of the psychological flexibility model and to our whole selves.

It is common for people to seek self-acceptance by changing thoughts about themselves to feel better sooner. Sadly, this can limit psychological flexibility and reduce valued living. If being loving is valued, then openly feeling its absence is an opportunity to change behavior to fit with what is deeply desired. RFT researchers have shown that values rely on a verbal transformation of stimulus functions

(Whelan & Barnes-Holmes, 2004 and Whelan, Barnes-Holmes, & Dymond, 2006). For example, suppose worries about adequacy lead to excessive work in a person who values having playful family relationships. Such a value can alter the automatic functions of worry when the values cost of workaholism is detected. A values-based plan such as "I'm going to work hard for two hours, and then I'm going to swim with my kids," can help the individual defuse from worry and to serve something more meaningful by resisting the urge to work more than is necessary.

In simple terms of psychological flexibility, one is working in the valued direction of family play. Whole living is the payoff for self-acceptance in this form: saying "yes" to values directions.

Commitment and Self-Acceptance

Saying "Yes" to Doing What Moves My Life in Chosen Directions

Doing what matters involves saying yes in all of the ways so far discussed. Self-acceptance (or saying "yes") blossoms in committed action—"the continuous redirection of behavior so as to construct larger and larger patterns of flexible and effective behavior" (Hayes et al., 2012, p. 136). Saying "no" can lead to the ultimate denial of self—the absence of valued living. Self-rejection in this form can become a life of narrow patterns of action disconnected from what is meaningful.

Doing what serves values is often limited by fusion or experiential avoidance and the self-accepting move in these cases is to take a stance of openness. Values provide meaning and purpose to openness itself. Feelings and urges can better be accepted, not as ends in and of themselves, not as a matter of wallowing for no purpose, but rather because they are part of a self-commitment to act in a way that builds a meaningful life.

Defining Psychologically Flexible Self-Acceptance

Having discussed the six core processes in psychological flexibility, we can bring them together in a broader definition of self-acceptance. We have presented the psychological flexibility model as if each process is a kind of question and the issue is whether an individual answers that specific question "yes" or "no." ***Psychologically flexible self-acceptance*** is answering "yes" to all of them rolled into a single overall question: ***From the perspective of a conscious, perspective-taking human self, distinct from the events outside and inside of my own skin of which I am aware, am I willing to feel, think, sense, and remember these events, fully and without needless defense, as I directly experience them to be and not what my mind says they are, and to do whatever it takes to move in the direction of what I truly value here and now?*** Said in a simpler way, am I willing to be my whole self, here and now,

and to live a life that accords with what I value? If the answer is "yes" for that moment the person is building a pattern of psychologically flexible self-acceptance. Self-acceptance in this perspective is not a thought, a feeling, or a state. It is an ongoing action of being true to oneself and what life itself affords.

Being human is a skill that human beings can acquire. Accepting oneself involves accepting being *human.* Acceptance of being human involves accepting difficult feelings and accepting the finite nature of life. It also involves accepting our capacity to care and to behave in ways that make a difference. As such the psychological flexibility model is similar to some of the assumptions of positive psychology (Seligman, 2002) and focuses on living fully and flexibly, not on alleviating or removing difficult content.

Psychologically Flexible Self-Acceptance in the Therapy Setting

The Therapeutic Relationship

"Powerful relationships are inherently psychologically flexible" (Hayes, et al. 2012, p. 143). The psychological flexibility model has been argued to provide a path not only for self-relating, but also for the therapeutic relationship. The model implies a partnership "that draws the client and therapist into one coherent system … They are both human beings, each struggling with their own experiences, and yet bound together to accomplish a common purpose that each one values" (Pierson & Hayes, 2007).

The psychological flexibility model can be applied to the therapeutic relationship in three ways. The first involves the posture of the therapist toward his or her own psychological events. The second is at the level of therapeutic process and the qualities of therapeutic interactions. The psychological flexibility model encourages interactions that are themselves accepting, defused, aware, present focused, valued-based, and conditionally active. The third involves using methods and techniques to help clients learn flexibility processes. This last domain is the subject of myriad books on ACT and is not our focus here, but the first two are more directly relevant because they involve the *therapist's own psychologically flexible self-acceptance*.

The therapeutic relationship is a human relationship. If you are a clinician, consider a moment of your own unexpressed and possibly subtle sadness, fear, or even anger with a client. The urge is often to ignore it or dismiss it as "just nothing" as if feelings without reasons or obvious explanations are not worth noting. You may dismiss your own moment of emotionality as nothing to do with the two of you. But saying "no" to the experience may be saying "no" to the relationship and is possibly a self-rejection. It is possible that this in turn will model self-rejection for the client, who may well sense the rise and fall of emotion in the session and will see—perhaps without full awareness—the act of turning away.

Self-acceptance in the psychological flexibility model calls for a compassionate awareness of the limits of language and verbal consciousness. An individual is so much more than his mind can say, and a relationship between two people will always be ineffable to a degree. William Follette, in his acknowledgments in a recent *Guide to Functional Analytic Therapy* (Tsai et al., 2009), modeled this posture: “I would like to thank all of those who have shaped my thinking, caring, and humor. I have no idea who all of you are and how you did it.” The summative psychological flexibility question does not stand outside of the session room, nor does it only enter it for the client. Acceptance of self is extended to “us” in the therapeutic relationship and in saying “yes” to the flexibility question for *us*.

Consider the literature on emotional facial expression. There is evidence that facial expressions evoke some reliable and particular emotional responses in others who observe them (Dimberg & Öhman, A, 1996; Keltner & Kring, 1998); even when presented below the conscious awareness of the observer (Esteves, Dimberg, & Öhman, 1994). We see more than we think and convey more that our mind can say to us about our experiences. Thus, emotions become a kind of indicator of what may not be intellectually “known” or consciously described: “For example, if you are feeling angry without obvious reason it might be useful to explore how the client deals with issues of anger, hurt, or vulnerability, or how the client is currently feeling.” (Hayes, et al., 2012, p. 148). This doesn’t mean you “know” that your client is dealing with an emotion related to your reaction, it just means clinicians need to be self-accepting to have access to the possible value of intuitive experiential information.

Compassion: Acceptance with Kindness

The psychological flexibility model implicitly includes self-compassion and compassion toward others. Compassion literally means to “suffer with” with suffering meaning have pain, not necessarily psychological struggle (although that may also apply). It is a quality of awareness and kindness that involves empathy and perspective-taking processes. Acceptance, defusion, contact with the present moment, and self-as-context, that make up the mindfulness processes of ACT, are conceptually congruent with those of compassion and self-compassion. For example, Neff (2003, p. 88) describes self-compassion as involving “the clear seeing and acceptance of mental and emotional phenomena” as they present themselves.

In the therapeutic relationship, it is not possible to fully accept others and to have compassion for their struggles without also being self-compassionate. This is true for a simple reason: seeing your pain pains me. If I need to reject my own pain, it becomes important to defend myself against seeing yours. The reverse is also true. I cannot genuinely accept myself while rejecting you because I would have to reject the pain of seeing your pain. Thus, a genuine therapeutic relationship requires perspective taking skills, openness to sensing the pain of others (empathy), and experiential acceptance. RFT researchers have shown that these three processes working together predict social caring (Vilardaga, Estévez, Levin, & Hayes, 2012).

From the psychological flexibility perspective, a lot of self-struggle comes from normal psychological processes, particularly those involving human language. Clearly, abnormal processes can also exist, but ordinary processes of self-reflective language and thought may make such conditions worse (Hayes et al., 2012). Humans naturally struggle with experience. We deny our feelings. We try to think ourselves out of thinking. We avoid attending to here now. We stick to utterly unworkable rules. Compassion for the "no" processes in ourselves and others, while being open and aware that they are happening, is ironically a key way of saying "yes." Just like experiential acceptance, this is neither submission nor tolerance. It is a way of coming into the present and moving on.

This is the way a psychologically flexible relationship works. We are all in the same boat. We can accept ourselves and others even when we are struggling with self-acceptance.

Selves in the Therapy Room

Since the chapters in this volume are each focused on different formulations of self-acceptance, it seems useful here to explain more about the senses of self previously described in terms of issues and opportunities related to therapy interactions. At the start of this section, it must be clear that accepting self and training self-acceptance with processes in the psychological flexibility model does not require that a client be made to believe that his or her self is "nothing", or that "I" is a word used to mean a constant perspective from "here/now" across multiple various settings and conditions within the skin. The client does not need to be convinced of or understand the model theoretically in order to say "yes" to psychological flexibility processes in the context of the therapeutic relationship. Some common sense terms are useful in therapy, and it is usually pointless to insist that the client understand technical concepts. Many meditations or mindfulness exercises include prompting individuals to notice the person "behind the eyes." In popular language and culture and some scientific communities, it is an often accepted assumption, though arguably unfounded, that there is some "seat of consciousness" that is the core, real self or center of our conscious person. This subjective experience is commonly reported (Bertossa, Besa, Ferrari, & Ferri, 2008), even though scientifically speaking it arguably does not exist except in the form of the whole body interacting with surroundings (Kantor, 1959; Noe, 2009, p. 7). It is merely pragmatically useful, in using the flexibility model, to metaphorically represent a physical position from which to observe.

To help clients toward self-acceptance, the three senses of selves are involved both for the client and the therapist. The therapist and client alike have a conceptualized self and a conceptualized other. The therapist and the client alike are reading their own processes and those of the other. But the therapists and client alike are also observing this content from a perspective taking repertoire—from self-as-context. This is the most interesting aspect of self in the therapeutic relationship because it is the context in which we develop theory of mind (Weil, Hayes, & Capurro, 2011; Wilson, 2012).

According to RFT (McHugh & Stewart, 2012), self-as-context is inherently social and expansive for this reason: the deictic verbal relations that give rise to it are (like all relations) bi-directional. It is not just "I"—it is "I/You." It is not just "here"—it is "Here/There." It is not just "now"—it is "Now/Then." "I/you" is the perspective of I interconnected with the perspective of you. Both emerge at the same time and the relational frame does not exist until both are present and interrelated. The same applies to all deictic relations (for a further discussion see Hayes, Muto, et al., 2011).

RFT argues that relational frames emerged from social cooperation as an extension of our eusociality (Hayes & Long, in press). In a deep sense, *we* are conscious as human beings. In therapy this sense of interconnection itself models self-acceptance.

Modeling Psychologically Flexible Self-Acceptance

A Transparent "Yes!" to the Therapist's Self-acceptance Question

As human beings and helpers, we can make transparent our own compassionate self-acceptance, or even our struggle with it as it relates to helping them. This does not, of course, mean making the session about the therapist. It just means opening the window to the therapist's process as it relates directly and usefully to the client's treatment. As clinicians, we can invite ourselves to stand as a living interacting "Yes!"—the answer that brings us to self-acceptance with our clients as a response to the clinician's question: ***From the perspective of a conscious human being, in the role of a therapist in relationship with another conscious human being, can I see myself as distinct from the events of which I am conscious inside of my own skin and that I perceive about the client, and am I willing to feel, think, sense, and remember these events, fully and without needless defense, as I directly experience them to be without buying what my mind or the client's mind says they are, and to do whatever it takes to move in the direction of what I truly value in serving the clients values?***

Consider how this might look in pieces

From the perspective of a conscious human being, in the role of a therapist in relationship with another conscious human being, can I see myself as distinct from the events of which I am conscious inside of my own skin and that I perceive about the client?

The sense of transcendence that emerges from shared consciousness can be part of the therapy in the body of the therapist and facilitate the relationship. Taking perspective on the individual and relationship processes empowers the work to be implicitly validating, compassionate, and conscious. Calm humility and sobriety can characterize the interactions as therapeutic processes are worked. The therapist can respect his own and the client's central person. Mindfulness and choice are facilitated from these centers. The therapist can model saying "yes" to the transcendent perspective by saying to the client, when appropriate, "I notice myself here now being caught up in the problem you face and wanting to solve it. I am pulled to be the 'good problem solver' here. From my core I sense that it will not be helpful."

Self-as-context expands the potential of acceptance and defusion in the present moment in therapy and in the relationship. Because perspective taking is a socially learned and engaged process, taking an open, accepting, and active stance with yourself entails also being able to do so for others and vice versa. Self-as-context awareness helps us take perspective on our own pain and also allows us to be conscious of the pain of others. This, in turn, is painful. These are precious therapeutic moments where modeling acceptance is possible. Here, as much as anywhere, compassion and self-acceptance are related to each other and to the model. "It's hard for me to see you in pain, but I am totally willing to feel what I feel here and you don't have to pretend," models acceptance. "From my center, I can see that we are perfectly ok here in this room even while my stomach is tight as we talk about our last session," models taking perspective.

- ***Am I willing to feel, think, sense, and remember these events, fully and without needless defense?***

When sessions are filled with intellectualizing or become mired in emotionality without attention to the whole of the present moment or deliberate attention to part of it, the opportunity to work on processes as they occur can be lost. This can occur if either party narrowly focuses away to thoughts of other times and places. The therapist can say "yes" to the present with acceptance in this moment, usually simply acknowledging that inattention has happened even in the therapist. This distraction is happening in the present, after all, and noticing that models present moment focus without self-judgment. Of course, it is often necessary to talk about other times and places, but even as that is happening, the talk is here and now between two people. It can be useful to model noticing in ways that can involve saying, "right now as you talk about your teacher, I myself feel a lump in my throat. What are you feeling in your body right now as we talk?" This is intimacy building and fosters the therapeutic relationship as alive in the moment. The present is shared and can be communicated to each other throughout. If the talk narrows your attention or that of the client to thoughts about there and then and others, you are not here now with each other and less of the contacted experience is shared.

- ***… As I directly experience them to be without buying what my mind or the client's mind says they are…***

Hayes, Strosahl, and Wilson (1999) mention the possibility of acknowledging to the client that there are almost like four people in the room: "you and I and your mind and my mind." In this way, and others, when a defused stance is adopted, the relationship and interventions can be more playful at times. The client may implicitly become reassured that the "therapy intellectual mind" is not going to be in charge continually bullying the both of you. When confusion shows up for both of you, it doesn't have to be a threat to either of you. In the context of fusion, and without a self-observing perspective, events that contradict our favorite stories can raise emotions and result in experiential avoidance (Mendolia & Baker, 2008). That is as true for the therapists and his or her stories (e.g., "I'm a great therapist") as it is for the client. What stories do we buy about ourselves in the therapy room? How does buying them affect clients? What do we do to try to make some of them seem

true or false? (Wilson & Dufrene, 2008, p. 61). When the therapist is able to let go of these stories and take a risk, clients sense what is happening. It models, instigates, and supports psychologically flexible self-acceptance in the client, to display and use those processes oneself as a therapist.

Developing a habit of defusing from judgment facilitates self and other acceptance. Looking at, rather than from, judgmental self-referential thoughts is similar to practicing defusion from judgmental thoughts toward others. Fusion with judgments may fuel many of the problems of stigma including self-stigma. The things we judge in others are often events and behavior of others or our own in our history. Seeing the difference between thought content and the rest of present moment experience undermines stigma when use with the model. This is relevant in the room. ACT has not only been tested with respect to self-stigma with clients (e.g., Lillis & Hayes, 2008; Yadavaia, 2012) but also examined with respect to the stigmatization of racial and ethnic groups (Lillis & Hayes, 2007). Most relevant to our stigmatizing processes as clinicians, the model has had impact on stigmatizing those with mental disorders (Masuda et al., 2007), and even to the tendency for clinicians to stigmatize their own clients (Hayes et al., 2004). These unhelpful effects are undermined by saying "yes" to this question—a move to become more flexibly self-accepting as we notice our judgments for what they are and reorient to our experiences and values with clients.

- ***…and to do whatever it takes to move in the direction of what I truly value in serving the clients values?***

There are moments in therapy when every therapist may find himself saying, "Why does the client keep doing that maladaptive stuff!? I have tried and tried to convince her and I just cannot get through!" This is a comical moment from a defused place when one considers that client values, therapist values, and clinical targets are not being served inside such entanglement. The therapist might as well ask "Why am I still doing this maladaptive stuff?" When this moment arises it is possible to see that you have come to an unworkable impasse with the client. Valuing is not happening for either of you, and it is almost certain that cognitive fusion, non-acceptance, and lack of perspective taking, are in the room.

Often, convincing the client about what he or she should want to do undermines saying "yes" to self-aware values choices for both of you. When you became a therapist, did you really imagine and hope that you would receive the award for the clinician who most effectively made clients do the specific behaviors you thought they should? If yes, then this is probably not your favorite chapter. If not, then step back and consider this: The pain of psychopathology in the psychological flexibility model has two sources. One is the pain of presence—the presence of uncomfortable thoughts, emotions, sensations, or situations that bring them on. Problem solving for the client and campaigning for the specific form of situational solutions may temporarily help with that if it does. If so, you have merely helped the client and yourself in a smaller way.

Another larger and more usefully targeted source, however, is the pain of missingness. Qualities of living that are absent can be painfully so. Pain here is not an enemy, but an indication of values. Pushing a client to enact your own agenda of

problem solving or to accept what you think the client should value is not a goal of the psychological flexibility model. A lot of value to you and your client will go missing if this is your goal. Getting in touch with what you really care about in clinical work is key to supporting what the client really cares about. To do so, Wilson and Dufrene (2008) talk about staying opening to what is felt in the moments we hesitate to take hold of what we really care about. "What if it were possible for you to be an instrument of extraordinary change? What if you could be an instrument of liberation in the lives of your clients? See if you can feel the push and pull that arises when you consider claiming that possibility." (p. 68).

The Therapeutic Relationship in Summary

The therapeutic relationship is inherently empowering in part because powerful therapeutic relationships support psychologically flexible self-acceptance. They model it; they use it; they target it. That is not just a claim: there is evidence for it. For example, when measures of client flexibility are allowed to compete with measures of the therapeutic alliance as predictors of clinical outcomes, changes in flexibility skills account for much of the variance that would otherwise be due to the therapeutic relationship (e.g., Gifford et al., 2011). This is not because the relationship is unimportant, but rather because the relationship is the primary means by which flexibility skills are usually imparted to the client. Relationships that function as accepting, defused, present, conscious, values-based, and flexibly active produce changes in the client's psychological flexibility and empower progress. So far this idea has not been examined outside of ACT—it would be a powerful extension of the analysis presented in this chapter to assess how therapists' psychologically flexible self-acceptance applies to other forms of intervention as well.

In Summary

Psychological flexibility processes work together to undermine normal processes of cognitive fusion and experiential avoidance that prevent us from living full lives and can lead to self-struggle. Actively and consciously saying "yes" to psychological flexibility processes produces psychologically flexible self-acceptance. It involves experiential acceptance and self-perspective taking in ways that are more apparent, but also includes all other components of the model. Psychological flexibility processes can inform approaches to the therapeutic relationship and empower it as the therapist practices and models psychologically flexible self-acceptance. When each person says "yes" to the flexibility questions, and when the therapist brings kindness and compassion to therapeutic interactions, clients are emboldened to step into consciousness in the present and to accept their histories, thoughts, and feelings. They are, most importantly, moved to lives of self-acceptance, building larger and larger patterns of flexible, values-based action.

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Unconditional Positive Self-Regard

Tom G. Patterson and Stephen Joseph

Introduction

The aim of this chapter is to discuss the concept of unconditional positive self-regard (UPSR), its assessment and utility in clinical practice and research. First, we will provide an historical overview of the concept of UPSR which will describe its origins within the person-centered psychology of Carl Rogers, based on his theory that living according to internalized conditions of worth thwarts the natural organismic tendencies of the person predisposing them to poorer psychological health. The main point we wish to emphasize is that person-centered psychology is a social psychology that grounds experiencing of the self within the social and cultural context of the developing person. Second, we will describe the development of a scale to measure UPSR and discuss recent developments in social psychological research and theory in unconditional or noncontingent self-relating, which are consistent with and advance the person-centered conceptualization of UPSR. Third, we will consider the therapeutic applications of the UPSR construct and person-centered theory in relation to recent developments in healthful approaches to self-relating from other therapeutic traditions (namely *third wave cognitive therapies*). We will consider points of conceptual and theoretical overlap and implications for future research and practice between the third wave therapies and person-centered psychology.

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Person-Centered Psychology

Person-centered psychology was originally developed by Carl Rogers in the 1950s (Rogers, 1951, 1959, 1961) and has since become one of the most influential systems of thought in relation to the helping professions (Barrett-Lennard, 1998). At its core is a social–developmental approach to understanding human functioning.

In brief, person-centered theory proposes that infants have a basic and universal need for positive regard from the social world around them. As the developing infant starts to become aware of the separation between *self* and others, this need comes more into play. The infant and then the child learns to respond in ways that result in receiving love and affection from parents, caregivers, and significant others. Some children subject to abuse and criticism do not find ways to satisfy their need for positive self-regard and develop low levels of self-regard. Others do develop a sense of positive self-regard. However, as love and affection from others can be communicated either conditionally or unconditionally, the child's positive self-regard can take two forms.

When children perceive themselves to be unconditionally regarded, they learn to trust in their own experiencing. In contrast, when they perceive themselves as conditionally regarded, a conflict is established in which they learn that in order to be loved (positively regarded), they must not trust their own experiencing. Thus, they introject from their familial and social interactions (from the social environment) various attitudes, beliefs, and values that provide them with rules for living that govern their behaviors (Rogers, 1959).

In person-centered terminology such rules are referred to as *conditions of worth*; that is to say we judge ourselves in terms of how well we live up to our conditions of worth and our self-regard becomes conditional upon them. In short, conditions of worth are the internalized rules and values upon which the individual's self-valuing has become contingent. As Rogers wrote:

> It is when he behaves in accordance with these introjected values that he may be said to have acquired conditions of worth. He cannot regard himself positively, as having worth, unless he lives in terms of these conditions. He now behaves with adience or avoidance toward certain behaviors solely because of these introjected conditions of self-regard, quite without reference to the organismic consequences of these behaviors. This is what is meant by living in terms of introjected values (the phrase formerly used) or conditions of worth. (Rogers, 1959, p.225).

The essence of person-centered theory is that it is an organismic theory of personality development which considers that humans, in common with all living organisms, are born with an innate motivational drive, the *actualizing tendency*. Rogers (1959) defined the actualizing tendency as:

> [T]he inherent tendency of the organism to develop all its capacities in ways which serve to maintain or enhance the organism … [This tendency involves] development toward autonomy and away from heteronomy, or control by external forces (p.196).

Under favorable social–environmental conditions, person-centered theory proposes that the individual's self-concept actualizes in accordance with his or her

organismic valuing process (OVP) such that, the more that positive regard from significant others is communicated unconditionally, the more the child learns to evaluate his or her experiences organismically. The OVP is thus conceptualized as a regulatory feedback system for checking in with self-experiencing and evaluating experiences in a manner that is consistent with intrinsic needs:

> … [T]he human infant is seen as having an inherent motivational system (which he shares in common with all living things) and a regulatory system (the valuing process) which by its 'feedback' keeps the organism 'on the beam' of satisfying his motivational needs (Rogers, 1959, p.222).

Unconditional positive self-regard therefore refers to the individual's acceptance of all of his or her subjective experiences, without reference to either the perceived attitudes of others or to rules or values that have been internalized from the social environment. It involves relating to all of one's experiences, whether positive or negative, with warmth and a nonjudgmental understanding. People differ in the extent to which they unconditionally regard themselves. Total UPSR might be regarded as an ideal; most people have at least some degree of conditional regard for themselves. When positive regard is communicated conditionally, the child goes on to internalize these conditions of worth, and over time compliance with the introjected conditions of worth replaces organismic valuing as the principle guiding the individual's behavior.

As the developing person becomes estranged from his or her organismic needs, there is a loss of ability to trust the evidence of one' s own senses, accompanied by the emergence of a tendency to defer to the judgment of others in order to determine the value of an experience. What this means is that individuals who over time have introjected many conditions of worth become alienated from the actualization tendency of the organism, lose the ability to trust the evidence of their senses and will, instead, often defer to the judgment of others in order to determine the value of an experience. It is of course not the objective other that the individual is responding to, but rather his or her perception of the other; something that is intimately tied to his or her internal world of inner experiencing, now governed by introjected conditions of worth.

Consequently, person-centered theory hypothesizes that vulnerability to psychological maladjustment arises through the internalization of conditions of worth as the child develops, i.e., the alienation of the individual from his or her organismic needs resulting in a greater vulnerability to psychological disturbance. Defensive processes of denial and/or distortion of self-experiences which do not fit with the individual's conditional view of self cause a state of *incongruence* between self and experience, whereby the individual's *self-regard* or valuing of himself or herself becomes increasingly conditional upon maintaining the standards demanded by his or her internalized conditions of worth. Inaccessible to the individual's awareness most of the time, these rules can break through defenses and into awareness in the face of experiences that overwhelm the defenses (Rogers, 1959).

We are not necessarily conscious of our conditions of worth although we can become conscious of them, which is one function of client-centered psychotherapy. The therapeutic goal of client-centered therapy is loosening of rigid internalized rules and values in order to allow the individual freedom to grow and develop, and

this is facilitated by establishing certain core or *necessary and sufficient* relationship conditions (of congruence, empathy, and unconditional positive regard). In this way, the client is encouraged to evaluate experiences organismically rather than in accordance with conditions of worth (Rogers, 1957, 1959) leading to positive therapeutic change, evidenced by an increase in his or her UPSR and a decrease in conditions of worth. An essential part of this process is the therapist's communication of unconditional positive regard to the client, creating a nonjudgmental and accepting therapeutic environment that is valuing of the client's inner experiencing (Rogers, 1957, 1959; Bozarth, 1998). Additionally, it is important to note that within client-centered therapy, working from the clients' *frame of reference* is given primacy (Rogers, 1957, 1959). The process is summarized as follows:

1. In order for the process of 'defense' to be reversed—for a customarily 'threatening experience' to be 'accurately symbolized' in 'awareness' and assimilated into the 'self-structure', certain conditions must exist.
   a. There must be a decrease in the 'conditions of worth'.
   b. There must be an increase in unconditional 'self-regard'.
2. The communicated 'unconditional positive regard' of a significant other is one way of achieving these conditions.
   a. In order for the 'unconditional positive regard' of a significant other to be communicated, it must exist in a context of 'empathic' understanding.
   b. When the individual 'perceives' such 'unconditional positive regard', existing 'conditions of worth' are weakened or dissolved.
   c. Another consequence is the increase in his own 'unconditional positive self-regard.'

> Conditions 2a and 2b above thus being met, 'threat' is reduced, the process of 'defense is reversed', and 'experiences' customarily 'threatening' are 'accurately symbolized' and integrated into the self concept.' (Rogers, 1959, p.230).
>
> With the increase in unconditional positive self-regard comes a less contingent way of relating oneself wherein, "(t)he client is more congruent, more open to his experience, less defensive." (Rogers, 1959, p.218).

Over recent years, therapeutic effectiveness has increasingly become restricted to the narrow focus on symptom-reduction informed by the dominant biomedical model of mental health. The biomedical model, however, ignores the range of different psychological, emotional, and relational processes described by the person-centered model, which offers social–psychological understandings of mental health that consider the individuals in relation to their social world. However, empirical investigations into person-centered hypotheses have been limited due to the lack of operational definitions of the core concepts.

As such, UPSR would seem to be an important variable for research in order to provide a non-medicalized therapeutic outcome measure for use in practice and in research (Patterson & Joseph, 2006). With such a measure, it was thought that giving more emphasis to a process outcome would allow therapists to evaluate therapy effectiveness without losing sight of either the whole person or the whole therapeutic approach (Patterson & Joseph, 2007b). In developing a scale for the measurement of UPSR (Patterson & Joseph, 2006, 2007b), we established an operational definition of the construct based on Rogers (1959) formal definition:

> When the individual perceives himself in such a way that no self-experience can be discriminated as more or less worthy of positive regard than any other, then he is experiencing unconditional positive self-regard. (Rogers, 1959, p.209).

According to this definition, there are two distinguishable facets of UPSR. The first element refers to the expression or withholding of positive regard toward oneself, or *positive self-regard*. Whether or not positive self-regard is expressed is *conditional* upon the individual's perception of his or her self-experiences as differentially worthy of positive regard. This *conditionality,* or conditional–unconditional continuum, is the second component of the construct of UPSR. It follows then, that UPSR attempts to capture an attitude, which is characterized by the individual's self-regard being positive while at the same time being non-contingently self-accepting.

The Measurement of Unconditional Positive Self-Regard

In our original study of a sample of 210 university student participants, principal component analysis identified two components or factors accounting for 56.9 % of the total variance of the unconditional positive self-regard scale (UPSRS; Patterson & Joseph, 2006). The first component comprised six items that referred to affective or cognitive evaluation of oneself in a more positive or less positive manner and was characterized as *Self-Regard*. A further six items loading onto the second component referred to either affective or cognitive evaluation of oneself in a less conditional or unconditional (noncontingent) manner. The second component was therefore characterized as *Conditionality* (see Table 1, below).

The principal components analysis indicated independence of components and this was supported by the finding that the two subscales showed a weak positive intercorrelation ($r = 0.29$, $p \leq 0.01$) indicating less than 9 % shared variance between the subscales. When scoring the UPSRS, scores are computed for each subscale but are not summated into a total score, thus providing information about the two identified dimensions of UPSR. Extensive psychometric work carried out in the development of the UPSRS showed that it has acceptable levels of internal consistency reliability (Cronbach's alpha = 0.88 for the Self-Regard subscale and 0.79 for the Conditionality subscale), robust construct validity as well as good convergent and discriminant validity in relation to other measures (Patterson & Joseph, 2006). In addition, findings indicated that participant responses to the measure were not influenced by socially desirable responding.

As predicted from person-centered theory, research using the UPSRS has demonstrated associations between UPSR and several indicators of psychological well-being. For example, higher levels of UPSR were associated with lower levels of depression and psychopathology (Patterson & Joseph, 2006). In relation to psychopathology our findings, showing a moderately significant relationship of the UPSRS self-regard subscale with anxiety and a strongly significant inverse relationship with depression, have been independently replicated in a separate study by Griffiths

Table 1 Showing factor loadings for the UPSRS[a]

Item	Self-regard	Conditionality
I really value myself	0.84	
I have a lot of respect for myself	0.81	
I truly like myself	0.80	
I feel that I appreciate myself as a person	0.79	
I feel deep affection for myself	0.78	
I treat myself in a warm and friendly way	0.70	
Whether other people are openly appreciative or openly critical of me, it does not really change how I feel about myself		0.79
Whether other people criticize me or praise me makes no real difference to the way I feel about myself		0.79
I don't think that anything I say or do really changes the way I feel about myself		0.70
How I feel toward myself is not dependent on how others feel toward me		0.65
Some things I do make me feel good about myself whereas other things I do cause me to be critical of myself		−0.62
There are certain things I like about myself and there are other things I don't like		−0.58

[a]Adapted from Patterson and Joseph (2006). Absolute values below 0.30 are not shown

(2012) providing support for the measure as an indicator of psychopathology as well as a measure of self-relating.

While the above scale development is needed to advance person-centered psychology, as a general framework these ideas have stood the test of time and as we will show below have found expression in other emerging lines of research and systems of thought which have been developed but which do not necessarily have their roots in the work of Carl Rogers, though together provide converging evidence.

Advances in the Social Psychology of Self-Relating

One of the most heavily researched concepts over the past 50 years has been self-esteem. Self-esteem has been variously defined as a person's global sense of worthiness and goodness (Rosenberg, 1965) and an overall affective evaluation of one's own worth (Blascovich & Tomaka, 1991). It is a construct that has been the subject of much research but which has also suffered from problems of measurement, and in particular, criticisms have been made of the lack of theoretically grounded measures (Blascovich & Tomaka, 1991).

While theoretical advances have been made in moving beyond a naïve unidimensional conceptualization of self-esteem, many studies continue to employ this now outdated conceptualization when researching self-esteem. For example, Orth, Trzesniewski, and Robins (2010) in attempting to model the typical trajectory of self-esteem over the life course, measured self-esteem using a three-item version of the Rosenberg Self-esteem Scale. This research, which was based on data from a national study in the USA, suggests that large-scale studies continue to be guided by a very basic understanding of self-esteem.

A more sophisticated approach to self-esteem was provided by Deci and Ryan (1995) who distinguish between *true* or stable self-esteem and *contingent* or unstable self-esteem. A person is viewed as having true self-esteem when their attitudes, behaviors and feelings about themselves are self-determined (regulated by intrinsic motives), whereas they are considered to have contingent self-esteem when their attitudes, actions and feelings about themselves are dependent upon meeting external or introjected evaluative standards. Within this model, contingent self-evaluation is argued to be related to psychologically unhealthy, defensive, and narcissistic traits (Deci & Ryan, 1995; Ryan & Brown, 2003). Thus, contingent self-evaluation can be seen to be similar to the Rogerian idea of self-regard being conditional upon introjected rules and values (Rogers, 1959), where the individual is guided more by external influences and introjected rules and values, in contrast to a more autonomous mode of functioning based on organismic valuing where the individual displays greater internal freedom regarding how he or she will act or respond:

> Contingent self-esteem is experienced by people who are preoccupied with questions of worth and esteem, and who see their worth as dependent upon reaching certain standards, appearing certain ways or accomplishing certain goals (Ryan & Brown, 2003, p.72).

Indeed, both person-centered theory and the above model proposed by Deci and Ryan (1995) and elaborated in their Self-Determination Theory argue that self-regulation with an intrinsic (rather than an extrinsic) basis is associated with a more open, autonomous, and self-determined mode of functioning (Patterson & Joseph, 2007a).

Related to this, though from a somewhat different research tradition, Crocker and colleagues emphasize that self-esteem for most people is tied to certain domains of self-worth within which achievements or successful outcomes are perceived by the individual as essential to one's worth as a person (Crocker, Luhtanen, Cooper, & Bouvrette, 2003; Crocker & Wolfe, 2001). In other words, the external or introjected evaluative standards proposed by Deci and Ryan (1995) and the introjected rules and values (conditions of worth) proposed by Rogers (1959) are viewed as being linked to certain domains of life particularly valued or prized by the individual. The particular domains differ from person to person but include areas such as competition (the need to do better than others); specific competencies or abilities (e.g., academic); need for acceptance or approval from generalized others; need for family support; need for religious faith; and need to feel morally adequate or virtuous (Crocker et al., 2003; Crocker & Wolfe, 2001). A well-validated measure of this construct, the contingencies of self-worth scale (CSWS; Crocker et al., 2003), has been developed to study these contingent domains of self-esteem.

Table 2 Showing correlations of the UPSRS subscales with Rosenberg Self-Esteem Inventory (RSE) and the Contingencies of Self-Worth Scale (CSWS)[a]

	Self-esteem (RSE)	Contingencies of self-worth
UPSR Self-regard	0.79[b]	0.09
UPSR Conditionality*	0.29[b]	−0.37[b]

[a]Adapted from Patterson and Joseph (2006)
[b]Pearson's correlation is significant at the 0.01 level (two-tailed)
*Note: Higher scores indicate less conditionality

Research using the UPSRS has tested associations between UPSR and both self-esteem and contingencies of self-worth (Patterson & Joseph, 2006). As can been seen in Table 2 (above), the UPSRS self-regard subscale was found to have a strong positive and statistically significant correlation with global self-esteem as measured using the Rosenberg Self-Esteem Scale (Rosenberg, 1965), indicating that the self-regard subscale is in essence providing a measure of self-esteem on a high-low dimension. However, the finding of a weaker, though still significant positive correlation between UPSRS *conditionality* and global self-esteem indicates that the *conditionalit*y subscale of the UPSRS is informing us of a qualitatively different facet of self-relating.

Our research also found a low to moderately significant inverse correlation between UPSRS conditionality and contingencies of self-worth as indicated by the full-scale score of an adapted version of the CSWS (Crocker & Wolfe, 2001), with no significant correlation being found for UPSRS self-regard (Patterson & Joseph, 2006), indicating that the conditionality subscale of the UPSRS does inform us about contingencies upon which positive self-relating is dependent. However, a limitation of the UPSRS measure may be that, being a brief measurement scale, the measure does not capture all the ways in which a person's self-regard may be conditional. For example, in terms of the CSWS subscales measuring particular domains of contingent self-worth, the UPSRS *conditionality* subscale shows stronger correlations with some domains of contingent self-worth than others (with unconditionality being strongly and inversely related to the CSWS domain of *others' approval*, moderately and inversely related to the domain of *virtue*, and weakly inversely related to the domain of *appearance*). This may indicate that the UPSRS does not necessarily reflect all internal rules, values, and standards upon which self-regard is contingent. Alternatively, it may be that the stronger inverse correlation of UPSRS conditionality with CSWS *others' approval*, indicates that *others' approval* (the individuals' perception of approval from significant others) may be a higher order contingency that mediates the relationship of conditionality with other domains of self-worth. While further research is necessary to test the veracity of this hypothesis, from a theoretical perspective it would make sense that the social environment (consisting of significant others) which communicates conditionality to the developing individual may result in the individual primarily basing his or her opinions, values, and behaviors on perceived approval of those significant others, with the content or particular focus of those opinions, values, and behaviors (e.g., that the

individuals should pay more attention to their appearance, or should achieve better grades at school, or should be more virtuous) being second order contingencies. In practical terms, the results also suggest that while the UPSRS does tell us about conditionality of self-regard, more information about the particular domains of greater contingency could potentially be of use to both clients and therapists striving to effect positive therapeutic advances and there may therefore be a case for using these two measures together in the context of evaluating psychotherapeutic change.

Crocker and Wolfe (2001) argue that individuals who have overall noncontingent self-esteem are likely to be quite rare and that furthermore, such individuals may have contingencies that either have not been identified or have not been challenged by life events due to stability or consistency of their environment. Similarly, we have argued that individuals with truly or fully unconditional self-regard and free from conditions of worth are likely to be a rarity.

Rather than Rogers' conceptualization of UPSR reflecting a naïve ideal, it can instead be seen as a radical approach to understanding self-relating that was somewhat ahead of its time in emphasizing the importance of being open to and valuing of all of one's experiencing or self-experiences. A social–psychological approach based on person-centered psychology provides a framework for a more skillful, open, and less defensive way of engaging with inner experiencing which may be helpful to psychotherapy researchers and practitioners.

Psychotherapy Research and Practice

As we have described above the person-centered approach offers a dynamic, process-focused account of personality development and functioning, of vulnerability to and development of psychopathology, and of therapeutic growth toward psychological wellbeing (Rogers, 1959). The main tenets of person-centered theory evolved during the 1950s based on naturalistic observation of the individual change processes that clients experience within the context of the therapeutic encounter (Rogers, 1951), and the effectiveness of client-centered therapy has generally been supported by subsequent research into the hypotheses generated by this process of observation (see Barrett-Lennard, 1998 for an overview of this research) such that the American Psychological Association's Division 29 Task Force recommendations on Empirically Supported Therapy Relationships found that the *general relationship* variables they reviewed, including the person-centered variables of empathy, positive regard, and congruence-genuineness, were either *demonstrably effective* or *promising and probably effective* in terms of successful therapeutic outcome (Ackerman, Benjamin, Beutler, Gelso, Goldfried, Hill et al., 2001; Cornelius-White, 2002). These findings are consistent with person-centered theory's assertion that the therapeutic relationship and the client's resources are critical variables in effective therapy (Rogers, 1951, 1957, 1959) and build on evidence that *common factors*, the most salient of which are *client* and *relationship* variables, predict therapeutic outcome regardless of the therapeutic approach adopted (Duncan & Miller, 2000; Duncan & Moynihan, 1994;

Luborsky et al., 2002). In addition, outcomes research has studies the assertion that client-centered therapy is an effective approach, finding it to be more effective than routine care from medics in general practice, and demonstrating equal effectiveness with CBT, in two comparisons of treatment of depression (Friedli, King, Lloyd, & Horder, 1997; King et al., 2000). Furthermore, a substantial body of empirical evidence from mainstream academic psychology literature and positive psychology literature provides strong support for the person-centered theory of personality that informs client-centered therapy (Joseph & Patterson, 2008; Patterson & Joseph, 2007a).

However, despite the above evidence there is limited recent research evaluating client-centered therapy using outcome measures that are theoretically congruent with person-centered theory. It has become usual practice to evaluate all therapies by criteria derived from the biomedical model; principally in terms of symptom reduction. We would encourage researchers and practitioners to begin to include theory consistent measures in order to understand more fully the limitations and strengths of client-centered therapy in relation to other therapeutic approaches. For example, while it may be that all therapies are equally effective in promoting self-regard, as we have argued above the very promotion of self-regard is not necessarily of positive benefit for the individual concerned unless it is also unconditional.

More broadly, we should perhaps ask if, conversely, other recent developments in psychological approaches to self-relating might be applicable to therapists engaged in attempting to facilitate the development of unconditional positive-self regard. One thinks of recent developments in third wave cognitive therapies such as compassion-focused therapies (Gilbert, 2009; Neff, 2003a) and mindfulness-based approaches, with their emphasis on self-acceptance (Segal, Williams, & Teasdale, 2002). In this final section we will briefly examine the relevance of UPSR as a psychological construct to both of these approaches.

Consistent with person-centered theory, compassion focused therapy suggests that in contrast to an emotionally cold/distant experience of parenting or one involving highly contingent warmth/acceptance, individuals who experience warm, empathic parenting with love and affection are more likely to be more self-accepting and therefore to experience better mental health (Gilbert, Baldwin, Irons, Baccus, & Palmer, 2006). The approach views self-criticism and inner shame as having a significant role in many forms of psychological disorder, including anxiety and depression (Allen & Knight, 2009; Gilbert et al., 2006; Gilbert & Irons, 2009), such that learning self-compassion is therapeutically healing. Self-compassion has been proposed as an alternative way of having a healthy attitude and relationship to oneself (Neff, 2003b; Neff, Kirkpatrick, & Rude, 2007). Neff argues that self-esteem involves judgments of oneself and comparison to others in order to determine self-worth, resulting in negative psychological sequelae both for individuals with low self-esteem (such as poor mental health) and for those with high self-esteem (such as narcissism) (Neff, 2003b). Compared to self-esteem, self-compassion is believed to be a more effective route to positive self-relating, with its nonevaluative emphasis

and with evidence suggesting that individuals who are more self-compassionate have healthier and more productive lives than those who are self-critical (Gilbert & Irons, 2009; Neff, 2003b; Neff & Vonk, 2009). As a psychological construct, self-compassion is defined as being able to treat oneself with kindness and involves accepting painful thoughts and feelings without being judgmental or self-pitying (Neff, 2003a; Neff et al., 2007). While there is clear conceptual similarity between self-compassion and UPSR as both reflecting healthier ways of relating to oneself, there is a need for future research to clarify the similarities and differences. Nonetheless, preliminary evidence supports the assertion that they are closely related concepts (Griffiths, 2012), indicating one potential direction for future research.

Mindfulness, which is conceptualized as a component of self-compassion by Neff (2003a, 2003b) but has also been developed separately as a therapeutic approach in the treatment of recurrent depression and other mental health difficulties (Baer, 2003; Segal et al., 2002), similarly involves a nonjudgmental approach to engaging with one's inner experiencing. Bishop et al. (2004), in their operational definition, propose that mindfulness encompasses two elements: *self-regulation of attention* (moment-to-moment awareness) and an attitude of *curiosity, openness, and acceptance toward one's experiences* including thoughts, perceptions, emotions, and sensations, while Kabat-Zinn defines the approach as, *paying attention in a particular way: on purpose, in the present moment, and non-judgmentally* (Kabat-Zinn, 1994, p.4)

Thus, these newer approaches to therapy, though from very different origins, seem to replicate in large part the person-centered approach with their emphasis on the importance of a warm, open, nonjudgmental approach to engaging with one's inner experiencing, and it would appear that the concept of UPSR, grounded as it is in a person-centered social–psychological model of human development and personality theory, offers a promising framework for integration of these diverse though conceptually very similar approaches to facilitating a more healthful approach to self-relating. Conversely, it may be that client-centered practitioners can also draw on and learn from these newer therapeutic approaches which embrace a nonjudgmental and accepting approach to engaging with one's inner experiencing that is consistent with person-centered theory.

Conclusion

UPSR appears to represent a psychologically skillful way of relating to one's subjective experiences, involving an acceptance of both positive and negative aspects of oneself, one's perceived strengths and weaknesses, without making one's positive self-regard dependent on the perceived expectations of others or internalized rules or values. In line with its roots in an organismic theory of personality development (Patterson & Joseph, 2007a; Rogers, 1959), unconditionally self-regarding individuals base self-regard on the evidence from their own senses through a process of trusting (or validating) this inner source of data about the value

of one's experiencing rather than validating the conditions of worth internalized from the significant others that formed their early social environment. It is clear that many individuals experiencing emotional distress and mental health difficulties are engaged in a highly conditional way of relating to themselves. In person-centered theory and client-centered therapy we have one approach to developing a less contingent mode of self-relating, supported by a growing evidence base.

It remains the case however that there is a relative dearth of theoretically grounded measures that can be used to provide information about more healthful modes of self-relating. There is a strong case for the application of theoretical frameworks such as the person-centered conceptualization of UPSR and person-centered social psychology more broadly with its clear account of how more conditional or contingent self-regard develops and can be reduced, in order to address this limitation. The construct of UPSR appears to be broadly supported by recent attempts to shift the focus of social–psychological research as well as therapeutic approaches away from concern with the construct of self-esteem and toward an empirical and theoretical interest in facilitating more healthful and more skilful modes of self-relating. The construct shows clear potential to contribute to our understanding of the proposed different forms of self-relating both by taking the dimension of conditionality–unconditionality into account and through its emphasis on relating to all of one's experiences, whether positive or negative, in a noncontingent manner. Furthermore, this focus on noncontingent or unconditional self-relating has also become the focus of a number of recent third-wave cognitive therapies. Finally, the UPSRS measure provides psychotherapy practitioners with a brief and relatively burden-free, non-medicalized measure of therapeutic outcome.

As research moves forward in addressing yet unanswered questions about the different forms of self-relating and how they differentially contribute to self-acceptance, the UPSRS provides a promising measure with potential application to a number of emerging lines of research in this area. In conclusion, we hope that our work encourages person-centered psychologists to investigate UPSR and to situate their work within the wider social–psychological context of research in to self-relating, and for social psychologists and third-wave therapists working in this area of self-relating to recognize the historical lineage of this tradition to person-centered psychology.

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Unconditional Self-Acceptance and Self-Compassion

Windy Dryden

Introduction

This book is largely concerned with one stance that it is possible to take towards the "self"—self-acceptance. However, it is possible to take a number of other productive stances towards the "self" and in this chapter I will consider the relationship between unconditional self-acceptance (USA) and one of these other stances: self-compassion (SC). In doing so, I will draw upon the ideas of several major theorists in these respective fields. Thus, in discussing USA, I will draw upon the work of Albert Ellis (2005), Maxie Maultsby (1984), Paul Hauck (1991) as well as those of my own (Dryden, 2003); and in discussing SC, I will draw heavily on the ideas of Kristin Neff (e.g. Neff, 2003a). While this chapter is based on the proposition that it is best to develop USA before SC, I will argue that these two concepts can be integrated both conceptually and practically. It is my basic thesis that the two concepts augment one another and that a therapeutic strategy based on the two together will be more productive than one based on each alone.[1] I will begin by defining precisely what I mean by unconditional self-acceptance and self-compassion.

The Definition of Unconditional Self-acceptance (USA)

A number of theorists have over the years been critical of the concept of "self-esteem" as a primary determinant of psychological health and well-being (e.g. Baumeister, Smart & Boden, 1996). A variety of alternative concepts have been

[1]This, of course, is an empirical question that needs investigation.

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proposed which do not appear to have the unintended consequences of raising self-esteem, i.e. increasing levels of narcissism and self-absorption (e.g. Seligman, 1995). One such concept is unconditional self-acceptance (USA),[2] which has been extensively represented in the work of Albert Ellis for over 50 years (e.g. Ellis, 1962, 2005). While Ellis has presented a number of different definitions of USA over the years (see Ellis, 2005), the one which is most consistent with the views expressed in this chapter is as follows: “I do not have intrinsic worth or worthlessness, but merely aliveness. I’d better rate my traits and acts, but not my totality or “self”. I fully accept myself, in the sense that I know I have aliveness and I choose to survive and live as happily as possible, and with minimum needless pain. I require only this knowledge and this choice—and no other kind of self-rating” (Ellis, 1999:6).

The term “unconditional self-acceptance” is comprised of three elements and I will consider these in the following order: the “self”, “acceptance” and “unconditional”.

1. *The “self”*: There are many definitions of the self (e.g. Hauck, 1991). However, rather than using any one such definition here, I will outline a number of defining attributes that comprise the “self” (Dryden, 2003; Ellis, 2005; Hauck, 1991).

   First, the “self” is highly complex. It includes your characteristics, traits, actions, feelings, thoughts, images, sensations and bodily aspects. As such, complexity is a defining attribute of the “self” which together with another of its intrinsic aspects—that it is in flux—means that the “self” cannot validly be rated. For example, if we take the process nature of the self (by which I mean that the “self” is not fixed, but fluid over time), any global rating of the “self” that is made would very soon be out of date as the “self” at the time of the evaluation would not be the same as it would be after it is made. Indeed, the very nature of the evaluation would change the “self”. As we shall see, you can validly rate discrete aspects of your “self”, but you cannot, validly, rate your entire “self”.

   There are three further defining attributes of the “self”. The first is that it is human. The second is that it is fallible. You are prone to error and this proneness cannot be eradicated. As Maxie C. Maultsby (1984) has said, all humans have an incurable error-making tendency. Finally, you are unique. There has never been and never will be, as far as we know, another you. Even if you were cloned, you and your clone would have different experiences and this would not invalidate your uniqueness.
2. *Acceptance*: In this chapter, when I use the term “acceptance”, I mean acknowledgment of the existence of something in the form in which it currently exists (Dryden, 2003). The term can also be understood by what it does not refer to. Thus, it does not involve evaluation, either positive or negative of you as a person and it also does not preclude change in what is being accepted.

[2] In this chapter. much of what I have to say about USA is based on the views of Albert Ellis (2005), the founder of rational emotive behaviour therapy (REBT).

3. *Unconditional*: By the term “unconditional”, I mean that which is without conditions or not contingent upon anything (Dryden, 2003).

   Putting these three aspects together, we have the following definition: “Unconditional self-acceptance involves you acknowledging that as a person you are human, unique, complex, in flux and fallible and that this is true about you no matter what conditions exist in the world. As such your “self” cannot be validly rated, but can be accepted unconditionally on the basis of the above ingredients.”

   Example: Marie was an actress who attended a very important audition, but did a poor job and failed it. Instead of condemning herself, Marie acknowledged that it was bad that she messed up, but that this failure did not define her. Rather, she acknowledged that she was a fallible human being who was not immune from failure and that even if she passed the audition this would not change her “self”.

The Definition of Self-Compassion

Neff (2003a) has also argued that the concept of self-compassion (SC) was proposed as one of a number of alternatives to the concept of self-esteem in outlining what would constitute a healthy attitude to oneself without the unintended negative consequences associated with attempts to raise self-esteem noted above. The proposal of self-compassion as a healthier alternative to self-esteem was also part of psychology’s increasing interest in what Eastern philosophies, and in particular Buddhism, have to offer our understanding of psychological well-being (e.g. Epstein, 1995).

Neff and Lamb (2009:864) have argued that as a particular stance towards the “self”, self-compassion has three components: “(a) self-kindness—extending kindness and understanding to oneself in instances of perceived inadequacy or suffering rather than harsh judgment and self-criticism; (b) common humanity—seeing one’s experiences as part of the larger human experience rather than seeing them as separating and isolating, and (c) mindfulness—holding one’s painful thoughts and feelings in balanced awareness rather than over-identifying with them in an exaggerated manner”.

Putting these three aspects together, we have the following definition: “Self-compassion involves showing yourself kindness, recognizing that you are connected to other humans and mindfully accepting your negative experiences without actively engaging with them”.

Example: Marie, whom we met above, talked kindly and supportively to herself even though she was disappointed in her behaviour which resulted in her failing the audition. She understood that she probably messed up because she was trying too hard and recognized that many other actors and actresses have done the same over the years. This helped her to learn from the experience without dwelling on it.

Similarities and Differences between USA and SC

In this section, I will consider together the concepts of unconditional self-acceptance (USA) and self-compassion (SC) and reflect on some of the similarities and differences between them.

1. *Absence of self-judgment*: As can be seen from the foregoing, when you accept yourself and show yourself compassion, you refrain from making a negative judgment about yourself and this lack of negative self-judgment is what is common between these two stances. However, while it is clear that Neff (2003a) considers negative self-judgment to be incompatible with self-compassion, it is not clear what her view is concerning positive self-judgment. As I have already shown, in the concept of unconditional self-acceptance employed in this chapter, both negative self-judgment and positive self-judgment are regarded as overgeneralizations about the "self" and therefore to be avoided, not because they are merely overgeneralizations, but because of the negative impact that self-evaluation has on mental health and well-being. This position follows logically from the definition of USA with its emphasis on the complexity of the "self". This "complexity" component appears not to be emphasized in SC.
2. *Fallibility*: In the stance known as USA, the concept of the "self" as fallible plays an important role. Thus, in exhorting clients to develop unconditional self-acceptance, clinicians implementing this concept are often heard encouraging clients to see themselves as "fallible human beings". It is clear that in USA, the concept of fallibility is an attitude that clients are urged to apply to themselves. Thus, it is basically an intra-personal concept, an attitude towards the "self" that the person applies to himself or herself irrespective of the actual or inferred global judgments that others make of that person's "self".

   When the focus of therapy shifts to the person's attitude towards others where this attitude is the source of the person's disturbance, then that person is likely to be encouraged to develop unconditional other-acceptance (UOA). This involves seeing others as human, unique, complex, in flux and fallible and that this is true about them no matter what conditions exist in the world. Only when the person develops USA and UOA at the same time does he (in this case) see his own situation in a wider human, interconnected context.

   By contrast, in the stance known as SC, the component known as "common humanity", or interconnectedness, where one is encouraged to "see one's experiences as part of the larger human experience rather than seeing them as separating and isolating" (Neff & Lamb, 2009:864), plays an integral role.
3. *Kindness*: If one considers the stance of USA carefully, it involves adopting what one might call an "acknowledging" attitude towards the "self". As I have already stated, when you accept yourself unconditionally, you acknowledge that your "self" has a number of features which do not change: uniqueness, complexity, being in flux and fallibility. This accepting/acknowledging attitude is the only attitude made explicit in USA. By contrast, if one considers the stance of SC carefully, it is clear that one of the main attitudes being advocated is that of

kindness where the person takes a fair-minded, empathic and supportive attitude towards "self". As I will discuss later in this chapter, developing an unconditionally self-accepting attitude helps you to develop a kindly attitude towards your "self", but the latter is not an integral part of the former as currently conceptualized.

4. *Acceptance, compassion and change*: As I will discuss later in this chapter, clients often resist developing the stances of USA and SC because of the negative constructions they place on these stances. This phenomenon can also be found in the professional literature. Thus, Neff and Lamb (2009:865) say that "while self-acceptance may theoretically entail passivity towards personal shortcomings, self-compassion involves the desire to alleviate one's suffering, and is therefore a powerful motivating force for growth and change". Actually, this statement is confusing as it is not clear whether Neff and Lamb (2009) mean that such passivity is part of the theoretical concept of self-acceptance or whether they mean that it is possible for self-acceptance to be taken as promoting such a passive stance.

   If Neff and Lamb mean that USA inherently involves passivity, then they are incorrect, since Ellis (e.g. 2005) has often made the point that USA does not promote passivity, but may actually promote change. Developing USA for a personal shortcoming does two things. First, it protects the person from self-disturbance, and second, it frees the person to focus on the shortcoming and think how best she (in this case) can address and change it. To use Neff and Lamb's (2009:865) own words, but made by them about self-compassion, unconditional self-acceptance "involves the desire to alleviate one's suffering, and is therefore a powerful motivating force for growth and change".

   However, if Neff and Lamb (2009) mean that it is possible that USA may be *seen* as promoting passivity then they are correct, although this also applies to self-compassion.

   In conclusion, USA and SC actually promote change, although they may both be incorrectly seen as promoting passivity.

5. *Mindfulness*: Neff (2003a) makes clear that mindfulness is one of three major components of SC, the other two being self-kindness and common humanity. By contrast, mindfulness is not seen as an integral part of unconditional self-acceptance but as a consequence of it. According to rational emotive behaviour theory, USA is a stance towards the "self" that is derived from a more primary, flexible rational belief. The hallmark of this primary flexible belief is that the person articulates her (in this case) desire, but acknowledges that this desire does not have to be met. As Dryden (2009) has noted there are three consequences of rational and irrational beliefs: emotional, behavioural and cognitive. In the face of an adversity, when the person holds a rigid belief and a self-depreciation belief that is derived from it, then the cognitive consequences of these irrational beliefs are likely to be highly distorted and skewed to the negative. Given the compelling nature of these highly distorted thoughts, it is very easy for the person to over-identify with them in an exaggerated manner and thus to ruminate on them. By contrast, in the face of the same adversity, when the person holds a flexible

belief and a USA belief that is derived from it, then the cognitive consequences of these rational beliefs are likely to be a mixture of thoughts that are realistic (albeit negative) and distorted. This will help the person to be more able to hold these in balanced awareness than if they are predominantly highly distorted and thereby not ruminate on them.[3] This holding in balance awareness is a main feature of mindfulness as outlined by Neff (Neff, 2003a, 2003b).

In conclusion, mindfulness is seen as an integral part of self-compassion, whereas in Ellis's (2005) view, it is seen as a state that stems from and best engaged with when the person holds a USA belief.

People Tend to Resist Developing USA and SC

The concepts of unconditional self-acceptance and self-compassion are often subject to misconceptions and criticized wrongly on the basis of such misconceptions. Consequently, people may resist developing USA and/or SC because they construe these concepts negatively. Here are six examples of such misconceptions to which I will provide a corrective response:

- "I don't deserve to accept myself or to show myself compassion"
  Response: This objection rests on an attitude of self-criticism which has been shown to be a major resistance to self-compassion (Gilbert et al., 2011). Here it is helpful to show the person that she would not hold that view towards a loved one and thus she could choose not to hold it about herself.
- "USA and SC lead to passive resignation and do not promote change"
  Response: As discussed above, both USA and SC promote change in that they help the person to focus on a personal shortcoming without self-disturbance, understand it in a compassionate context and think about ways of changing it when she sees that it is in her interests to do so and it can be changed.
- "USA and SC absolve people from taking responsibility for their actions"
  Response: This is not correct. You can accept yourself and show compassion to yourself while still taking responsibility for your actions. Assuming such responsibility will be without self-blame, however.
- "USA and SC lead to smugness"
  Response: Again this is incorrect. Smugness implies that you rest on your laurels in a self-satisfied manner. Neither USA nor SC encourage such an approach. As mentioned above both USA and SC motivate you to change what you can change about yourself.

[3]It should be made clear here that mindfulness involves holding in balanced awareness negative thoughts whether these are realistic (albeit negative) or highly distorted without actively engaging with these thoughts. My point is that it is easier for people to be mindful of negative thoughts if they are a mixture of the realistic and the distorted than if they are predominantly highly distorted.

- "USA and SC lead to self-indulgence"
  Response: Here, you think that if you know that you can accept yourself and show compassion for yourself then you can afford to indulge yourself in activities that are not good for you. This view is incorrect because it ignores the fact that self-indulgence tends to stem from a philosophy of short-range hedonism and selfishness rather than from a stance towards the self that emphasizes unconditional acceptance or compassion. Dealing with this philosophy is difficult as it involves self-regulation failure. USA and SC can actually help you to learn from such failure and can help you to work towards greater self-discipline rather than to greater self-indulgence, by freeing you to identify, question and change one's particular short-range hedonistic philosophy.
- "USA and SC reinforce a preoccupation with the 'self'"
  Response: Actually, the reverse tends to be the case. When you judge yourself, criticize yourself or in other ways reject yourself these stances towards the "self" lead you to become preoccupied with whatever it is you are rejecting yourself for. USA and SC actually help to free you from self-preoccupation since they tend to promote constructive change wherever possible and help to minimize the rumination that accompanies self-preoccupation.

An Investigation of Items Comprising the Self-Compassion Scale with Implications for USA

In this part of the chapter, I will consider the items on The Self-Compassion Scale (SCS) that have relevance for USA and its possible integration with SC.

The SCS is a 26 item scale that has six sub-scales: self-kindness vs. self-judgment, common humanity vs. isolation, mindfulness vs. over-identification. Each item is rated on a five-point scale with the scores on negative subscale items—self-judgment, isolation and over-identification—reversed (Neff, 2003a, 2003b)

The main issue that arises from the content of this scale that is relevant to the theme of this chapter concerns the stance taken towards the "self". From the perspective of unconditional self-acceptance (USA), it is important to distinguish between the attitude that a person takes towards his entire "self" and the attitude that he takes towards aspects of his "self". Thus, a person may dislike and make a negative judgment of an aspect of his "self" (e.g. his procrastinating behaviour), but still accept himself unconditionally for his behaviour. When we look carefully at the items on the self-kindness and self-judgment sub-scales, this distinction is not always made.

Looking at the self-kindness items first (Neff, 2003b), three of the items describe a kindly attitude towards the "self" (Item 5: I try to be loving towards myself when I'm feeling emotional pain; Item 12: When I'm going through a very hard time, I give myself the caring and tenderness I need; and Item 19: I'm kind to myself when I'm experiencing suffering) while two outline a similar attitude towards aspects of the "self" (Item 23: I'm tolerant of my own flaws and inadequacies and Item 26: I try to be understanding and patient towards those aspects of my personality I don't like).

Second, considering the self-judgment items (Neff, 2003b), three outline a negative judgment of the "self" (Item 8: When times are really difficult, I tend to be tough on myself; Item 16: When I see aspects of myself that I don't like, I get down on myself and Item 21: I can be a bit cold-hearted towards myself when I'm experiencing suffering), while two outline a similar attitude towards aspects of the "self" (Item 1: I'm disapproving and judgmental about my own flaws and inadequacies and Item 11: I'm intolerant and impatient towards those aspects of my personality I don't like).

It may be that from the perspective of self-compassion theory (Neff, 2003a), the distinction between adopting a compassionate stance towards the "self" as a whole and aspects of the "self" is not crucial, but it is from the perspective of the theory underpinning USA. It means that attempts to integrate USA with SC have to be made with due care when considering attitudes towards the "self" as a whole as opposed to its aspects.

Integrating USA and SC with Respect to Therapeutic Change

In this section of the chapter, I will outline how I think that self-compassion and its elements can be integrated with the concept of unconditional self-acceptance to make the latter a richer concept and one that may be more acceptable to theorists and clients alike with respect to therapeutic change.

However, first let me review how USA has been conceptualized in relationship to therapeutic change (see Fig. 1). Developing USA enables a person to focus on a negative aspect of himself that he wants to change without self-disturbance. Once the person has focused on this negative aspect without self-disturbance, he can initiate attempts to change[4] it if he can change it or to accept matters if he cannot change it (the latter is known as stasis).

One of the issues that concerns clients about the concept of unconditional self-acceptance is that it does not allow them to develop a positive attitude towards the "self" when they wish to do so. Ellis (2005) was aware of this and offered such people an alternative concept that I refer to as "unconditional self-esteem". Applying this concept, you would again acknowledge that you were human, unique, complex, fallible and in flux and that these conditions are unchangeable, but this time you would choose to give yourself a positive rating (e.g. "I recognise that I am a unique, complex, fallible human being who is in flux and that these conditions are constant as long as I am alive and thus, I choose to like myself and/or to regard myself as a good or worthwhile person"). Now, Ellis (2005) was well aware of the arbitrary nature of such a positive evaluation. He argued that it would be equally justifiable for you to give yourself a negative evaluation in this circumstance (e.g. "I recognise that I am a unique, complex, fallible human being who is in flux and that these

[4] Such attempts at self-change are facilitated when the person is able to tolerate the ensuing discomfort. This is known as discomfort tolerance.

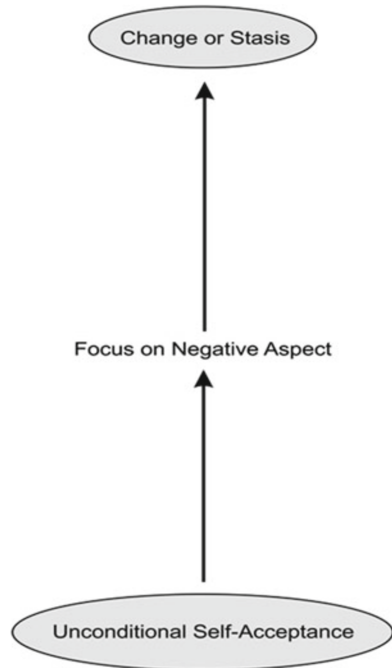

Fig. 1 The impact of unconditional self-acceptance on attempting to change a negative aspect of oneself (In Fig. 1, by "negative aspect" I mean either an internal aspect (e.g. negative personal characteristic or behaviour) or external aspect (e.g. an outside adversity))

conditions are constant as long as I am alive and thus, I choose to dislike myself"). However, if you choose and continue to choose to give yourself a positive evaluation under these circumstances, you will not be vulnerable to ego disturbance (e.g. low self-esteem) because of the unconditional nature of your positive self-evaluation.

Note, however, that by awarding your "self" such a positive evaluation, albeit one that is unconditional, you are asserting that you can give yourself a global rating as a human being. However, as I have already discussed, it is just not possible, in any valid sense, to assign a global evaluation to an extremely complex organism, and one that is in flux, in a way that completely accounts for that organism. However, as Ellis (2005) has pointed out in his book, "The Myth of Self-esteem", it is a matter of choice for clients as to whether they choose unconditional self-acceptance (as defined here) or unconditional self-esteem. As will be discussed in the forthcoming section on "USA, SC and Pluralism" what is important is that clients understand the concepts of unconditional self-acceptance and unconditional self-esteem together with their advantages and disadvantages and choose to implement the concept that has most meaning for them.

In my view, USA and SC can be integrated in a way that preserves the best of both concepts and I will now outline how this can best be done. While the following order is only notional it is, perhaps, the most logical (see Fig. 2).

1. The person would be encouraged to accept himself unconditionally as a unique, complex, fallible human being who is in flux and that cannot be validly given a global evaluation.

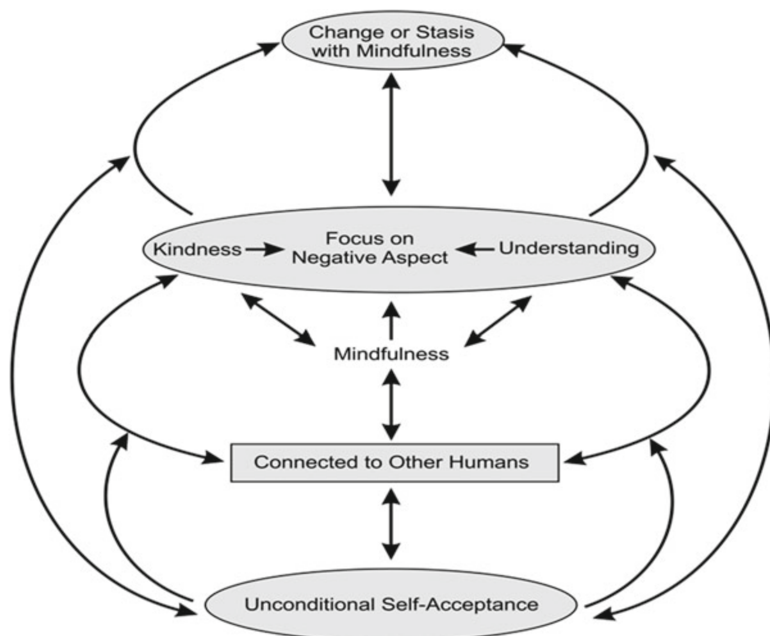

Fig. 2 Integrating self-compassion with unconditional self-acceptance and the subsequent impact on attempting to change a negative aspect of oneself. (In Fig. 2, by "negative aspect" I again mean either an internal aspect (e.g. a negative personal characteristic or behaviour) or an external aspect (e.g. an outside adversity))

2. He would also be encouraged to see himself as connected to other humans—this is the common humanity aspect that Neff (2003a) highlights as an integral part of SC.
3. He would adopt a balanced attitude towards any reverberating disturbed emotional and cognitive states. This means that he would be aware of such states, understand that they will be present for a while until he has more fully digested the attitude of USA and thus he would not engage with such states. Rather, he would allow them to be present until they fade away. This is the mindfulness aspect that Neff (2003a) sees as the third integral part of SC.
4. The person would then be able to look at his many aspects and would acknowledge those that he liked and those that he disliked.
5. He would be encouraged to focus on a particular negative aspect and to do so with kindness—this is the self-kindness aspect that Neff (2003a) also says is an integral aspect of SC—and with understanding and see if he could change this aspect and how best to do so.
6. Whether or not he is able to effect change in this area, the person would be encouraged to develop a balanced awareness towards any residual states of emotional and/or cognitive disturbance and not to engage with these states as in point 3 above.

Interestingly, in response to an enquiry from me concerning the relationship between USA and SC, Neff (personal communication, 27th December, 2011) said

the following which is consistent with Ellis's (2005) position on the importance of developing USA before SC: "I think self-compassion and self-acceptance are highly related, and that self-compassion basically requires self-acceptance. The main difference would be that self-compassion includes elements of active self-soothing, a sense of common humanity, and mindfulness (although self-acceptance can be seen to be embedded in mindfulness)."

Integrating USA and SC: How Best to Deal with Chronic Guilt

Chronic guilt is a problem where a person tends to blame himself for whatever goes wrong within the sphere of his involvement (Dryden, 1994).[5] Attempts by a therapist, for example, to encourage the person to stand back and take a self-compassionate attitude when he feels guilty may tend to fail or be short-lasting. Generally, it may be the case in such instances that the person needs to develop USA first and here it is important to elicit and respond to any doubts, reservations and objections that the person has to the concept of USA. If the person is blaming himself he will tend to resist efforts to encourage him to develop SC.

Once the person has made progress at developing USA, he is more open to the idea that his experiences are connected to those of other people and that he can begin to detach himself from ruminations centred on the theme: "If only I did this or did not do that." USA will also help him to develop a greater level of objectivity in understanding the dynamics of chronic guilt and how it works. At this point, he is much more open to understand the impact of external variables on his behaviour and on the behaviour of others involved. Also, he can begin to apply the compassion that he would tend to show others for the same behaviour to himself. He can also identify any of his behaviours that may have unwittingly contributed to the bad outcome and can focus without self-blame on addressing such behaviours. Whether or not he is successful in changing his behaviour he can learn to detach mindfully from any remaining ruminative thoughts and concentrate on getting on with pursuing his valued goals.

Example: Teresa had a problem with chronic guilt and tended to blame herself when anything went wrong in social settings in which she was present. In using the concept of unconditional self-acceptance without self-compassion (see Fig. 1) the therapist would encourage Teresa to accept herself for any wrongdoing (i.e. negative aspect) she thought she did in these settings and then to change

[5] Most theorists in the field now distinguish shame from guilt and see shame linked to some global judgment of self and guilt focused on behaviour. I see them both as based on self-judgments where shame is linked to the idea that the self is defective, diminished or disgusting and guilt is linked to the idea that the self is bad in some respect (Dryden, 2012).

her behaviour. The therapist would also help Teresa to understand that the core self-depreciation belief that underpinned her chronic guilt would lead her to assume that she was to blame when anything went wrong in social settings and that her alternative core unconditional self-acceptance belief would lead her to see that there might be other reasons why such things went wrong which did not involve her.

In integrating self-compassion with USA (see Fig. 2), the therapist would do the same as above, but he would also do the following:

- He would encourage Teresa to see that others felt the same way as she did in holding the same belief.
- He would help Teresa to understand that even when rehearsing her USA belief, she might still think that she was to blame for things going wrong. He would teach her how to acknowledge the existence of such thoughts without actively engaging with them.
- He would help Teresa to understand some of the factors that may have contributed to the development of her chronic guilt problem and to view herself with kindness as she grappled with this problem. In doing so, he would encourage her to be empathic with herself, support herself through the process and, if necessary, to soothe herself.
- In assuming temporarily that she did contribute to things going wrong socially, he would not only help Teresa to accept herself for this negative aspect, but to view herself kindly and with understanding as she addressed this behaviour.
- Whether or not Teresa effected a positive change, the therapist would encourage her again to adopt a mindful attitude to any reverberating cognitive and emotional states.

USA, SC and Pluralism

Up to now, this chapter has been based on the principle that it is best to think rationally about oneself before addressing such matters as connecting one's experiences to those of others, showing oneself kindness and holding a mindful attitude towards residual disturbed emotional and cognitive states (Ellis, 2005). Although as is shown in Fig. 2, USA is deemed to interact with these three components of self-compassion, it is nevertheless seen as a foundation of compassionate-based change or stasis.

An alternative view of the relationship between USA, SC and change/stasis comes from a pluralistic perspective on counselling and psychotherapy and I will conclude this chapter by considering what a pluralistic perspective on USA and SC might involve. This perspective is underpinned by the following viewpoints (Cooper & McLeod, 2011):

1. There are multiple pathways to therapeutic change
2. If we want to know what is likely to be most helpful for an individual client, we should start by exploring it with them
3. It is vitally important to develop with clients a way of talking about therapy and to collaborate with them on its implementation

Adopting these principles means, in this context, that clients may hold different views to the ones outlined in this chapter concerning the best way to use the concepts of unconditional self-acceptance (Ellis, 2005) and self-compassion (Neff, 2003a, 2003b). Some clients may not find the concept of USA valuable, while others may not consider SC to be a helpful concept.[6] Some may agree with Ellis (2005) that they need to develop USA before SC, while others may hold the opposing viewpoint. Pluralistic practitioners take their clients' views very seriously even if they disagree with them and attempt to resolve such disagreements empirically rather than referring to expert authority—their own or that of others. Such practitioners wisely hold that while a principle may hold true in the general case, it may not hold true with specific clients at specific times. In this way, pluralistic practitioners take their clients' views as seriously as they do both their own theory and the research that supports this theory.

Questions concerning the effectiveness of a theory-driven approach to the development of USA and SC vs. a pluralistic, client-driven approach remain to be investigated.

Conclusion

In this chapter, I outlined the concept of unconditional self-acceptance based on the ideas of Albert Ellis (2005) and others including my own (Dryden, 2003) and discussed its relationship with self-compassion based on the work of Neff (2003a). In doing so, I considered the similarities and differences between the two concepts and showed how integrating self-compassion with unconditional self-acceptance can lead to a richer understanding of clinical phenomena with consequent healthier results for clients with self-esteem problems. I demonstrated this briefly in the treatment of chronic guilt. I concluded the chapter by offering a pluralistic perspective on the relationship between USA and SC.

The rationale of this book is to explore how the concept of self-acceptance contributes to positive well-being. I hope I have shown how integrating unconditional self-acceptance and self-compassion can enhance and enrich this project.

[6] I accept the point that clients may hold misconceptions about USA and SC and that these need to be addressed by their therapist. However, after such discussion clients may still hold doubts, reservations or objections to these concepts and these need to be taken seriously in jointly planning and implementing a therapeutic programme.

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Self-Acceptance and Happiness

Aurora Szentagotai and Daniel David

Keywords Positive psychology • Eudaimonic happiness • Hedonic happiness • Authentic happiness • Signature strengths • Flourishing • Rational happiness • Irrational happiness • Albert Ellis • REBT • Positive emotions • Self • Self-rating • Self-esteem

The nature of happiness and the good life have preoccupied people for millennia, and the idea that what matters is not just to live, but to *live well* has been central to both Eastern and Western thought (Kesebir & Diener, 2008). Democritus, Socrates, Plato, Aristotle, and the Stoics and Epicureans were the first Western philosophers to ponder over the nature of happiness, inaugurating a tradition that has spanned over the centuries into the twenty-first century. Philosophical treatments of this issue have been predominant for a long time (Kesebir & Diener). However, more recently, it has become the subject of intense scientific scrutiny, as behavioral and social sciences have begun to devote increased attention to this topic (Kesebir & Diener; Ryan & Deci, 2001).

Interest in happiness and wellbeing is particularly prominent in psychology (Ryan & Deci, 2001). Although, during much of the last century, the focus on alleviating suffering and reducing psychopathology has overshadowed the study of happiness and wellbeing, a shift towards them can be seen in the 1960s, peaking

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with the positive psychology movement in the late 1990s (Ryan & Deci; Seligman, 2000). Indeed, positive psychology was conceptualized as having three major concerns: (a) positive subjective experiences; (b) positive individual traits; (c) institutions that foster positive subjective experiences and adaptive individual traits (Robins, 2008; Seligman, 2000).

Current approaches to the study of happiness in psychology fall into two overlapping, but separate categories, revolving around distinct philosophies: the hedonic view and the eudaimonic view (Ryan & Deci, 2001; Waterman, 1993). Before analyzing the role of self-acceptance in happiness, we briefly review these approaches and their main contributions to the field. Following the lead of prominent authors, throughout this chapter, we use the concepts of happiness and wellbeing interchangeably.

Happiness as Enjoyment: The Hedonic Approach

The term *hedonism* derives from the Greek word *hêdonê*, pleasure (White, 2006). This perspective equates happiness with the positive affect resulting from getting the material goods one wishes to possess or from the action opportunities one wishes to experience (Waterman, Schwartz, & Conti, 2008). Conceptualizing happiness as pleasure has a long history. In Plato's dialogue named after him, the Greek sophist *Gorgias* (fifth century BC) appears to indicate that happiness consists in getting whatever one wants, and that this is "the greatest good" (White, 2006). This view, not supported by Plato, was adopted by his contemporary, Aristippus of Cyrene, pupil of Socrates and founder of the Cyrenaic school of philosophy, who argued that "No considerations should restrain one in the pursuit of pleasure, for everything other than pleasure is unimportant, and virtue is least important of all" (Tatarkiewicz, 1976, p. 317). Popular versions of these ideas can later be found in the writings of Thomas Hobbes, John Locke, and Jeremy Bentham.

Psychologists who endorse the hedonic view have usually adopted a broad view of hedonism, which includes physical and psychological desires and pleasures and involves judgments about a variety of elements of life (Ryan & Deci, 2001). Research in this paradigm has mainly used *subjective wellbeing* (SWB) (Diener, 1984) as a measure of happiness (Kesebir & Diener, 2008; Ryan & Deci, 2001). SWB is a combination of the hedonic approach with the so-called life-satisfaction approach (Kristjánsson, 2010). It reflects a general evaluation of a person's life, and involves the following major components: *life satisfaction* (global and domain-related), *positive affect* (i.e., the prevalence of positive emotions and moods), and *negative affect* (i.e., low levels of negative emotions and moods) (Diener, Napa Scollon, & Lucas, 2003; Kesebir & Diener, 2008).

This line of study has offered important insights into age-old questions concerning the determinants and effects of happiness (Haybron, 2000). Thus, data seem to indicate that there is a genetically determined set point for happiness (Lyubomirsky, Sheldon, & Schkade, 2005). Based on twin and adoption studies, it has been

concluded that the heritability of wellbeing is as high as 50 % (Lykken & Tellegen, 1996). Changes in life circumstances (both positive and negative) have a limited impact on people's levels of happiness over the long run, accounting for about 10 % of an individual's happiness level (Diener, Lucas, & Napa Scollon, 2006; Lyubomirsky et al., 2005). The remaining 40 % is explained by intentional activity, particularly associated with the pursuit of personal goals (Lyubomirsky et al.).

Happiness Beyond Enjoyment: The Eudaimonic Approach

The eudaimonic perspective intimately links happiness to virtue (McMahon, 2004). Similar to hedonism, it can also be traced back to classical Greek philosophy, where it received its most notable treatment in Aristotle's Nichomachean Ethics, written in 350 BC (McMahon). Aristotle rejects the Cyrenaic perspective. A significant part of the Nichomachean Ethics is concerned with rebutting the idea that happiness consists of satisfying one's desires. Essential to his view is the idea of striving towards excellence based on one's unique potential (Ryff & Singer, 2008). Rather than being concerned with pleasure, Aristotle was interested in *self-realization* as the highest good towards which people should be striving, expressed in the selection and pursuit of life goals based on one's true nature (*daimon*) (Norton, 1976; Ryff & Singer, 2008; Waterman et al., 2008). Similar ideas can be found much later in the writings of John Stuart Mill and Bertrand Russell (Ryff & Singer, 2008).

The state of eudaimonia has also been an important issue in psychology. Human flourishing and self-realization were fundamental for both Abraham Maslow and Carl Rogers (Huta, 2013; Robins, 2008). Among more recent developments of the eudaimonic perspective are the *psychological wellbeing* (*PWB*) *model* (Ryff & Singer, 1998, 2000, 2008), the *self-determination theory* (SDT) (Ryan & Deci, 2000), and the positive psychology approach to happiness (Seligman, 2002, 2011).

The Integration of the Hedonic and Eudaimonic Views: Positive Psychology

During the last decade, professionals embracing positive psychology have been among the most important advocates of the need of studying human happiness, conditions that lead to it, and ways in which it can be developed and maintained (Seligman, 2000). The hedonic and the eudaimonic approach are both present in positive psychology (Jørgensen & Nafstad, 2004). The most influential theory of happiness in the field, developed by Martin Seligman (2002, 2011), one of the founding fathers of positive psychology, draws heavily on Aristotle's idea of eudaimonia although it is, in fact, a combination of the two perspectives.

In his book, *Authentic Happiness*, Seligman (2002) describes three types of happy lives: *the pleasant life* (hedonic perspective), *the good life* (eudaimonic and hedonic perspective), *and the meaningful life* (eudaimonic perspective). The pleasant life is mainly about positive emotions and is defined as: "life that successfully pursues the positive emotions about the present, past and future" (Seligman, p. 262). Thus, in contrast to Diener's (2000) SWB model, which emphasizes both the lack of negative emotions and the presence of positive ones as necessary to happiness, Seligman's theory focuses only on positive emotions.

The good life is about positive traits, most importantly *strengths and virtues* (see Dahlsgaard, Peterson, & Seligman, 2005). In Seligman's words, it is "using your signature strengths to obtain abundant gratification in the main realms of one's life" (p. 262). A good life cannot be attained as a permanent state, but is a continuous development of the individual's strengths and values (Jørgensen & Nafstad, 2004).

The most complex form of happy life is the meaningful life, which has to do with things that transcend the individual. It is defined by "using your signature strengths and virtues in the service of something much larger than you are" (Seligman, 2002, p. 263).

In his 2011 book, *Flourish*: *A visionary new understanding of happiness and wellbeing*, Seligman advances a new version of the theory which, in addition to *positive emotions* (i.e., pleasant life), *engagement* (i.e., good life), and *meaning* (i.e., meaningful life), presents *relationships* and *achievement* as being essential conditions to flourishing.

> Seligman's theory of happiness thus represents a combination of the hedonic and eudaimonic views. Other authors have also supported the attempts of combining these two major perspectives into a comprehensive psychological image of human happiness (see Keyes, Shmotkin, & Ryff, 2002; Ryan & Deci, 2001).

Refinement of the Integrated Perspective: "Rational" and "Irrational" Happiness

Martin Seligman has called Albert Ellis, founder of Rational Emotive Behavior Therapy (REBT), an "unsung hero of positive psychology." Indeed, in addition to his preoccupation with the development, maintenance, and treatment of emotional problems, Ellis was deeply interested in what made people happy and in how happiness could be achieved (Bernard, 2011). Titles of some of his most popular books are a reflection of this interest: *A Guide to Personal Happiness* (Ellis & Becker, 1982); *How to Make Yourself Happy and Remarkably Less Disturbable* (Ellis, 1999); *How to Stubbornly Refuse to Make Yourself Miserable About Anything—Yes*, *Anything* (Ellis, 1988); *A Guide to Successful Marriage* (Ellis & Harper, 1961); *How to Raise an Emotionally Healthy*, *Happy Child* (Ellis, Wolfe, & Moseley, 1966).

According to Ellis, REBT has two major goals: to help people overcome their disturbances and to help them self-actualize, become fully functioning, and happy:

> [REBT] primarily deals with disturbed human evaluations, emotions and behaviors. It is rational and scientific but uses rationality and science to enable humans to live and be happy. It is hedonistic, but it espouses long-range instead of short-term hedonism so that people may achieve the pleasure of the moment and of the future, and may arrive at maximum freedom and discipline (Ellis & Dryden, 1997, p. 5).

Ellis thus distinguishes two types of happiness—both of which people are encouraged to pursue—*short-term satisfaction* and *long-term fulfillment* (see also Ellis & Harper, 1975; Bernard, 2011). Short-term happiness is defined in terms of feelings of pleasure, which can be achieved through active involvement in a wide range of activities (Bernard; Ellis & Becker, 1982). Long-term happiness is also conceptualized as positive emotions, resulting from the fulfillment of individual potential, striving towards excellence and self-actualization (Bernard, 2011; Ellis, 1973, 1988). It involves a choice, an active quest, and it is intimately related to goals: "according to REBT theory, humans are happiest when they establish important life goals and purposes, and actively strive to attain these" (Ellis & Dryden, 1997, p. 4). In this context, Ellis differentiates between having the *will* and having the *willpower* to pursue happiness (Bernard, 2011; Ellis, 1999). While having the will refers to making the choice, expressing the decision of working towards being happy, having the willpower is harder, and it involves persisting in trying to reach a goal, taking the appropriate actions doing them again and again, until the goal is reached (Ellis).

As there is no universal road to wellbeing, each person must establish his or her goals in accordance with his or her preferences and talents. However, in Ellis' view, long-term happiness is very likely to be related to the pursuit and achievement of goals that reduce emotional pain and maximize comfort and pleasure, and that lead to profound and satisfying relationships and excellence at work and other activities (Bernard, 2011).

In relation to happiness, even more important than the content of our goals is whether they are formulated in *rational or irrational* terms. The emphasis on the importance of *how* we wish for something, in addition to *what* we wish for is a major, often neglected, contribution of REBT to the understanding of happiness. This is a key distinction that does not appear in other approaches, and allows for a differentiation between what could be called *rational and irrational happiness*.

According to REBT, cognitions, emotions, and behaviors are highly interconnected, with cognitions, more specifically evaluative cognitions, playing a major role in the generation of our feelings and actions (Ellis, 1988; Ellis & Dryden, 1997). A distinction is made between two types of evaluative cognitions: rational and irrational. Ellis maintains that both these thinking patterns, the self-enhancing (i.e., rationality) and self-defeating (i.e., irrationality), are biologically based, not just the result of interacting with a particular environment (Ellis, 1988; Ellis & Dryden, 1997; Bernard, 2011). Thus, in addition to the self-actualizing tendency that Rogers and Maslow talk about, human beings are also characterized by a natural self-defeating tendency, one that they can, however, learn to control. This assumption of a biologically based predisposition for rationality/irrationality is interesting to look at in light of the findings regarding the genetic basis of happiness.

The core of rationality is the preferential (non-absolutistic) formulation of our goals and desires. Associated with preferential thinking are three other rational beliefs: frustration tolerance, non-awfulizing, and unconditional acceptance. Unconditional acceptance involves acceptance of self (i.e., unconditional self-acceptance (USA)), of others (i.e., unconditional other-acceptance), and of life (i.e., unconditional life-acceptance) (Dryden, Neenan, & Yankura, 1999). A person thinking in rational terms will experience feelings of pleasure and satisfaction when his or her goals and desires are met, and feelings of dissatisfaction when they are not met. These negative feelings (i.e., functional negative feelings) will be healthy, normal responses to negative events, will not prevent the person from attaining his or her goals, and will not prevent the experiencing of positive emotions associated with other goals (Ellis & Dryden, 1997).

The core of irrationality is the absolutistic (dogmatic) formulation of one's goals and desires. Resulting from it are three other irrational thinking tendencies: low frustration tolerance, awfulizing, and global evaluation. In this case, when a person's goals and desires are not met, he or she will have unhealthy (i.e., dysfunctional) negative feelings that interfere with goal attainment and with experiencing positive emotions associated with other goals (Ellis & Dryden, 1997).

Rational thinking is central to the REBT theory of happiness, while irrational thinking is central to the theory of unhappiness and psychopathology. REBT thus advances the idea of rational/irrational happiness, advocating that the way our goals and desires are formulated is equally important as their content and their attainment. The flexible, non-absolutistic formulation of goals promotes wellbeing even if and when they cannot be reached.

This perspective leads to a view of negative emotions consistent with the eudaimonic approach which maintains that, under certain conditions, having negative emotions is more reflective of healthy functioning than not having them or avoiding them (Ryan & Deci). REBT goes one step further, distinguishing between *functional negative emotions*, resulting from rational beliefs, and considered adaptive reactions to negative events, and *dysfunctional negative emotions*, generated by irrational thinking, which have a significant deleterious impact on adaptation and wellbeing. Moreover, from this perspective, positive emotions can also be problematic. When activating events confirm our irrationally formulated desires, we experience *dysfunctional positive emotions*. They are dysfunctional because they reinforce their underlying irrational beliefs. For example, the belief "I must absolutely only get good grades" will generate a (dysfunctional) positive emotion if the person does get a good grade, but the same belief will lead to a (dysfunctional) negative emotion if he or she does not get the grade he or she demands he or she should get.

All of the above things considered, we believe REBT theory offers some valuable insights to be considered by the positive psychology perspective on happiness. Regarding *pleasant life*, an important thing is that not all behaviors associated with positive emotions are adaptive. Pleasant feelings may arise from behaviors that are dysfunctional on the short or long run. Also, positive emotions themselves can be dysfunctional, if they are the result and contribute to the maintenance of irrational beliefs (Ellis, 1994).

When we talk about the *good life*, a key issue, besides goals that allow the expression of individual strengths, is how these goals are formulated. An irrational formulation of our desires, in terms of demands, will result in dysfunctional negative feelings when desires are not met, and in dysfunctional positive feelings, when they are met (Ellis, 1994). We must thus strive towards a rational formulation of our goals.

Finally, a rational perspective on the *meaningful life* draws attention to the fact that values people choose to adhere to should also be endorsed in a non-absolutistic, nondogmatic way, in order to be able to accept self and others, and be free of dysfunctional negative feelings (Ellis, 1994).

The so-called *Decalogue of Rationality* below summarizes REBT insights into wellbeing in a format that can be easily used with clients (see David, 2006). It comprises rational ways of thinking about the self, others, and life that lead to functional emotional and behavioral consequences.

The Decalogue of Rationality (David, 2006)

1. IT WOULD BE PREFERABLE to succeed at everything you do, and do everything humanly possible to succeed, BUT IF YOU DON'T, it does not mean that you are a worthless human being; it only means that you've had a less efficient behavior, which can probably be improved in the future. As a human being, you are valuable by the mere fact that you exist. Therefore, it's good to unconditionally accept yourself, which does not imply that you also have to unconditionally accept your failures without at least trying to correct them, as much as humanly possible
2. IT WOULD BE PREFERABLE to succeed at everything you do, and do everything humanly possible to succeed, BUT IF YOU DON'T, remember that it's just (very) bad, not catastrophic (the worse thing that could happen to you), and that you can find joy in other activities, even if it's not easy in the beginning. No matter how bad is the thing that's happened to you, it's not the worse thing that could happen!
3. IT WOULD BE PREFERABLE to succeed at everything you do, and do everything humanly possible to succeed, BUT IF YOU DON'T, you can take/tolerate this, and you can go on, finding joy in other activities, even if it's not easy in the beginning.
4. IT WOULD BE PREFERABLE that the others be fair and/or nice to you, BUT IF THEY ARE NOT, it doesn't mean that you or they are worthless human beings; it only means that they've had an inadequate behavior, which, in principle, can be changed in the future. The others are valuable as human beings by the mere fact they exist. Therefore, it's good to unconditionally accept them, which does not imply that you also have to unconditionally accept their inadequate behaviors without trying, as much as humanly possible, to help them correct these behaviors.

(continued)

(continued)

5. IT WOULD BE PREFERABLE that the others be fair and/or nice to you, BUT IF THEY ARE NOT, remember that it's just (very) bad, not catastrophic (the worse thing that could happen), and that you can find joy in other activities, even if it's not easy in the beginning.
6. IT WOULD BE PREFERABLE that the others be fair and/or nice to you, BUT IF THEY ARE NOT, you can take/tolerate this, and you can go on, finding joy in other activities, even if it's not easy in the beginning.
7. IT WOULD BE PREFERABLE that life be generally fair (to you and/or the others) and pleasant/easy, BUT IF IT'S NOT, it does not mean that life is unfair and that you are a worthless human being. Life is a mixture of good and bad, and we should try to maximize (if possible) and/or see the good parts, and reduce (if possible) and/or learn from the bad ones.
8. IT WOULD BE PREFERABLE that life be generally fair (to you and/or the others) and pleasant/easy, BUT IF IT'S NOT, remember that it's just (very) bad, not catastrophic (the worse thing that could happen), and that you can find joy in specific activities, even if it's not easy in the beginning.
9. IT WOULD BE PREFERABLE that life be generally fair (to you and/or the others) and pleasant/easy, BUT IF IT'S NOT, you can take/tolerate this, and you can go on, finding joy in specific activities, even if it's not easy in the beginning.
10. THE ONLY MUST—even though it's conditional, non-absolutistic: only if you wish to be healthy and happy—IS THAT NOTHING MUST. The fact that you really wish for something, and that you do everything humanly possible to attain it, does not mean that it must absolutely happen. In other words, it's good to understand and accept that it is not written anywhere that our desires, be them intense and justified by the effort invested in them, must come true, just because we wish and fight for this. Only God's requirements/desires can mandatorily acquire ontological reality; our desires sometimes come true, while sometimes they do not, no matter how justified they are, because life and/or others block them (or don't care about them at all). Therefore, it is good to desire things, to fight for them, but, at the same time, to be ready to accept that, despite our efforts, what we desire might not happen. It would be good to understand and accept this!

The Self

The notion of self has been central to psychology. However, similar to other fundamental concepts in the field, the self is not easy to define in a noncircular way (Gillihan & Farah, 2005), and there is no widespread scientific consensus about what it means "to be a self" (Gallagher & Zahavi, 2008, p. 197).

In *Principles of Psychology*, William James (1890/1950) defines it as everything we are "tempted to call by the name of *me*" (p. 183), and distinguishes among several selves: *the material self*, *the social self*, *and the spiritual self*. Since James, numerous definitions of the construct have been offered, and concepts related to the self have been given particular attention in the writings of personality theorists, social psychologists and clinical psychologists, and psychotherapists.

Baumaister and Bushman (2011) describe the self as having three main components. The first is *self-knowledge* (or *self-concept*), and it is related to such aspects as self-awareness, self-esteem, and self-deception. The second is the *social self* (*or public self*), which involves elements related to social presentation, group membership, relationships to others, and social roles. Finally, the *agent-self* (or *executive function*) refers to decision-making, self-control, and so on.

Regardless of how it is defined, the self is closely related to evaluative or rating processes, as terms such as self-esteem, self-efficacy, and self-confidence show. In this sense, one of the most commonly and consensually endorsed assumptions in research on the self is that people need to see themselves in a positive light (Heine, Lehman, Markus, & Kitayama, 1999). Indeed, evaluations and attitudes towards the self seem to be highly relevant for mental health and wellbeing. In this context, *self-acceptance* has been conceptualized as particularly important.

Self-Acceptance and Happiness: Theoretical Approaches

Although the importance of self-acceptance was stressed by theorists such as Alfred Adler, Karen Horney, and Harry Stack Sullivan (Berger, 1952; Williams & Lynn, 2010), it has been mainly identified within the humanistic movement and some forms of cognitive-behavioral therapy (CBT), particularly with REBT and third-wave CBTs.

According to Maslow, who endorsed an eudaimonic perspective of the good life, self-acceptance (along with the acceptance of others and of nature) is one of the most important characteristics of self-actualized people (Maslow, 1954): "Our healthy individuals find it possible to accept themselves and their own nature without chagrin or complaint or, for that matter, even without thinking about the matter very much" (p. 155). Maslow's writings foreshadow the non-evaluative acceptance of human nature espoused by Albert Ellis in his view of mental health and happiness (Bernard, 2011):

> What we must rather say is that they [self-actualized individuals] can take the frailties, the sins, weaknesses, and evils of human nature in the same unquestioning spirit with which one accepts the characteristics of nature. One does not complain about water because it is wet or about rocks because they are hard, or about trees because they are green. As the child looks out upon the world with wide, uncritical, undemanding, innocent eyes, simply noting and observing what is the case, without either arguing the matter or demanding that it be otherwise, so does the self-actualizing person tend to look upon human nature in himself and in others. (Maslow, 1954, pp. 155–156).

Rogers held a similar view of the importance of self-acceptance, both as an element of the therapeutic process, and as an ingredient of wellbeing. He viewed complete acceptance as one of the key ingredients of contentment and individual freedom from negative emotions:

> It would appear that when all of the ways in which the individual perceives himself—all perceptions of the qualities, abilities, impulses, and attitudes of the person, and all perceptions of himself in relation to others—are accepted into the organized conscious concept of the self, then this achievement is accompanied by feelings of comfort and freedom from tension (Rogers, 1947, p. 364).

Studies conducted beginning with the late 1940s, mostly under the influence of the humanistic perspective on acceptance, have confirmed that high levels of self-acceptance are related to positive emotions, satisfying social relationships, achievement, and adjustment to negative life events (see Williams & Lynn, 2010 for a review).

Already a pivotal concept in REBT (Ellis, 1962), developed in the 1950s, acceptance is also an integral part of most third-wave cognitive behavioral psychotherapies, developed beginning with the 1980s. Promoting acceptance is fundamental to acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999), dialectical behavior therapy (DBT; Linehan, 1993), mindfulness-based stress reduction and mindfulness-based cognitive therapy (MBSR and MBCT; Kabat-Zinn, 1994; Segal, Williams, & Teasdale, 2002). According to Hayes, Strosahl, Bunting, Twohig, and Wilson (2004) "acceptance involves taking a stance of non-judgmental awareness and actively embracing the experience of thoughts, feelings and bodily sensations as they occur" (p. 7). Acceptance becomes a main goal particularly in aversive situations that cannot be avoided, escaped, or eliminated without considerable costs for the individual.

Over the past 20 years, research in this paradigm has produced, an impressive amount of evidence related to the importance of acceptance for mental health and wellbeing. The detrimental effects of psychological phenomena opposite to acceptance, such as suppression and avoidance have also been extensively documented (see Williams & Lynn, 2010 for a review).

Self-Acceptance in REBT

We now turn to self-acceptance as advocated by Albert Ellis and REBT. Although acceptance appeared in the writings of Albert Ellis before some of the perspectives discussed above, we have chosen to discuss it at the end, due to its unique features and far reaching implications for the idea of happiness. While third-wave cognitive behavioral therapies mainly stress the importance of accepting internal events, the object of acceptance in REBT is much broader, directed towards life conditions, others, and self (Dryden & David, 2008).

According to REBT, self-rating is detrimental and can lead to dysfunctional emotional and behavioral consequences. Ellis' solution to this problem is USA, meaning that "the individual fully and unconditionally accepts himself whether or

not he behaves intelligently, correctly or competently, and whether or not other people approve, respect or love him" (Ellis, 1977, p. 101).

The core of the REBT idea of USA is thus the affirmation of human worth above and beyond human behavior. In this view, a person cannot be given a single global rating that defines them and their worth. Personal value is not to be defined by conditions that change (Dryden & Neenan, 2004). USA involves acknowledging that we are complex beings, subject to constant change, that defy rating by ourselves or others, while at the same time accepting that we are essentially fallible (Ellis & Dryden, 1997). However, this does not mean that our individual behaviors cannot be subject to evaluation. USA allows people to rate their actions and traits, and encourages such ratings as a means of personal change and improvement, but not their self, their essence (Bernard, 2011).

Acceptance in this form is considered "crucial to solid emotional and behavioral health" (Ellis & Robb, 1994, p. 91). By eliminating self-rating and strengthening self-acceptance, people become liberated of anxiety, feelings of inadequacy and fear of criticism and rejection, and are free to explore and pursue the things that really make them happy (Bernard, 2011). Being happy and enjoying life is, in Ellis' view, far more important than proving oneself (Bernard). Self-rating and other-rating, although not responsible for all human emotional problems, "very possibly create most of it" (Ellis, 2005, p. 157).

A distinctive feature of REBT is its view of self-esteem, which is not only conceptualized as different from USA, but is seen as a dysfunctional global rating process (Ellis, 1962, 1988). Indeed, self-esteem is defined as how much value people place on themselves, and is constituted by judgments and comparisons (Baumaister, Campbell, Krueger, & Vohs, 2003; Neff, 2003). While high self-esteem refers to a favorable global evaluation, low self-esteem reflects an unfavorable definition of the self (Baumaister et al., 2003). Therefore, REBT sees both high and low self-esteem as unhealthy; regardless of the level, they reflect an overall evaluation of one's worth, eventually leading to dysfunctional emotions (Chamberlain & Haaga, 2001a; Ellis, 1962, 1988).

Self-Acceptance and Happiness: Research Findings

We have so far discussed the way self-acceptance has been conceptualized in relation to wellbeing in some of the major theories concerned with happiness and the good life. Below, we present data linking self-acceptance to the most important elements of happiness, as described in the hedonic and eudaimonic view: positive emotions, positive relationships, goals and achievement, and meaning.

Studies relating self-acceptance to negative outcomes outnumber those looking at the link between self-acceptance and positive emotions. Existing data indicate a significant association between self-acceptance and positive emotions. A study conducted by Chamberlain and Haaga (2001b) on a nonclinical sample has indicated a positive association between USA on the one hand, and happiness and satisfaction

with life on the other hand. These results have been confirmed by Macinnes (2006), who has reported a positive correlation between USA and PWB. At the same time, USA is negatively related to anxiety, depression, and it mediates the relationship between some forms of perfectionism and depression (Chamberlain & Haaga, 2001b; Flett et al., 2003; Macinnes, 2006; Scott, 2007). Moreover, USA is significantly negatively related with neuroticism, one of the most important personality predictors of SWB (Davies, 2006).

It has long been proposed that the self is an anchoring point influencing our perceptions and attitudes towards others (Suinn, 1961). Adler (1926), Horney (1939) Maslow (1954), Rogers (1951), and Ellis (1999) have all emphasized the fact that self-attitudes are essential to healthy relationships. In fact, some of the first studies on self-acceptance were focused on exploring this issue (Williams & Lynn, 2010). This early research has confirmed the connection between self-acceptance and other acceptance on populations ranging from healthy students and adults to patients and prison inmates (Berger, 1952; Omwake, 1954; Phillips, 1951; Sheerer, 1949; Suinn, 1961).

Recent research in REBT has consistently documented the detrimental effects of global self-rating (i.e., self-downing) on relationships. For example, self-downing has been related to both unhealthy anger suppression and violent anger expression (DiGiuseppe & Tafrate, 2007; Martin & Dahlen, 2004). Jones and Trower (2004) found that the activation of self-downing beliefs was central in the experience of anger in a sample of clinically angry individuals. Similarly, self-downing is associated with couple/marital problems (Addis & Bernard, 2002; Möller, Rabe, & Nortje, 2001; Möller & De Beer, 1998). In a study on marital conflict, Möller and De Beer presented couples with several marital scenes with conflict present or absent, and found self-downing to be one of the core beliefs associated with conflict.

Where goals and achievement are concerned, Ellis maintains that USA has a fundamental role in selecting and pursuing the goals that are really important for short- and long-term happiness, as it liberates the individual of fear of failure and of being judged by others (Ellis, 1999; Bernard, 2011). It has been shown that irrational beliefs in general have a detrimental effect on goal selection and pursuit (Wicker, Brown, Hagen, Boring, & Wiehe, 1990) and on motor and intellectual performance (Kombos, Fournet, & Estes, 1989; Prola, 1985; Shahmohamadi, Khaledian, & Ahmadi, 2011). However, the relationship between USA and goals and USA and achievement has not been sufficiently explored in the literature. So far we know that USA is negatively correlated with maladaptive perfectionism, and that it mediates the association between socially prescribed perfectionism and depression (Flett, Besser, Davis, & Hewitt, 2003). Thus, perfectionists, who evaluate themselves in terms of global worth, are more vulnerable to negative emotional reactions that can affect their goals, when confronted with events that do not affirm their worth (Flett et al. 2003). In a study on the relation between USA and reaction to negative feedback Chamberlain and Haaga (2001a) have shown that individuals scoring higher on USA were more objective in their evaluation of their performances and less prone to denigrate people who had criticized them.

As predicted by REBT theory, self-acceptance also seems to correlate with performance, as illustrated by a study by Denmark (1973) showing that leaders with high levels of self-acceptance are rated as being most effective by their superiors.

To our knowledge, no data are available on the association between USA, as defined by REBT, and meaning in life, but research in the PWB model (Ryff, 1989; Ryff & Singer, 2008) has shown self-acceptance and purpose in life to be positively related (Keyes et al., 2002).

According to Ellis, one of the key features of REBT is its philosophical nature and the emphasis on "profound and fundamental philosophical change" (Ellis, 2005, p. 156). This change, known as the *elegant solution* to human disturbance is mainly achieved by teaching people to formulate their goals and desires in a flexible, preferential manner, and through promoting unconditional self, other, and life acceptance. Giving up global evaluation of self and others eliminates one of the most important sources of unhappiness in people's lives and offers them a new outlook on themselves and the world (Ellis).

Conclusions

This chapter offers an overview of the major perspectives on happiness in psychology and discusses the role of self-acceptance in wellbeing. A review of the REBT theory in light of these perspectives outlines valuable insights that REBT has to offer on the topic of happiness. Specifically, similar to the mainstream perspective in positive psychology, REBT views happiness as a combination of hedonic and eudaimonic elements, but further refines the concept, distinguishing between what we have called "rational" and "irrational" happiness.

"Rational" happiness is the expression of adaptive behaviors, functional positive and negative emotions, and preferentially, non-dogmatically formulated goals and values. USA is at the core of this view of happiness. "Irrational" happiness, on the other hand, is characterized by maladaptive behaviors, dysfunctional positive and negative emotions, and rigidly, dogmatically formulated goals and values. Self-downing is viewed as a major source of distress and suffering.

Considering the significant empirical support for these ideas (see David, Szentagotai, Kallay, & Macavei, 2005), we believe that REBT theory can substantially contribute not only to our understanding of what happiness is but also of how it can be gained and maintained.

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Measuring and Characterizing Unconditional Self-Acceptance

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Keywords Acceptance of others • Bernard • Self-esteem • Self-acceptance and psychological health • Rogers • REBT • Self-rating • Albert Ellis • Unconditional self-acceptance

Introduction

The theoretical conceptualization of self-acceptance has been in development for the last century. Early research focused on studying self-acceptance in relation to acceptance of others, whereas more recently researchers have emphasized trying to understand the association of self-acceptance with other aspects of psychological well-being, and the differentiation of self-acceptance from self-esteem. To facilitate empirical work on these issues, a number of measures of unconditional self-acceptance have been developed. Research using one of these measures, the Unconditional Self-Acceptance Questionnaire (USAQ), based on Ellis's rational emotive behavior therapy (REBT) model, has uncovered extensive empirical support for an association of self-acceptance with psychological health. More research is needed, however, on aspects of the reliability and validity of this scale, and more generally on theoretical views of self-acceptance. This chapter will address these issues.

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Early History of Self-Acceptance

Self-acceptance has been a focus of psychological theory, research, and assessment for at least a century. Early work on the subject often centered on the distinction between self- and other-acceptance. For example, Freud (1914/1957) proposed that the way people regarded themselves ("ego-love") would be inversely related to how they viewed others ("object-love"): "We see … an antithesis between ego-libido and object-libido. The more the one is employed, the more the other becomes depleted" (p. 76). Conversely, other theorists proposed that views of self and other would be positively correlated. Adler (1927), for instance, posited that people who feel inferior and lack self-worth try to feel better by disparaging others. Likewise, Horney (1937) speculated that children who lack parental love do not develop the capacity to love themselves or others. Similarly, Fromm (1947) believed that people could only love others if they were first capable of developing self-love, concluding that "Love of others and love of ourselves are not alternatives. On the contrary, an attitude of love toward themselves will be found in all those who are capable of loving others" (p. 129).

Consistent with this emerging view of self-acceptance as having favorable implications for interpersonal functioning, psychodynamic therapists began to identify self-acceptance as an important treatment objective (Horney, 1950; Rank, 1945; Taft, 1933). In a historical review of the concept of acceptance, Williams and Lynn (2010) discussed case studies and chart review studies that seemed to corroborate the association of increased self-acceptance with successful therapy outcomes in diverse areas including alcohol dependence (Grant, 1929), postdivorce adjustment (Waller, 1930), and schizoid personality (Tidd, 1937).

More systematic and quantitative therapy process research was inspired by Rogers' (1940, 1944) conceptualization of self-acceptance as a key interim goal, such that clients must be able to accept themselves to achieve insight in therapy. Empirical tests of this hypothesis began with a dissertation by Raimy (1948), who solicited judges' ratings of 14 therapy clients' verbalizations of positive and negative self-references during sessions. In the successfully treated cases, but not the less successful ones, the number and proportion of positive self-references increased as therapy progressed.

As conceptualizations of self-acceptance evolved, scale development followed. Sheerer (1949) elaborated upon Raimy's work by developing an expanded coding scheme for rating clients' statements in sessions as reflecting varying degrees of acceptance of self or of other. Self-acceptance and other-acceptance ratings showed a sizable positive correlation ($r = 0.51$) and tended to change in tandem, both showing increases over the course of treatment. Using a partially overlapping set of cases, Stock (1949) replicated Sheerer's (1949) results, obtaining a correlation between self- and other-acceptance of $r = 0.38$.

Scale Development

Empirical work on self-acceptance accelerated in the 1950s with the development of several self-report measures of self- and other-acceptance. Availability of such scales made it feasible to use larger samples (due to the greater ease of scoring questionnaires, relative to coding therapy transcripts) and more diverse samples (as a function of not being tied to the therapy context) in studies of self-acceptance.

Expressed Acceptance of Self and Others Scale (Berger, 1952). One prominent self-report scale fostering research in the 1950s was Berger's Expressed Acceptance of Self and Others Scale, which used slightly modified versions of Sheerer's (1949) definitions of acceptance and respect for oneself and others. Some aspects of Berger's multifaceted definition of self-acceptance are consistent with contemporary usage (e.g., "considers himself a person of worth on an equal plane with others," p. 779), whereas others appear to incorporate predicted correlations of self-acceptance into its very definition (e.g., "is not shy or self-conscious," p. 779), and still others read as a bit dated ("does not regard himself as totally different from others, 'queer', or generally abnormal in his reactions," p. 779). The scale consists of 64 items, 36 of which pertain to self-acceptance, 28 to acceptance of others.

The initial validation study of the scale was conducted with a large ($N=315$) combined sample gathered from school, community, prison, and clinical settings. Convergent validity was assessed by correlating the self-acceptance scale scores and ratings of the participants' levels of self-acceptance inferred from a writing sample, which was very high ($r=0.90$), and internal consistency coefficients for the self-acceptance scale ranged from 0.75 to 0.89 (Berger, 1952). Concurrent validity was supported by research showing negative correlations between self-acceptance as measured by the Expressed Acceptance of Self and Others Scale and indicators of psychopathology (e.g., Berger, 1955).

Thus, the Expressed Acceptance of Self and Others Scale is clearly measuring something consistently, and something broadly associated with wellbeing. Its primary drawback as a measure of self-acceptance for current research is that we do not know whether the construct being measured is really self-acceptance per se. Conceptually, as noted earlier, the scale is grounded in an expansive definition of self-acceptance. Perhaps as a result, it has been deployed by subsequent researchers to index alternate constructs such as self-esteem, confidence, or perceived competence (e.g., Eagly & Whitehead, 1972; Neff, 2003), rather than self-acceptance.

Empirically, multi-trait multi-method matrix (MTMMM) data using the methodology advocated by Campbell and Fiske (1959) for test validation called into question the discriminant validity of the Expressed Acceptance of Self and Others Scale and other self-acceptance indicators. In particular, Shepard (1979) conducted an ambitious MTMMM study of self-acceptance, acceptance of others, and self-description, with each being measured via seven distinct methods: checklist, rating scale (Expressed Acceptance of Self and Others Scale selected as the self-acceptance

rating scale), sentence completion, forced-choice questionnaire, semantic differential, Thematic Apperception Test, and Q-sort. The sample was drawn from a university community and consisted of 137 middle-class high school and college students, parents of high school students, and residents of a retirement community. Across the different methods of self-acceptance measures that were used, an average convergent validity coefficient of 0.55 was obtained. Self-acceptance showed discriminant validity from acceptance of others (average correlation of self- and other-acceptance = 0.22), though less so from self-description (average correlation of self-acceptance measure with a self-description measure = 0.41). Indeed, self-acceptance measures correlated better with self-description measures using the same measurement method (average $r = 0.64$) than with other methods used to measure the same construct, self-acceptance (average $r = 0.55$), suggesting a lack of discriminant validity and in particular excessive influence of method variance. In theory, self-acceptance added a value component to self-description; whereas I might describe myself by endorsing "I am reserved around people I do not know well," acceptance would entail believing "It is fine that I am reserved around people I do not know well." The MTMMM data, however, suggested that the Expressed Acceptance of Self and Others Scale was not up to the task of validly making this discrimination.

California Psychological Inventory, Self-Acceptance Subscale (CPI; Gough, 1957). Another effort to construct a selfreport measure of self-acceptance is a subscale of the CPI (Gough, 1957). The CPI on the whole was based on the Minnesota Multiphasic Personality Inventory (MMPI; Hathaway & McKinley, 1940), as many MMPI items were taken directly or rewritten for inclusion on the CPI. Although the MMPI was designed to assess degrees of maladjustment, the CPI was developed as a normal-range measure of personality and interpersonal traits. It has been cited at least 2,000 times (Gough, 2002). The original CPI (Gough, 1957) contained 480 true–false items with 18 subscales. The CPI has since been revised several times to bring item content up-to-date and to eliminate medically related items, and a short form was released in 2002 (Gough & Bradley, 2005).

The self-acceptance subscale was included in the CPI with the hope that it would, "identify individuals who would manifest a comfortable and imperturbable sense of personal worth, and who would be seen as secure and sure of themselves whether active or inactive in social behavior" (Gough, 1987, p. 10). Vingoe (1968) assessed the validity of the self-acceptance subscale in a study of college freshmen women who lived in an on-campus dormitory ($N = 66$). Participants were asked to rate themselves and their peers on different CPI subscales, and correlations were computed between self- and averaged peer-ratings. The convergent validity of the self-acceptance subscale was supported, with a significant positive correlation between self- and mean peer-ratings ($r = 0.44$). However, the self-acceptance subscale has proven to be one of the least reliable subscales of the CPI, with test–retest reliability coefficients of 0.60 and 0.74, and internal consistency coefficients ranging from 0.51 to 0.58 (Gough, 1987; Megargee, 1972).

Personal Orientation Inventory, Self-Acceptance Subscale (POI; Shostrom, 1964). Still another self-report measure of self-acceptance is a subscale of the POI which

consists of 150 pairs of two-choice items and is designed to measure psychological wellbeing, mental health, and self-actualization (Shostrom, 1964). The 26-item self-acceptance subscale is intended to capture "affirmation or acceptance of self in spite of weaknesses or deficiencies" (Shostrom, 1973, p. 6). Increases in self-acceptance scores on the POI during participation in a sensitivity training group correlated as expected with increases in self-awareness reflected in judges' ratings made on the basis of speech samples (Culbert, Clark, & Bobele, 1968).

Although there is a large body of research that uses the POI, few studies have investigated the psychometric properties of the self-acceptance subscale in particular. One-week retest reliability was high (0.77) in a college student sample (Shostrom, 1966). In a large sample of male prisoners ($N=500$), the internal consistency of the POI self-acceptance subscale was modest (0.58) (Silverstein & Fisher, 1973), though it is not known how well this finding would generalize to other settings or to a mixed-sex sample.

There is also uncertainty regarding the discriminant validity of the POI self-acceptance and self-regard subscales. One study in a college sample showed a significant positive correlation between the two (Knapp, 1965), and Shepard (1979) argued based on a content analysis that the items comprising the two subscales were not consistently distinguishable along the intended lines.

Scales of Psychological Wellbeing, Self-Acceptance Subscale (SPWB; Ryff, 1989), The SPWB is an 84-item measure of psychological wellbeing, containing six 14-item subscales including self-acceptance. The SPWB has been cited nearly 3,000 times. A respondent with high scores on the self-acceptance subscale "possesses a positive attitude toward the self; acknowledges and accepts multiple aspects of self, including good and bad qualities; feels positive about past life" (Ryff, p. 1072).

During initial scale development, the measure was administered to 321 young, middle-aged, and older adults. For the self-acceptance subscale, internal consistency (0.93) and 6-week retest reliability (0.85) were high. No age or sex differences in self-acceptance were evident. Concurrent validity of the self-acceptance subscale was supported by sizable correlations with positive (minus negative) affect (0.55) and with depression (–0.59).

Differentiation of Self-Acceptance from Self-Esteem

Although the focus in the beginning of the empirical study of self-acceptance was on understanding and measuring self-acceptance and its distinction from other-acceptance (e.g., Raimy, 1948; Sheerer, 1949), emphasis has shifted over time to studying how self-acceptance differs from other constructs (e.g., Shepard, 1979), and in particular, self-esteem. The relevance of this consideration is apparent in Ryff's (1989) test development research on the SPWB. As noted earlier, having a "positive attitude toward the self" was considered part of the definition of

self-acceptance, and a measure of self-esteem was included in her research "because of its apparent resemblance to the dimension of self-acceptance in the proposed formulation of psychological well-being" (p. 1073). Empirically, self-esteem correlated highly ($r = 0.62$) with the self-acceptance subscale of the SPWB.

Subsequent research and theorizing have suggested that it may be important to differentiate self-acceptance, as an aspect of psychological health, from high or favorable self-esteem. Low self-esteem, that is, a general negative rating of one's worth, has obvious negative implications for emotional life and is a well-established correlate of depression (e.g., Parry & Brewin, 1988). What may be less obvious, however, is what could be wrong with high self-esteem or general *positive* evaluations of the self. Empirically, many of the purported benefits of high self-esteem (e.g., for increased achievement, better friendships, etc.) have proven elusive when studies measure these consequences objectively and use longitudinal designs that can support causal inference to some extent (Baumeister, Campbell, Krueger, & Vohs, 2005). High self-esteem can bleed into narcissism if accompanied by a sense that one is not only great and worthy but also *more* worthy and special than others. If the grandiose person's favorable self-rating exceeds his or her objective performance and the perceptions of others, there may be unfavorable consequences in the long term (e.g., Robins & Beer, 2001) including rejection by peers (Perez, Pettit, David, Kistner, & Joiner, 2001). Indeed, highly favorable views of the self that are threatened in some manner have been linked to violent behavior (Baumeister, Smart, & Boden, 1996).

Self-Acceptance in Rational Emotive Behavior Therapy

REBT practitioners try to help patients navigate to avoid the sadness associated with low self-esteem and the vulnerabilities associated with high self-esteem by challenging the practice of "self-esteeming" or global self-rating altogether (Ellis, 1977). General self-rating can be questioned on logical grounds, given that everyone has strengths and weaknesses, and there is no obvious logical basis for aggregating them into one overall measure of worth ranging from high to low. Accordingly, "Ellis rejected any notion of a universalistic definition of what it means to be a good or bad person, and adopted the position that while it is beneficial for people to measure and evaluate their own traits and behaviors, it is not sensible to use their performances or other's opinions of them as a basis for globally rating themselves." (Bernard, Froh, DiGiuseppe, Joyce, & Dryden, 2010, p. 305).

The utility of general self-rating is also questionable in that it can create emotional vulnerability. In particular, a high global self-rating carries with it the implication that this rating could fall if future performances fail to measure up to the past ones forming the basis of the high self-rating. Just as parents are advised to be specific in expressing praise for efforts ("I like the way you tried all kinds of strategies on that math problem until you finally got it.") rather than generically praising seemingly fixed attributes ("great job! You're so smart") (e.g., Dweck, 2007), so too the individual should foster more resilient, less easily overturned by future setbacks, emotional health by rating

behaviors ("I did well at managing my time on that work project") as opposed to the whole self ("I am a great person because I got that project done on time").

In lieu of self-rating, REBT has long emphasized the desirability of unconditional self-acceptance, what Arnold Lazarus (1977) once called "an egoless state of being." Unconditional self-acceptance in REBT "means that the individual fully and unconditionally accepts himself whether or not he behaves intelligently, correctly, or competently and whether or not other people approve, respect, or love him" (Ellis, 1977, p. 101). Unconditional self-acceptance may be distinguished from making any global, generalized evaluation of one's worth or value.

Despite the frequent elaboration of this conceptual point of emphasis within REBT, for many years REBT research projects did not measure or analyze unconditional self-acceptance (Haaga & Davison, 1989), leaving a thin empirical basis for claims about the characteristics of self-acceptors. Accordingly, Chamberlain and Haaga (2001a) developed a test of self-acceptance, the USAQ. The USAQ, as slightly revised by Chamberlain and Haaga (2001b) to enhance internal consistency, includes 20 items rated on a 1 ("almost always untrue") to 7 ("almost always true") scale. Eleven items are reverse-scored (e.g., "To feel like a worthwhile person, I must be loved by the people who are important to me"), whereas the other nine are scored directly (e.g., "I believe that I am worthwhile simply because I am a human being"). Thus, total scores can range from 20 to 140, with higher scores reflecting greater self-acceptance. The psychometric properties of the USAQ-R are as follows.

Reliability. The initial version of the USAQ showed acceptable internal consistency (alpha = 0.72; Chamberlain & Haaga, 2001a), and rewording of three problematic items improved internal consistency (alpha = 0.86; Chamberlain & Haaga, 2001b). Subsequent studies in adult samples have reported satisfactory internal consistency for the USAQ-R in English (0.76–0.83; Davies, 2006; Hall, Hill, Appleton, & Kozub, 2009; Thompson & Waltz, 2008) and Serbian (0.75; Stankovic & Vukosavljevic-Gvozden, 2011).

Conversely, alpha was only 0.61 in a sample of British male youth (average age = 14) soccer players (Hill, Hall, Appleton, & Kozub, 2008). The readability of the USAQ-R is estimated at a grade level of 5.8, averaging across several formulae available at http://www.readability-score.com/. Fifth to sixth grade reading level is typical of major broadband normal adult personality inventories (Schinka & Borum, 1994) but may be excessive for youth samples.

A review of all English-language published articles citing the USAQ-R revealed no studies of its retest reliability, which is a major gap in knowledge about the test as a measure of a presumably enduring individual-difference characteristic.

Norms. There have been no systematic epidemiological studies using the USAQ-R, so it is not possible to identify scores on the test suggestive of abnormally low or high self-acceptance. For what it is worth, however, the mean score in a college student convenience sample in Chamberlain and Haaga (2001b) was 82.78 (SD = 17.28). Mean scores within one-third of one standard deviation above or below this value have been reported for Canadian (Flett, Besser, Davis, & Hewitt, 2003), British (Davies, 2006, 2007a, 2007b) or Serbian (Stankovic &

Vukosavljevic-Gvozden, 2011) university students, a nonclinical British adult sample (Scott, 2007), and British middle distance runners with average age of 40 (Hall et al., 2009). The score distribution did not differ significantly from normality in Stankovic and Vukosavljevic-Gvozden (2011), and no significant sex differences have been obtained (Scott, 2007; Stankovic & Vukosavljevic-Gvozden, 2011). Thus, pending assessment of a truly representative sample, it seems that adult samples of either sex can be expected to average in about the mid-80s, with about two-thirds of respondents scoring 70–100, on the USAQ-R.

Validity. There have been no studies relating the USAQ-R to other indicators of self-acceptance, and as such its convergent validity is unknown.

What might be viewed as concurrent validity studies of the USAQ-R (cross-sectional associations with measures of criteria to which a valid measure of self-acceptance should relate) are also interpretable as studies of the correlates of self-acceptance. Such studies have found inverse relations of self-acceptance with depressive symptoms (Chamberlain & Haaga, 2001a; Flett et al., 2003; Scott, 2007; Stankovic & Vukosavljevic-Gvozden, 2011), self-rated proneness to depression (Chamberlain & Haaga, 2001b), anxiety (Chamberlain & Haaga, 2001a; Stankovic & Vukosavljevic-Gvozden, 2011), anger (Stankovic & Vukosavljevic-Gvozden, 2011), perfectionism (Flett et al., 2003; Hall et al., 2009; Scott, 2007), irrational beliefs (Davies, 2006, 2007b), irrational beliefs about parenting in particular (Gavita, David, DiGiuseppe, & DelVecchio, 2011), neuroticism, and conscientiousness (Davies, 2006). Positive correlations of USAQ-R scores have been obtained with happiness, life satisfaction, state mood after an imaginal setback in a lab study (Chamberlain & Haaga, 2001a), and mindfulness (Thompson & Waltz, 2008).

Multivariate analyses have shown USAQ-R scores to mediate the association of socially prescribed perfectionism with either depressive symptoms (Flett et al., 2003; Scott, 2007) or exercise dependence (Hall et al., 2009).

Cross-sectional correlations are of course indeterminate as to direction of causality. A creative experimental method employed by Davies (2007a) entailed reading and concentrating on self-statements varying in the degree of self-acceptance implied, or in other experimental conditions' statements varying with respect to irrationality. Results indicated that priming irrational beliefs in this manner lowered self-acceptance scores (and priming rational beliefs raised them), whereas there was no reverse effect of self-acceptance priming on irrational beliefs. The specific beliefs showing this effect the most clearly were self-downing, need for achievement, and need for approval (Davies, 2007b). Further research in this vein would be interesting, in particular if converging operations were employed in priming self-acceptance. It is not clear whether the manipulation of USA failed to alter irrational beliefs because self-acceptance is more an effect than a cause of rationality, or if the intended manipulation of USA actually failed to induce self-acceptance.

Discrimination from Self-Esteem. Surprisingly, despite the derivation of the USAQ from REBT theory with its emphasis on distinguishing self-acceptance from self-esteem, the scale has turned out to be just about as highly correlated with self-esteem as were earlier measures of self-acceptance. Indeed, studies consistently show the

USAQ to be strongly positively correlated with measures of self-esteem, with correlations ranging from 0.51 to 0.59 (Chamberlain & Haaga, 2001a, 2001b; Davies, 2006; Stankovic & Vukosavljevic-Gvozden, 2011; Thompson & Waltz, 2008). There are at least three possible ways to interpret this result. First, trait self-esteem measures may be confounded by self-acceptance and thus lack discriminant validity. The frequently used Rosenberg (1965) Self-Esteem Scale, for instance, includes the reverse-keyed item "I certainly feel useless at times." "Useless" of course conveys a negative self-rating, but "at times" implies that the negative self-rating is conditional, and a person endorsing this item may be making as much of a statement about his or her lack of self-acceptance as about his or her low self-esteem.

Second, self-esteem and self-acceptance may actually be validly correlated. Assuming no mortals actually completely forego self-rating, perhaps those high in self-acceptance are more likely to rate themselves favorably when they do think in terms of global self-evaluation (Chamberlain & Haaga, 2001a).

Finally, perhaps the sizable positive correlation of the USAQ-R with self-esteem reflects at least in part a lack of discriminant validity on the part of the USAQ-R. Researchers who consider this hypothesis plausible have adopted two distinct strategies for addressing it empirically. First, one can control statistically for self-esteem in computing partial correlations of self-acceptance with other indicators. Using this method, self-acceptance was not significantly related to depression, happiness, or life satisfaction (Chamberlain & Haaga, 2001a). However, it was negatively correlated with anxiety and narcissism (Chamberlain & Haaga, 2001a) as well as labile self-esteem and depression proneness (Chamberlain & Haaga, 2001b) and irrational beliefs (Davies, 2007b). Self-acceptance, controlling for self-esteem, was also positively associated with being objective about one's own performance in a public speaking task and negatively associated with (presumably defensive) denigration of peers who had ostensibly provided critical evaluation of the subject's speech (Chamberlain & Haaga, 2001b).

An alternate strategy for measuring self-acceptance independent of self-esteem was developed by Davies (2006). A joint factor analysis of the USAQ along with a self-esteem measure revealed that 11 USAQ items belonged on the first factor along with self-esteem items. The other nine USAQ items formed a second factor distinct from self-esteem, scores on which were not significantly correlated with self-esteem. This purified self-esteem-free self-acceptance indicator was not correlated with any of the Big five personality dimensions but was negatively correlated with irrational beliefs (Davies).

Future Research Directions on Unconditional Self-Acceptance

In sum, research using the USAQ-R paints a flattering picture of the self-acceptor. People scoring high in self-acceptance report being less depressed, anxious, angry, perfectionistic, or irrational. They are higher in self-esteem, but this association—even if viewed entirely as an undesirable measurement problem—does not seem to

account for all the results. Self-acceptance, independent of self-esteem, appears to be associated with low anxiety, low narcissism, low depression proneness, low levels of irrational beliefs, and a greater ability to be objective about one's own behavior and gracious in response to criticism. Research on causal models is scarce, but mediational models indicate that self-acceptance may help explain a link between socially prescribed perfectionism and depression, and initial experimental work indicates that low self-acceptance may be a consequence rather than cause of irrational beliefs.

Many measurement and substantive questions about unconditional self-acceptance remain. As noted earlier, there is no research on the retest reliability or the convergent validity of the USAQ-R. It could also be useful to develop a peer-report version of the USAQ-R for completion by people who know the respondent well. Ryff (1995) made a similar point in relation to the SPWB as a self-report measure, noting that in certain contexts respondents may be prone to giving unrealistic but socially desirable descriptions of themselves as highly self-accepting.

Also, no research has tested whether REBT increases self-acceptance, whether it does so specifically (i.e., more powerfully than do other psychotherapies) or preferentially (i.e., more so than it influences self-esteem), or whether its effects on psychological disorders are mediated by its effects on self-acceptance. There is therefore a pressing need for treatment research on self-acceptance.

It would also be helpful to get a greater sense of the developmental origins of unconditional self-acceptance, in particular whether specific parenting or teaching practices that cultivate self-acceptance could be identified.

There is no information on normal age-related changes in self-acceptance, for instance whether old age might tend to increase it as the struggle to attract a mate and to achieve a certain level of professional accomplishment begins to recede for most people.

Associations of unconditional self-acceptance with clinical disorders remain largely untested. Whether unconditional acceptance of the self is associated with acceptance of more circumscribed aspects of psychological functioning (e.g., distress tolerance, low experiential avoidance) is unknown.

Finally, the specific mechanisms by which high self-acceptors protect themselves from excessive distress in the wake of setbacks are unknown. That is, it is one thing to say that self-acceptors become less distressed by negative feedback and therefore have no need to denigrate those giving them the feedback (Chamberlain & Haaga, 2001b), but a further question of interest is how in particular they achieve this effect. It could be for instance that they use specific self-instructions ("her perception that I messed up does not make me a louse; I just need to consider the feedback carefully and decide whether there is anything I can take from it to try to do better next time") that others might be encouraged to emulate. Or it could be that self-acceptance, at least in adulthood, is an overlearned response not requiring explicit attention except perhaps in more extreme negative situations.

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Part II
Practice

Self-Acceptance in the Education and Counseling of Young People

Michael E. Bernard, Ann Vernon, Mark Terjesen, and Robyn Kurasaki

The contributors to this chapter all share a common view that central to an understanding of the emotional difficulties of young people as well as their happiness and life satisfaction is "self-acceptance." We all believe that as a strength of character, self-acceptance provides young people with a way of looking at the world and, in particular, how they consider their own value and self-worth and leads to their emotional regulation, resilience (e.g., Bernard, 2004a; Bernard & Pires, 2006) as well as their willingness to experience life and grow. We recognize the central importance that schools and homes play in supporting the development of children's self-acceptance. This chapter will focus on the different ways that self-acceptance can be communicated and taught in schools to young people of all ages who may or may not be experiencing problems of adjustment.

We share the view that self-acceptance is a very important strength of character and pillar of emotional health in large part because of the theory of Albert Ellis. Ellis and his colleagues (e.g., Ellis, Wolfe, & Moseley, 1968; Knaus, 1974) have written about the pernicious effects of self-depreciation on the mental health of children and the need for adults to not only combat young people's tendencies to negatively self-rate, but also to explicitly teach self-acceptance.

> Teach children to never rate themselves in terms of their behavior and to separate judgments of their actions from judgments of self-worth. Encourage them to acknowledge and accept responsibility for their *traits* and *behaviors*—both good and bad- without evaluating

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> *themselves* as good or bad. Help combat children's tendencies towards self-downing by reminding them they are made up of many good qualities (and some that are not so helpful) and that they do not lose their good qualities when bad things happen. Explain to children that all human beings are capable and likeable in their unique ways and, therefore, it is good for children to accept themselves unconditionally without having to prove themselves (from Ellis et al., 1968, *How to Raise an Emotionally Healthy, Happy Child*).

In 1968, Albert Ellis founded *The Living School* for elementary-age students at what was then called the Institute for Rational Living (New York City). There, children were not only taught the standard academic curriculum but also *Rational Emotive Education* (Knaus, 1974)—a curriculum of lessons designed to teach emotional literacy including the role of thinking in emotions and behavior and a variety of rational beliefs including high frustration tolerance, acceptance of others, and self-acceptance.

In this chapter, we present a theoretical conception of self-acceptance that is largely grounded in Ellis' views (e.g., 1962/1994). Additionally, we expand Ellis' conception of self to include not only a self-accepting element, but also an appreciative element of who one is. We shall present research that shows the deleterious impact the lack of self-acceptance has on mental health of young people. A new scale *The Child and Adolescent Scale of Positive Self-Regard and Self-Acceptance* (Bernard) Bernard and Ward (2012) shall be presented that measures both negative self-evaluation and positive self-regard and research data that supports the relationship of young people's self-acceptance and self-regard to positive and negative emotional states and life satisfaction. We will discuss how self-acceptance can be taught in classrooms to children of all ages as part of a character or value education program as well as in a preventative, mental health program. We discuss the place for self-acceptance in early childhood education. We describe how mental health practitioners using rational emotive behavior therapy (REBT) counseling methods with individuals and groups can challenge self-depreciation of young people and develop their self-acceptance. Finally, we will speak to the important role teachers' understanding and internalization of self-acceptance plays in their efforts to instill self-acceptance in their students.

Defining Self-Acceptance

In some ways, it is easier to illustrate the meaning of self-acceptance by its converse, *self-depreciation* (also referred to as self-downing or negative self-rating). Semantically, self-depreciation involves the mislabeling of one's overall value as a person as worthless, hopeless, or failure. Logically, self-depreciation is seen as a non-sequitur where a conclusion is reached that because one (or more) aspect of one's behavior or traits is bad, therefore, all aspects of oneself are bad. Empirically, self-depreciation results from selective abstraction of one or more aspects of one's negative behavior or traits to arrive at the false conclusion that all aspects of oneself are bad.

The significant role self-depreciation plays in a young person's low self-esteem, hopelessness, and depression is illustrated below using the ABC model of emotions (Ellis, 1994). The bolded type reflects self-rating (from Bernard, 2004b).

Example 1
Activating events: loss of parental love through desertion/abandonment/neglect or death

Beliefs

Inferences (conclusions, predictions): My parent doesn't love me. It's my fault my parent never wants to see me. I cannot do anything to get his/her to love me. I cannot be happy without his/her love. Life is not worth living if I cannot have his/her love.
Absolutes (shoulds, oughts, musts, needs): I need my parent's love.
Evaluations: I cannot bear to live without her love. **This proves how unlovable and hopeless I am**. This is terrible.

Consequence (emotional, behavioral): down, crying, periods of inactivity, avoidance of people and tasks, tiredness, irritability.

Example 2
Activating events: poor school performance

Beliefs

Inferences (conclusions, predictions): I'm not good at any of my schoolwork and never will be. I am hopeless in everything I do.
Absolutes (shoulds, oughts, musts, needs): I should/must achieve in my schoolwork.
Evaluations: It is awful to make mistakes and do so poorly, I really can't stand it. **This proves I am really a total failure**.

Consequence (emotional, behavioral): down, crying, periods of inactivity, avoidance of people and tasks, tiredness, irritability.

Example 3
Activating events: social rejection, teasing, no one to play with, not being invited, loss of boyfriend/girlfriend.

Beliefs

Inferences (conclusions, predictions): Everyone is against me. Everyone is teasing me. No one likes me. I'll never have any friends.
I can't be happy without his/her love or attention.
Absolutes (shoulds, oughts, musts, needs): I need people to like and approve of me.
Evaluations: It is awful to be criticized, laughed at and alone. I can't stand it. **This proves that I really am a hopeless person**.

Consequence (emotional, behavioral): down, crying, periods of inactivity, avoidance of people and tasks, tiredness, irritability.

There are two forms of self-acceptance that Albert Ellis discusses, both of which can be taught to children and adolescents. When self-acceptance is characterized by

semantic precision, logic, and is evidence-based, it can be described as the elegant solution to the problem of self-depreciation and self-rating. "Self-acceptance means that the individual fully and unconditionally accepts herself whether or not she behaves intelligently, correctly or competently and whether or not other people approve, respect, or love her"(Ellis & Bernard, 2006). Simply stated, self-acceptance is the belief that one is a worthy person just because one exists, and despite one's faults (Walen, Wessler, & DiGiuseppe, 1993). *Unconditional* self-acceptance has been described as the acknowledgement of one's fallibility and flaws, without rating one's worth either positively or negatively. USA involves the focus on one's performance and using this information to decide on future behaviors without getting distracted by thoughts about oneself as a global entity. USA does not mean that one approves of, likes, or ignores ones flaws and weaknesses (DiGiuseppe, Doyle, Dryden, & Backx, 2013). Here, the individual avoids self-rating of one's value as a person discarding self-labels, over-generalizations, and faulty conclusions about oneself. The individual accepts that all humans are fallible and who inevitably behave and perform imperfectly. Beecher (1988, 2009) discusses how self-acceptance involves detaching one's self appraisal from what others think:

> 'Self Acceptance' is, simply, acknowledging yourself. It is accepting totally the fact that 'I am me' and recognizing that everything about you is a fact. It is realizing inside yourself that this total you is a fact, whether you like different aspects about yourself or not. Self Acceptance is unconditional. When the notion of 'self esteem' is replaced with 'Self Acceptance', there is no such dependence on others. For Self Acceptance learners rely totally on themselves—'I can take it in my own hands'—and create their own security. In this inner security they find inner strength. Their potential is released.

Ellis & Bernard (2006) has also written about an inelegant solution to the problem of self-depreciation that involves the individual making an arbitrary but practical definition of self-worth: "I accept myself as good or evaluate myself as good because I exist." According to Ellis, this proposition while not semantically precise, logical, or scientific, does eliminate negative self-rating and as a consequence has many advantages and few disadvantages in helping people to avoid feelings of worthlessness.

Over the many years of our collective research, clinical practice, and the development of psycho-educational programs for young people of all ages, we continue to advocate for Ellis' view that parents and teachers had better teach young people not to rate their self-worth on the basis of their achievements or what others think of them and their value as people. We teach young people that everyone is made up of many positive and some not-go-good qualities and that it does not make sense to make overall judgments of their value as people based on their achievements or popularity. We encourage young people to accept themselves no matter what—and to work hard to change and make self-improvement in behavior that are leading to negative consequences for them and others in the short- and long-term. As we shall discuss shortly, it is no easy task for people of any age to shift their mindset from one of self-depreciation to self-acceptance. However, the benefits are substantial especially for those "at risk" young people—who experience low self-esteem and display poor resilience.

More recently, one of the authors (MEB) has begun exploring an aspect of self-acceptance that involves a different cognitive process that can be called positive

self-regard or positive self-appreciation. Self-regard is conceived of as a process whereby the individual is aware of and evaluates aspects of him/herself in a positive manner. While self-regard is an evaluative process, it does not involve an overall evaluation of self-worth. As such, self-regard is not seen as being inconsistent with Ellis' conception of self-acceptance and non-self-rating. Here is the thinking on the benefits of incorporating self-regard within a broader conception of self-acceptance.

Ellis' (1994) conception of self-acceptance as a non-evaluative cognitive process of "self" serves to eliminate many aspects of the negative emotions of depression and anxiety. For example, the adolescent who comes to accept that he is not a failure or totally hopeless when his grades in school are lower than those he and his family desire will as a result feel less miserable. And while this outcome is extremely beneficial, it does not appear that the rational belief of unconditional self-acceptance leads to an increase in positive emotions. Ellis' elegant solution can be seen to be affectively neutral. It is recognized that in time, freed from anxiety and depression, self-acceptance can lead people to discover new pursuits that can bring them greater enjoyment and happiness.

It would seem that self-regard and acceptance of self are complimentary processes that contribute to the reduction of much emotional misery and the experience of positive affectivity. A new conception of self-acceptance as a character strength is, therefore, offered:

> Self-acceptance is a distinguishing quality of a person that remains relatively stable across time and situations where young people are (1) self-aware and appreciative of their positive characteristics and developing potentialities (personality, aptitude, family, religious, cultural characteristics) and (2) when negative events occur (lack of success, criticism or rejection by others) or when they engage in negative interpersonal behavior, they continue to be proud of and accepting of themselves unconditionally; they do not rate their value and self-worth negatively.

When young people adopt this mindset, their motivation to change imperfect and "bad" behavior is not to prove to themselves or to others that they are, indeed, good people. Rather, the motivation to change is seen when their behavior leads to the failure to achieve basic goals in life; namely, to be successful, loved and accepted by others, and to be healthy and relatively stress-free.

Current Theoretical Conceptions of Self-Acceptance in Young People

The ability of children to accept themselves despite self-perceived shortcomings and when they are treated badly or rejected by others would appear to develop around the age of seven when children experience a qualitative shift in their reasoning abilities described by Piaget as the concrete operational stage of development (Piaget, 1936). Piaget considered the concrete stage a major turning point in the child's cognitive development, because it marks the beginning of logical or operational thought. The key feature of this stage of cognitive development is

conservation. Conservation is the ability to understand that something stays the same even though its appearance changes. The ability to conserve enables children to understand that how people react to their behavior, and despite not always being successful in learning, their self (who they are) including their value as a person remains the same. *Conservation of self* would appear fundamental to the development of self-acceptance especially if one adopts Ellis' inelegant definition of self-acceptance that has the person accepting that he or she is a worthwhile or good person simply because he or she exists. Kegan (1995) discusses a similar developmental construct when elaborating on the "cross categorical self."

The cognitive immaturity of children younger than seven makes self-acceptance problematic as they are prone to a variety of cognitive errors including personalization, over-generalization, and all- or none thinking (e.g., Bernard & Joyce, 1984). Additionally, given the propensity of humans who experience emotional problems to cognitively process events in their lives in ways characteristic of the pre-concrete operational period of development (e.g., Beck, 1976), it is no wonder that people find self-acceptance an appealing belief but difficult to put into practice.

Ellis' theory of personality development and his proposition that people's emotional adjustment is a function of two, opposing biological tendencies is compelling (Ellis, 1962/1994). He argues that all people have an *irrationality* disposition that characterizes their thoughts, feelings, and actions when infants, and young children and that continues to exert a strong influence over our emotional lives across the life span. The capacity for *rationality* emerges at about the age of seven and develops through learning and life experience enabling the individual to self-manage and emotionally regulate. Ellis has written most extensively about the power of challenging and changing irrational beliefs using more rational, scientific cognitive processes. He also recognized the importance of explicitly teaching rational beliefs such as self-acceptance to all young people in school in the form of psycho-education as well as when counseling individual children who present with low self-esteem, depression, and other issues related to their self-depreciation (Bernard, 2009).

Ellis argued for a largely biological basis for irrationality (including the tendency towards self-depreciation). He proposed that 80 % of irrationality was a function of biological make-up while learning including parenting and education accounted for 20 %. He also argued for significant individual differences in people's tendencies towards irrationality citing as evidence the differences shown in the psychological make-up of siblings growing up in the same family. So, the reason why some young people who experience emotional difficulties have more highly developed cognitive processes for viewing the world in irrational ways may have more to do with their biology than their environment.

Finally, Ellis forcefully argued that self-depreciation was derivative from and secondary to *absolutistic thinking* (Ellis, 1994). Ellis argued that helping eliminate *demands, should, oughts, and musts* from the thinking of young people about achievement and success would have somewhat of a domino effect on other irrational processes such as *awfulizing*, *I can-stand-it-it is and global rating of self, others, and world*.

Research on Self-Acceptance

From a review of the research, one of the problems we see in understanding the concept of self-acceptance is that it is often defined inconsistently. Further, self-acceptance is also used interchangeably with the concepts of self-worth and self-esteem, making it difficult to truly understand self-acceptance, its relationship to mental health, and ultimately the strategies that may be used to promote this concept.

Research reveals the relationship of low self-acceptance as indicated by a high degree of self-depreciation and childhood disorders (e.g., Ellis & Bernard, 2006). For example, using the *Child and Adolescent Scale of Irrationality to measure self-depreciation*, Bernard and Cronan (1999) found significant positive relationships between self-depreciation, trait anxiety, trait anger, and teacher ratings of student low effort in school and behavior problems. Pannes (1963) found significant associations between low dogmatism in adolescents and low degrees of self-acceptance. Self-acceptance has been shown to be related to both internalizing and externalizing behaviors (Kassay, Terjesen, & Smidt, 2010) as well as academics (Brooks, 1999) among both clinical samples and typically developing youth.

Recently, Bernard designed the *Child and Adolescent Survey of Positive Self-Regard and Self-Acceptance* (see Appendix 1) that contains items reflecting dimensions of positive self-regard as well as negative self-evaluation. In its original form, 12 items were written tapping each dimension and were edited and agreed to by three different experts in rational emotive behavior therapy. The survey was administered to 254 students (169 in grades 5/6; 85 in grades 7/8) in four different schools in Victoria, Australia. An exploratory factor analysis revealed a two-factor solution with eight items being dropped due to item-factor loadings lower than 0.50. The factors were negatively correlated (0.49).

Items loading on Factor 1 "Positive Self-Regard" but not Factor 2 reflect an self-awareness of positive attributes especially when faced with negative events.

- When I think about what I cannot do very well, I still accept who I am.
- When I get a lower grade than I want, I am good at reminding myself I am capable.
- When I look in the mirror and see something I don't like (for example, my skin, my hair, my nose), I know I still have good things about me.
- I know a lot about my good qualities.

Factor 2 "Negative Self-Evaluation" consists of items that reflect global self-rating as well as the importance of other people's opinions and school performance as a basis for determining one's value as a person.

- When my friends don't ask me to do things with them, I think I'm a loser.
- People would like me a lot more if I wasn't such a loser.
- When things are boring, I think I'm a dull and uninteresting person.
- I am someone who needs my friends to like me to feel important and to be worthwhile.
- When I don't succeed in a subject that is important to me, I am likely to think I'm a complete failure.

Table 1 Relationship between self-regard and negative self-evaluation with positive/negative emotions and life satisfaction

	Positive affect	Negative affect	Life satisfaction
Positive self-regard	0.55	−0.22	0.63
Negative self-evaluation	−0.37	0.38	−0.51
Total	0.52	−0.34	0.64

To examine the relationship of positive self-regard and negative self-evaluation to the emotional life and life satisfaction of young people, the revised 16-item *Child and Adolescent Survey of Positive Self-Regard and Self-Acceptance*, *Students' Life Satisfaction Scale* (six-item short form), and the 20-item *Positive and Negative Affect Scale for Children* (Laurent et al., 1999) were administered to 175 students (90 in grades 5/6; 85 in grades 7/8) in four different schools in Victoria, Australia. Significant relationships are reported in Table 1.

Positive affect correlated 0.58 with Life Satisfaction whereas negative affect correlated −0.53. No gender differences were found and there was some evidence that older students score lower in Factor 1 (positive self-regard) than younger students.

Both dimensions, positive self-regard and negative self-evaluation, were associated with life satisfaction. As might be expected, positive self-regard was most strongly correlated with the experience of positive emotions while negative self-evaluation was most strongly correlated with the experience of negative emotions. Overall, these preliminary findings suggest that education programs for young people should include learning experiences that promote the development of positive self-regard and the elimination of negative self-evaluation.

The research that directly targets the promotion of self-acceptance among youth is somewhat sparse. That is, while it can be assumed that many investigations that utilized Rational Emotive Behavior Therapy as their theoretical approach incorporated some direct instruction in self-acceptance, unfortunately few of them specify as to whether they did, how they did it, and to what degree (Esposito, 2009). While there are a number of programs that clearly have self-acceptance as a cornerstone, the researchers who evaluate the efficacy of these programs would be better served to highlight specifically what components of the program were used to examine their relation to outcome. That is, if we are able to ascertain what part of the program leads to therapeutic change for specific clinical problems, then those areas could be targeted clinically and enhance therapeutic efficacy.

Self-acceptance may also serve as a protective factor to reduce the likelihood of more severe negative outcomes among individuals who have experienced a traumatic event or reduce the likelihood of the development of psychopathology. An example of this is seen in the research by Tanaka, Wekerele, Schmuck, and Paglia-Boak (2011) who examined the relationship among childhood maltreatment and self-compassion among 117 youths receiving services through Child Protective Services (CPS) over the course of 2 years. The authors defined self-compassion as positive acceptance of self and described these youth as a high-risk group and reported a negative correlation between self-compassion and higher childhood emotional abuse, emotional neglect, and physical abuse. Youths with lower self-compassion scores were at increased risk

of experiencing psychological distress, problem alcohol use, and reporting a serious suicide attempt. This research offers many interesting considerations for the role of self-acceptance in child functioning. To begin, there is a relationship with self-compassion/acceptance and childhood abuse, which may be a possible area for the clinician to target in their clinical work with this population. Further, as those with higher self-compassion/acceptance are at less risk for maladaptive functioning, this may serve as a call to implement curricula that address self-acceptance at an earlier point in development as a preventative approach.

The buffering impact of self-acceptance may also be seen in recent research that looked at the development of body dissatisfaction and psychopathology (Maxwell & Cole, 2012). The authors reported that adolescents' use of self-acceptance strategies appeared to attenuate the relation between body dissatisfaction and psychopathology. Now the scales that measured self-acceptance may not be exactly in line with the conceptualization of self-acceptance for this chapter (e.g., "I would say to myself that I am perfect the way I am," "I would tell myself that I like the way I look"); these results may provide insights into healthy and unhealthy strategies that adolescents may use to manage negative affective states and body dissatisfaction, may warrant further investigation, and further support the importance of this concept as a buffer to pathology.

In sum, self-acceptance has been demonstrated to be related to healthy affective states and behavior among youth, and also has been used as a component of varied clinical interventions and educational programs that have resulted in positive outcomes. The combination of the continued efficacy of cognitive-behavioral interventions for youth, with the desire for more preventative programming and efficiency of clinical work may in fact spur further investigation into examining the science of self-acceptance among youth. Researchers would greatly benefit the work of clinicians who work with youth if they more clearly articulated specific treatment procedures and therapeutic strategies and linked these to outcome. We need to consider the generalizability of findings across regions, cultures, and age groups as well as the transportability of self-acceptance-based interventions within contexts in which clinical care is more often to occur (i.e., schools, community mental health centers). More attention to developing specific methodologies that assess self-acceptance and evaluate its impact within these programs or curriculums is warranted. This greater elucidation of the exact role of self-acceptance in reducing the risk of aversive consequences and promoting student social-emotional acceptance will further our knowledge in this area and increase our educational and psychological practices when working with youth.

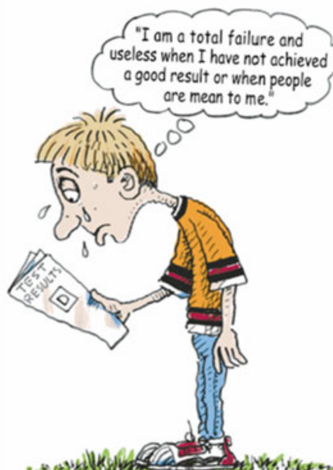
Classroom Applications

There are a number of ways to teach self-acceptance to a whole class of students (Vernon & Bernard, 2006).

1. Bernard's (2013) recommends in his curricula *I Accept Myself No Matter What* that teachers should "sell" the idea to students that self-acceptance is valuable

and important to their happiness and success (see Appendix 2 "Introducing Self-acceptance to Your Students").

2. To help encourage the development of positive self-regard, teachers can design activities for students to become more aware of and appreciate their positive qualities including: character strengths (e.g., Peterson & Seligman, 2004), types of multiple intelligence (e.g., Gardner, 2011), family, religious, and cultural background.
3. Once presented with different meanings of the word "self-acceptance," students should be given the opportunity to develop in their own words what self-acceptance means (see Appendices 3 and 4). They should also be given examples of how self-accepting self-talk can be applied when confronted with different difficult situations ("Happenings").
4. In discussing the meaning of self-acceptance (accepting myself) (Bernard, 2013), visual reminders that communicate self-acceptance should be displayed in the classroom. Sometimes, when self-depreciation (self-downing) is also being taught, contrasting images can be displayed together.



Accepting Myself Self-Downing

5. At different teachable moments, teachers should help students to use self-acceptance as a way of thinking when they are faced with teasing, rejection of lower than wished for school performance ("Remember, you are not a 'D'; person because you received a grade of 'D'"). The message that teachers can have their students internalize to deal with an act of bullying or teasing is "I am still a worthwhile person" (Bernard, 2012b).
6. Many books written for young people of different ages contain portray characters that display varying degrees of self-acceptance. These stories contain common messages about accepting and celebrating who you are and to be proud of your

differences. Some popular examples of books and stories that can be incorporated in the language arts curriculum. include:

Freddie Flounder: Virginia Waters (Age Level: 8 Years+)
Content:
How to handle making mistakes:

Step 1. Accept yourself *totally*, mistakes and all. Try not to put *yourself* down, no matter what you do. (no self-rating)
Step 2. Accept responsibility for having made mistake or doing something badly
Step 3. Try to correct mistake
Step 4. See what you can do to avoid making mistake in the future

Cool Cat: Ann Vernon (Age Level: 6–7 Years+) (Story Appears in Following Section)
Content:
Accept differences and deficiencies; no overall self-rating.

What I Like About Me: Allia Zobel-Nolan (Age Level: 5 Years+)
Content: Opportunity for children to explore what they like about themselves; we are all different; life is great.

Oliver Onion: *The Onion Who Learns to Accept and Be Himself*: Dianne Murrell (Age Level: 4–10 Years)
Content: you cannot run away from who you are; celebrate your uniqueness; do not try to be like someone else, you cannot; it's very difficult to be something you are not; "I am an onion and an onion is all I want to be." Every shape and color is wonderful. From now on, he would like and accept himself and not try to change into someone else.

We're Different, We're the Same… and we are all wonderful!: Sesame Street (Age Level: 5 Years+)
Content: We're the same. We're different. That's what makes the world such fun. Many kinds of people, not just one! What makes a rainbow beautiful is that it has every hue; so aren't you glad, you look like you?

It's Okay to Be Different: Todd Parr (Age Level: 5–6 Years)
Content: Its OK to be different. You are special and important because of being who you are ("It's OK to be proud of who you are")

7. A most common classroom practice for teaching self-acceptance is presenting developmentally and culturally appropriate lessons that explicitly teach different aspects of self-acceptance. Activities can be sourced from published curricula such as Bernard's *Program Achieve* (2008), Bernard's *I Accept Myself No Matter What* (2013), Vernon's *Thinking, Feeling, Behaving* (2006), and Sabine Beecher's *Resilience through Self Acceptance Skills* (2009). Bernard and Vernon's curricula include lessons that suit students from lower elementary to upper secondary levels of schooling (see Appendix 5 for samples of lessons).

Self-Acceptance in Early Childhood Education

With the goal of self-acceptance to promote social-emotional development and resiliency, careful consideration on how self-acceptance is taught and integrated into educational curriculums and programs for younger children warrants considerable attention. Further, with increased awareness about the impact of social-emotional learning on child and adolescent outcomes (Bornstein, Hahn, & Haynes, 2010; CASEL, 2005; NASP, 2012; Payton et al., 2008; Zins, Walberg, & Weisberg, 2004) and prevalence rates for mental health problems in pediatric populations (Merikangas et al., 2010), the need to prepare our youth early for the challenges of life is essential (Barrish, 1997, p. 74). The promotion of a child's social-emotional development in educational institutions is not a foreign notion to educators as research has demonstrated relationships between academic performance and social-emotional well-being (Malecki & Elliott, 2002; Zins, Walberg, & Weisberg, 2004) and as policies and regulations (e.g., Dignity for All Students Act, NYSED, 2010) have been created to both encourage and mandate educational institutions to implement programming to improve social-emotional functioning, dignity, tolerance, and respect (Stuart-Cassel, Bell, & Springer, 2011). However, the regular or consistent practice of teaching social-emotional concepts like self-acceptance with younger children is less understood.

The idea of promoting self-acceptance in early childhood education makes logical and practical sense. Early childhood education encompasses a developmental range where children learn through discovery, observation, play, and direct instruction (Ashdown & Bernard, 2012; Berk, 2010; Bernard, 2004c). It is a time where children are educated in classrooms with other children and adults who may have different experiences and views from their own and from the somewhat homogeneous experiences they may have had at home. Here, they can recognize differences in physical appearances, capabilities, and family demographics. They will also encounter success, difficulties, and failures. Even at very young ages children show displeasure they make a mistake, or rate themselves through comparison with their peers (Barrish, 1997). Promoting self-acceptance in early childhood can also serve as a protective or preventative factor in the development of future mental health problems. Both parents and teachers can teach and encourage the practice of self-acceptance within the child's environment. Therefore, it is important that self-acceptance be taught and promoted in early childhood education.

In light of the unique characteristics of early childhood education, special considerations can be made in the instruction and promotion of self-acceptance within the school environment. In general, when promoting self-acceptance, practitioners would be wise to consider developmental levels in regard to language, materials, and implementation. Having the language used by teachers and staff and within curriculum materials is age-appropriate and culture sensitive will be advantageous. When defining terms like self-acceptance, using a vocabulary that is familiar and comprehensible by young students is key to their recall and application of self-acceptance in their lives. Through preparation, teachers and staff could pre-teach

vocabulary, provide relatable examples, and elicit student's background knowledge and experiences to help make connections within their learning. Similarly, having materials that are engaging and interesting (e.g., illustrated short stories, songs, the use of puppets/dolls, or even the use of technology like computer/smartboards) can all capture and sustain the student's attention and help increase participation (Keengwe & Onchwari, 2009). Second, to enhance student learning within early childhood education, the strategies used to promote self-acceptance should need rehearsal, modeling, and reinforcement in the natural learning environment. Similar to teaching academic concepts, instruction in self-acceptance at younger ages needs to be direct and specific and involve many diverse examples that are relevant to the children's experiences and opportunities to practice these concepts offered. Further, concepts taught through direct instruction should also be highlighted and used throughout the day and not in isolation, increasing generalizability of these skills into real life. As situations in school arise, teachers and staff can use as teachable moments. These situations during the school day can allow for the practice and reinforcement of skills as well as assisting the students cope with the situation. For example, if a student made an error on their art project and begins to cry, the teacher could help the child cope with the situation of making a mistake and rehearse self-statements such as "We all make mistakes, but just because we made a mistake does not mean that we are bad." Additionally, if a student becomes upset due to a physical impairment, rehearsing self-acceptance statements could include, "I don't like that I need hearing aids, but it doesn't make me less special and it's not going to stop me from coming to school."

Students of all ages but particularly young children learn through observation and reinforcement. One of the keys to teaching and promoting self-acceptance lies with working with key players (i.e., parents, teachers, and staff). Therefore, teachers, parents, and staff are recommended to model self-acceptance within themselves and with one another. As parents and early childhood educators have a large impact on child behavior, it seems vital for both parents and teachers to receive education and resources to further help their children. Thus, many of these curriculums for early childhood education have a parent component that provides parents with psycho-education and strategies (Bernard, 2003). Particularly, parent and teachers also need to learn about self-acceptance and about strategies to teach and reinforce the concept of self-acceptance in younger children. It is also important to reinforce and acknowledge their student's competence and achievement (Barrish & Barrish, 1989) while emphasizing the idea that when negative events occur, children do not rate themselves in a negative fashion. In addition, many educators design and use classroom rules or classroom management systems in their classes. The reinforcement of students for both peer and self-acceptance can easily be incorporated into their management systems.

Self-acceptance is also described or listed in other curriculums as self-awareness is a key component in many social-emotional curriculums for elementary-aged populations. Regrettably, despite the aforementioned importance of setting patterns within the early years, there are far less curriculums for children younger than the age of kindergarten (CASEL, 2005). These curriculums targeting self-acceptance/

self-awareness in young children has been developed for implementation in several settings, including classrooms, groups, or individual formats. Children are taught the idea of self-acceptance through lessons that may involve stories, activities, or content that illustrates how one can practice self-acceptance (Bernard, 2003; Vernon, 2006). Many of these lessons with younger children also involve the rehearsal of self-statements. This appears to be particularly useful for young children as they may lack the vocabulary to develop these statements independently. Examples of self-accepting statements include, "Even when I did something wrong, I am still an important person" or "I am special because of who I am, not just because of how I did on this test" (Barrish, 1997), "Our differences make us special." It is important that the rehearsal and use of these statements are reinforced and practiced within the real-life settings.

Individual Counseling

It is not at all uncommon for children and adolescents to struggle with self-acceptance. We live in a world that places so much emphasis on winning or losing, and young people are conditioned at a very young age that it is best to be a "winner." However, this type of dichotomous thinking can be very detrimental and as mental health and school counseling practitioners, we have an important role to play in helping them accept themselves.

In teaching a young person self-acceptance, a prerequisite step often involves the disputing of self-depreciation. You can explain that disputing involves asking three questions about one's thinking:

1. Is what I am thinking true? Is there evidence to support what I am thinking?
2. Is my thinking logical? Does it make sense to think this way?
3. Does it help me to think this way? Does my thought help me to achieve my goals and manage my emotions?

When a young person answers "No" to any one of these questions, he/she should with your help try to change the thought to one that is true, sensible, and helpful.

To dispute self-downing, you will want to show young clients how their thinking "I'm hopeless, a loser" does not make sense and is not true. You can begin by having the young person identify a range of positive and negative traits using a self-concept circle divided into segments with pluses and minuses in each segment. Once completed, ask young client "Does it make sense to think because something bad happened (e.g., poor grade, teased, rejection) that you are totally bad?" "Do you lose all your positive qualities when you make something bad happen?" You can also discuss the concept of human fallibility. Indicate that everyone is born as a mistake maker and, as such, it never makes sense to think, "I must not make mistakes" as mistakes are inevitable.

You can ask a young client: "Would you put a friend of yours down because she didn't do well in a subject or wasn't invited to a party? Would it make sense to think that she was a total loser?" Once the young person agrees that it wouldn't make

sense to think that way, you can ask: "Well then, why are you putting yourself down because of what happened. If you would not put your friend down, does it make sense to put yourself down?"

An analogy can be used to dispute self-depreciation. Ask: "Would you trash a car if it had a flat tire?" When the young person can see that it would not make sense to do so, you can help him/her begin to see that trashing himself when something bad happens does not make sense.

An example of semantic disputation of self-depreciation is seen in the following exchange between a therapist and young client.

> T: So, let me get this straight. When, you were not invited to the party at Mary's house and your friend was, you thought of yourself as a "loser." Is that what you thought?
> C: Yeah, I mean like Dina and Stephanie were invited.
> T: Well, I would upset myself about what happened, too. But, if you don't want to get so down, let's examine what you were telling yourself and see if it is rational.
> C: OK.
> T: When you think of yourself as a loser, the word "loser" means more than "I am not popular enough with Mary to get invited to her party."

The word "loser" means loser in everything you have done, are doing, and will be doing. It means your total essence is one of being a loser. Now, is your use of the word "loser" really true to this meaning?

The following ideas can be taught to help engender both self-acceptance and other-acceptance: "(1) Every person is complex, not simple, (2) I am complex, not simple, (3) Every person is made up of many positive and negative qualities, (4) I am made up of many positive and negative qualities, (5) A person is not all good or all bad because of some of his or her characteristics, (6) I am not all good or all bad, (7) When I only focus on the negative characteristics of a person, I feel worse about the person, (8) When I only focus on my negative qualities, I feel worse about myself, (9) Focusing only on the negative qualities of someone else and thinking he is totally bad is irrational. People who do the wrong thing also have other positive qualities. (10) Only focusing on my negative qualities and concluding 'I am hopeless' is irrational. Even when I do the wrong thing, I still retain my positive qualities."

During individual counseling sessions, specific interventions can target self-acceptance in developmentally and culturally appropriate ways that facilitate healthy development in young clients. As with classroom guidance activities, it is more effective if a variety of interventions employing different creative arts techniques are employed because there is a greater likelihood that younger clients will retain the concepts (Vernon & Barry, 2013).

Young children respond well to concrete techniques, such as using a balloon and a hard rubber ball to emphasize "bouncing back" after being put down, for example, for a child struggling with this issue, give him a balloon to blow up and tie, then give him a straight pin and ask him to prick the balloon with it until it pops. Then have him prick the rubber ball with the pin, discussing the difference between the balloon that pops and a rubber ball… the ball is still intact but the balloon isn't. Use this method to help the child see that if he personalizes everything and thinks he is what others say he is when they put him down, he "deflates," whereas if he thinks about

his strengths and weaknesses and doesn't personalize every bad thing others say about him, he will be much more likely to "bounce back" like a rubber ball.

Teenagers are notorious for "soaking up the negative" when peers call them names or put them down, so a concrete strategy that works well with this age group is to use a large sponge and a bucket of water. First have them hold the sponge when it is dry and light, then dip it in the bucket of water and hold it again. They readily realize that it is much heavier when it is wet. Draw the analogy that if they "soak up" everything others say about them without "wringing out" the sponge and differentiating between who they are and what others say they are, their self-acceptance is negatively impacted.

During individual counseling sessions, it is also important to help clients learn that they are complex human beings with multiple characteristics. Mental health practitioners and school counselors can use an intervention called The Whole Picture (Vernon, 2009, pp. 279–280) to convey this concept to clients struggling with this issue. Use a child's puzzle, a sheet of construction paper that is cut into ten shapes that fit together like a puzzle, transparent tape, and a pen. First have the client put the puzzle together, discussing what happens if there are missing pieces and that all pieces are needed to see the whole picture. Then give her the construction paper puzzle pieces and explain that this is a personal puzzle. She needs to think about different "pieces" of herself and write them on the individual pieces and then put her puzzle together and tape it. Again, discuss how all parts are needed for the "whole picture."

Another technique that can be used to enhance self-acceptance and teach clients to avoid equating their self-worth with how they describe themselves is called Who, Me? Yes, You (Vernon, 2009, p. 281). This intervention requires a short checklist with characteristics such as: intelligent, fun to be with, responsible, dependable, loyal, trustworthy, outgoing, popular, good looking, musically talented, and so forth. The client completes the checklist and you discuss which characteristics were like or unlike him, asking if he is "better" if he has more check marks. Then ask the client to read the characteristics out loud, saying "I am only a good person if I am _______ (intelligent, responsible, and so forth)." Tape recording this and playing it back helps clients really hear what they are saying: I am only a good person if … and has proven to be an effective way of helping them understand that they are good regardless of specific characteristics.

Another intervention appropriate for adolescents is to engage them in an activity called IAWAC (Vernon, 2002, pp. 74–76). This strategy helps teenage clients understand that they don't have to take every criticism or comment personally and put themselves down as a result, helping them accept themselves and build emotional resiliency. First, give the client a sheet of paper with the letters IAWAC written across it, informing her that this paper represents her self-worth. Next, tell her a story about a girl who gets up late for school and is yelled at by her parents for being irresponsible, which sets off her whole day. She is almost late for the bus, so she can't sit with her friends who ignore her, she misses most of the problems on the algebra board drill and considers herself stupid, and she forgets to go to play practice, so her parents cite this as yet another example of her irresponsible behavior. As you read the story, instruct the client to tear off a part of her IAWAC sign each time she or someone else is critical of her. By the end of the story there won't be much left of

her worth. Then give her another IAWAC sign and tell the story again, but this time instead of tearing off part of the sign when she misses problems and calls herself stupid, the girl in the story thinks to herself, "I'm not a stupid person… I just missed problems," and tears off a smaller part of the sign. Or, instead of tearing off a large piece of her sign when her parents called her irresponsible, she could tear off a small piece while thinking to herself, "I may not be the most responsible kid, but that doesn't make me a bad person." At the end of the story, discuss the rational self-talk that helped the girl in the story to be more accepting of herself and how the client might use these concepts to deal with her own lack of self-acceptance.

Case study. The following case study illustrates further application of self-acceptance principles in individual counseling. The client is a 15-year-old female, referred to counseling by her parents who are concerned about her depression which they feel directly relates to low self-esteem and the pressure she puts on herself because she thinks she has to be perfect.

During the first session with Amanda, she admitted that she was very self-critical and that it contributed in a major way to her depression. When asked to talk more about feeling depressed, she stated that it was because she was ugly, fat, stupid, and unpopular. In fact, she was an attractive young woman who was not at all overweight and who was obviously not stupid based on the fact that her grades were all A's and B's. According to her parents, she did have friends and even a boyfriend, but as is typical with adolescents, those relationships would be on again and off again, which caused Amanda to think that she wasn't popular or worthy of having a boyfriend when the relationships were rocky. Unbeknownst to her parents, when she went through periods where she was rejected by friends or fighting with her boyfriend, she admitted to drinking rather heavily and also toyed with the idea of becoming anorexic because she thought that might make her more attractive.

It was so apparent that this young client had an unrealistic picture of herself and for some time had only seen herself in a negative light, which resulted in a lot of insecurity and anxiety, as well as depression. During an initial session, I gave her an envelope and asked her to write words describing the "public" Amanda on the outside—words that others would use to describe her. Although most of them were negative, there were a few positives. Then I invited her to write words that she used to describe herself—characteristics that others may not even know about her, and put those on slips of paper inside the envelope. When we discussed what she had written, it was once again very evident that she basically didn't see her strengths, only her weaknesses. Even challenging her perception that she was stupid with the fact that she got A's and B's was difficult because she stubbornly held onto the notion that she was stupid because she didn't get all A's and because she didn't, she wasn't a good person. In challenging this, I asked her if she would consider her best friend a bad person because she didn't get all A's, and Amanda said she wouldn't. "So if you wouldn't think your friend was a bad person, why would you think you are? Does that make sense?" She admitted that it didn't make much sense, but I could tell we needed to continue to work on letting go of this irrational belief.

It also appeared that Amanda was like Velcro; everything that was implied or directly stated or even misinterpreted by her would automatically "stick" to her. For example,

when her best friend was sitting by someone else, Amanda assumed she didn't like her and that she wasn't worthy of her friendship. Or, when her boyfriend didn't call her at the exact time he had said he would, she assumed he was out with another girl because she wasn't good enough for him. Incidents like this depressed her even more to the point where she didn't concentrate well at school and resulted in some bad grades on tests. Of course, this further confirmed her perception that she was stupid.

Several different interventions were employed over the course of many months to address self-acceptance issues, which seemed to be the root of Amanda's problems and were spiraling out of control. First, I shared the concept of unconditional self-acceptance—USA—with her, emphasizing that humans are fallible people who make mistakes, they are not their behavior, and that one doesn't have to be perfect to be worthwhile. To get these points across, I used an intervention entitled USA (Vernon, 2002, p. 78), which involved giving her a paper bag labeled USA. Inside the bag were five strips of paper with the following phrases, one per card: school performance, peer relationships, sports, music or drama, jobs or chores, daughter. I then explained that it is not good to globally rate herself as a good or a bad person, but rather, she should remember that she is comprised of many different traits and that it is preferable to rate those to give her a more accurate picture of herself. I encouraged her to think about her performance in each area and rate herself on a 1–5 scale, as objectively and factually as possible. True to form, she did not rate herself high in any category, so I challenged her perception that she was average in music with the fact that she had recently been asked to try out for an honor choir. "But I know I won't make the final cut," she said. "You have a crystal ball, I asked?" "And even if you don't make it, doesn't the fact that you were asked to try out mean that you have better than average musical ability?" She reluctantly agreed. "But even if you actually had average or below average talent, does that make you a bad person, I asked?" "I guess not" was her response. I continued to work with her on each of the areas listed on the cards, helping her see that she did have strengths as well as weaknesses but that her worth as a person wasn't related to her performance or her behavior.

Another intervention was used to help her accept herself more unconditionally. Because she had a tendency to jump to conclusions that she wasn't good enough, I asked her to write down every single negative thought she had ever had about herself. Then one by one, we went through the list and I asked her to prove to me that she in fact was that "bad." For example, one of the things on her list was that she was inconsiderate. I asked for an example, and she provided one. "Well," I said, "surely there must be lots of other examples; name a few more." She really couldn't think of any at the moment, so I asked her if it was in fact accurate to label herself as inconsiderate when she could only recall one incident. After doing some of this sort of challenging, I then asked her to select ten labels that she could let go of because they were one-time occurrences or overgeneralizations. She selected these and then wrote them on individual slips of paper, stuffed them into balloons that she then blew up and tied. We went outside and she let them go. We continued to do this for the next two sessions until we got to the point where she had a more realistic concept of herself and was able to accept the labels that were left as part of her, but not defining her as a good or a bad person.

Another intervention used to help Amanda address her perfectionism was Too Perfect? (Vernon, 2009, pp. 283–285). This intervention utilized a short checklist

with items such as: I must be perfect because if I'm not, I'm not worthwhile; I must be perfect so that I am better than others; I must be perfect because others will like me better, and so forth. After she checked off the items that applied to her, we discussed the reasons why she thought she had to be perfect and talked about where her "should be perfect" ideas were coming from. Then she filled out a worksheet with three columns: why must I be perfect? advantages of being perfect, and disadvantages of being perfect. There were multiple lines under each category so that she could thoroughly explore this issue. Together we discussed her irrational idea that she had to be perfect to be accepted and worthwhile and weighed the advantages and disadvantages of demanding that she always be perfect. This took repeated work, but she gradually relaxed her self-imposed standards and found out that others still accepted her even if she wasn't perfect.

Helping children and adolescents understand and internalize the concept of self-acceptance isn't easy, but as this case illustrated, there are various ways to help them learn the concepts, and the end result benefits clients in numerous ways. If they can begin to think, like Amanda did, that they are worthwhile individuals regardless of their performance and that accepting themselves with strengths as well as weaknesses is a healthier way to live, they will be better able to face.

Teaching Self-Acceptance in Counseling Groups

With the efficacy of educational and clinical interventions for youth that typically have acceptance as a cornerstone to the theoretical approach (i.e., REBT), it stands to reason that promotion of acceptance is an important area to consider for application in counseling groups. As such, it is important to examine the impact of studies that specifically targeted self-acceptance and to what degree can self-acceptance be taught in a group-counseling format? Esposito (2009), in a meta-analytic review of REBT, reported that treatment conducted in a group format is just as effective as individual treatment with a strong mean effect size of group-based interventions of 0.87. Regrettably, as highlighted earlier, the outcome literature that clearly delineates the interventions that focus on self-acceptance is limited in nature. Typically, self-acceptance is one of a variety of interventions that are used in social-emotional learning and cognitive-behavioral interventions and often it is a challenge to discern from the literature how much and to what degree did the self-acceptance component of the intervention facilitate change. Further, with many investigations highlighting the positive impact of interventions on self-esteem, without clear distinctive definitions of self-esteem, self-acceptance, and self-confidence, it may be difficult to truly understand the impact of the intervention on self-acceptance.

Using group counseling as a prevention program among Southeast Asian adolescent girls, Queener and Kenyon (2001) targeted "growth regarding self-acceptance" (p. 350) as a goal to be facilitated within a culturally relevant framework. While the authors do not provide any data to measure the outcome of this group approach, they do describe the therapeutic process and highlight promotion of self-acceptance

as it relates to cultural identification. This cultural component may be important for practitioners to consider when developing and implementing group-based interventions. Additional research that closely examines culture as a variable in developing and maintaining self-acceptance is warranted.

Below we provide some guidelines for clinicians and educators for how and where they could implement self-acceptance into a group therapy process. To begin, it would be important for the group leader to consider the purpose of the group and how self-acceptance could tie into the goals of the group. That is, if it is a specific type of group with homogeneity among the presenting clinical problem (e.g., depression), the group leader could provide education about the concept of self-acceptance and how it relates to the presenting problem. Alternatively, if the group is more heterogeneous in nature, the group leader may wish to identify self-acceptance as a core skill related to healthier functioning and that through the development of this skill, this will assist the students in working towards their goals. It is important for the group leader to consider to what degree self-acceptance might be contributing to some of the difficulties that students may be experiencing. By helping the students understand that by learning and applying the concepts taught in group therapy that it may assist in remediating some of the present difficulties that they are reporting it may also help prevent future problems from developing. This may enhance the students' engagement in the therapy process as well as motivate them to work towards change.

To guide the therapeutic process, we think it important to have clearly delineated goals of the group and goals for the individual within the group and regularly address these. While students may be more adept at identifying behavioral goals (e.g., "Stop fighting with my sister"; "Study more"), the group leader may use this as an opportunity to link these goals to self-acceptance and establish goals that link development of self-acceptance with a behavioral or emotive goal. These goals can then also be used as part of the weekly assignments between sessions. We suggest that assignments be more concrete with students and involve both behavioral and cognitive tasks. That is, if the goal was for an anxious student to ask to play basketball with the group that regularly plays without him, we would rehearse effective coping statements related to self-acceptance (e.g., "If I ask and they say NO, I can stand it and it does not mean I am a bad person"; "If I play and play very poorly, that is just one part of who I am. I still like who I am") with behavioral skill building (e.g., practicing what to say).

While the goals of the group may often be symptom reduction, it would be helpful for the group leader to provide a balance of approaches that targets specific symptoms for reduction as well as develops helpful coping strategies for promotion of self-acceptance going forward. That is, group leaders may wish to target unhealthy beliefs that may be leading to specific negative affective states and problematic behaviors while also promoting healthier, more self-accepting beliefs. Tying these self-accepting beliefs into healthier, adaptive behaviors may also be something that the group leader wants to educate the group members about. As an example, for students who may be experiencing symptoms of depression, the group leader could target and challenge unhealthy beliefs (e.g., "I am stupid because I failed the test") while also reinforcing more self-accepting beliefs (e.g., "Failing a test does not make me a failure") while also teaching organizational and study skills.

Within group therapy, psycho-education about the concept of self-acceptance can be a challenge for the group leader. That is, in comparison with teaching social skills, a behavior that can be seen, students may not see the benefit of developing this abstract concept of self-acceptance. With younger students, psycho-education may focus more on the development of an emotional vocabulary initially before working on introducing abstract concepts like irrational beliefs and self-acceptance. Group leaders may wish to try some icebreaker activities that can provide for an opportunity for discussion of self-acceptance. For example, group leaders can have students make lists of three things that they are good at and three things that they are not good at. They can then look at what feelings they experience when they are asked to do both these "good" and "bad" tasks and how they feel about themselves when they succeed and when they fail. Some will report no differences in their feelings while others may present with some negative self-talk (e.g., "I think I'm an idiot"). This would provide the leader with the opportunity to introduce the concept of self-acceptance and how oftentimes we link our ratings of ourselves to some external criteria of success and failure.

Other approaches towards psycho-education may involve use of cartoons or movie clips to demonstrate how others may have examples of low or high self-acceptance. As students come to understand the concept of self-acceptance, they may then be asked for personal examples where they have rated themselves and not their behavior and have experienced unhealthy emotions as a result. The group may then work on examining the different unhealthy beliefs that may be contributing to their affective state and create and practice, newer, healthier, self-accepting beliefs. Students may then be asked how they think they would feel and behave if in fact they truly thought in this more self-accepting manner. We think that this may be particularly helpful to have be a part of the group process, as peers may learn how to challenge the unhealthy beliefs and become more accepting by the modeling of these behaviors by others when they are not the focus of the discussion. That is, if they are on the "hot seat" and are the focus of the discussion they may just wish to get "off" the hot seat and may not process all the discussion about acceptance. Alternatively, when it is not their problem, they may be more likely to understand the connection between thoughts, feelings, and behaviors and be able to generalize it to themselves.

In addition to psycho-education and goal setting, several strategies may also assist in building self-acceptance in the group therapy process. These include role-playing of situations where students may be particularly prone to rate themselves and having them practice self-acceptance statements along with strategies to behaviorally manage these situations. An additional exercise that can help reinforce self-acceptance among group members would be to have them write situations where they have rated themselves on a piece of paper and have the group leader put these up on the board and have the group challenge those ideas and develop alternative, healthy ways to think. Another strategy to enhance self-acceptance may be more behaviorally oriented by having group members do something they normally would not do for fear of failure and practice self-acceptance (Terjesen & Esposito, 2005).

While the concept of self-acceptance is core for a number of clinical interventions, educational programs, and preventative strategies, group-based approaches may be an effective strategy in which to teach these beliefs to youth. Students who

are prone to rate themselves may benefit from hearing that they are not alone in this tendency while also receiving support from the group leaders and their peers in challenging these self-rating beliefs and developing more of an accepting philosophy. Students may also be more motivated to change their rating behavior when participating in a group as opposed to being in individual therapy and the group may be seen as a safe environment for them to take risks.

Self-Acceptance of Teachers: Professional Development

The extent to which teachers are self-accepting is a determining factor in their ability to inculcate self-acceptance in their students. This awareness involves an understanding of the negative effects of self-depreciations and the positive effects that self-acceptance has on their own development and well-being. Research (Bums, 1989) has shown a positive association between teacher self-acceptance and positive attitudes towards students including handling conflict situations as well as progressive child-centered educational practices.

Teachers need time and opportunity to begin to internalize self-acceptance. Experience (MEB) has been that teachers come to appreciate the importance of teaching self-acceptance to their students when they see its relevance and utility for their own job performance and well-being. Bernard (2013) has developed a teacher professional development program *The Character Strength of Self-Acceptance: I Accept Myself No Matter What* that is designed to be presented to groups of teachers in a half-day workshop (see Appendix 6 for a sample summary handout from the program of tips to increase teacher self-acceptance).

Conclusion

We are of the opinion that self-acceptance is vital to the emotional well-being and productivity of all members of a school community—students, teachers, support staff, administrators, and parents. We believe "acceptance" should be explicitly incorporated as a core value of a school and incorporated within school culture. All members of a school community will benefit from the character strength of self-acceptance that communicates the importance of valuing oneself because of one's unique strengths and differences and not using the opinions of others or one's performance as the measuring rod or scale of one's worth as a person. It is clear that more research needs to be conducted to determine the relationship of self-acceptance to other character strengths and social-emotional skills as well as to isolate its' influence in effecting positive change in young people. We are also keen to learn more about the relationship of self-acceptance and self-regard in terms of their relative contributions to positive emotions and life satisfaction of young people.

Appendix 1 Child and Adolescent Survey of Self-Acceptance (Bernard, 2012a)

Gender: (circle one): boy girl School ______________________________
Grade/Class______________

When you are ready to begin, please reach each sentence below and pick your answer by circling a number from "1" to "5." The five possible answers for each sentence are:

1 = Strongly Disagree 2 = Disagree 3 = Not Sure 4 = Agree 5 = Strongly Agree

For example, if you were given the sentence "I like to read comic books," you would circle a "1" if you Strongly Disagree. If you were given the sentence "I like to keep my room neat and tidy," you would circle a "5" if you Strongly Agree. Please be sure to answer all of the questions.

	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
1. When I think about me, I am proud of whom I am	1	2	3	4	5
2. Saying something stupid in front of others shows I am an idiot	1	2	3	4	5
3. When my father or mother criticizes me for doing the wrong thing, I know that I still have my good points	1	2	3	4	5
4. I am someone who needs my friends to like me to feel important and to be worthwhile	1	2	3	4	5
5. When a classmate treats me unfairly, I think I must be a hopeless person	1	2	3	4	5
6. When a classmate teases me about the way I look or talk or what I say, I think it is okay to be different	1	2	3	4	5
7. When my friends don't ask me to do things with them, I think I'm a loser	1	2	3	4	5
8. When I get a lower grade than I want, I am good at reminding myself that I am capable.	1	2	3	4	5
9. When I think about what I cannot do very well, I still proud of who I am	1	2	3	4	5
10. People would like me more if I wasn't such a loser	1	2	3	4	5
11. When I don't succeed in school in a subject that is important to me, I am likely to think I'm a complete failure	1	2	3	4	5
12. I know a lot about my positive qualities	1	2	3	4	5
13. When things are boring, I think I'm a dull and uninteresting person	1	2	3	4	5

(continued)

(continued)

	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
14. When I look in the mirror and see something I don't like (for example, my hair, my skin, my nose), I know I still have good things about me	1	2	3	4	5
15. When I make mistakes in my schoolwork, I can think of things I am good at	1	2	3	4	5
16. I am someone who needs to get good grades to feel important and worthwhile	1	2	3	4	5

Positive Self-Regard : $\frac{_}{1} + \frac{_}{3} + \frac{_}{6} + \frac{_}{8} + \frac{_}{9} + \frac{__}{12} + \frac{__}{14} + \frac{__}{15}$

Negative Self-Evaluation : $\frac{_}{2} + \frac{_}{4} + \frac{_}{5} + \frac{_}{7} + \frac{__}{10} + \frac{__}{11} + \frac{__}{13} + \frac{__}{16}$

Appendix 2 Introducing Self-Acceptance to Your Students

I want to introduce you to a topic we are going to be learning about over the next few weeks that is called "Self Acceptance." I'll write that on the board for you to see.

Who has an idea of what you think we might mean by "self acceptance?" Think about it yourself and then take a minute to talk quietly to the person beside you about what those words might mean.

Who wants to share your ideas with the class? Let's hear a few ideas around the room. Great suggestions! You're really on the ball!

We say "Self Acceptance is being proud of who you are no matter what." I'll write that on the board.

Now, why do we think it is so important to teach you about self-acceptance? Well, self-acceptance is a powerful thing. It can help you to stay positive when you hit a challenging situation. And we all have those at times, don't we?

Has anyone ever got a bad mark on a project or a test? Well, accepting myself thinking encourages us to not to be too hard on ourselves and put ourselves down when something like that happens.

Has anyone ever been teased, or left out of a game? Well, accepting myself thinking encourages us not to think badly about ourselves just because of something someone else said or did.

Has anyone ever felt bad because they weren't able to do something very well and other kids could do it well? Well, accepting myself thinking reminds us that we can't be good at everything and that we all have our own skills and talents.

So, hands up who thinks they'd like to learn more about this important topic? Fantastic! And do you know what? It's not just kids who need to learn about self-acceptance! It's adults too! Your teachers, your parents, EVERYONE needs to work on developing and practicing their self-acceptance!

Appendix 3 Introducing Self-Acceptance (Bernard, 2013)

Self-acceptance means

… being aware of all your strengths (personal, family, cultural) and your not-so-positive qualities that everyone has because no one is perfect. It also means being aware of how you are similar to and different from others…

… you believe that it is okay to be different. You believe you have the right to be yourself and the way you want to be providing that the health and wellbeing of others and yourself are respected.

… if you are not good at doing something, if someone is critical of you or if you have behaved badly, you still respect who you are while trying to improve what you do. You do not think negatively about who you are.

… you do not need everyone to like you all the time to feel worthwhile. You do not need to get the top grade to feel that you are valuable. You do not judge your self-worth by your school performance and by what other people think of you.

… you are proud of who you are because of your special and important qualities.

Examples of "Accepting Myself" Self-Talk

Happening: You get a C- in English.
Self-Talk: "Let's try and get more out of the next exam, Let's have more practice. My value as a person is not made up by my test/exam score."

Happening: Being excluded from a game.
Self-Talk: "I can cope with being excluded, it doesn't mean I am a loser. I am who I am, I'm still proud of who I am. I don't need to be included in a game to feel good about myself, to be a worthwhile people."

Happening: Failing a test on one of my good subjects.
Self-Talk: "I can try again. Believe in myself. Be resilient. Be myself."

Happening: When I am not good enough at doing something.
Self-Talk: "I don't need to be good/have to be good at everything. It's who I am and who I think I am that's important." "I need to respect myself for who I am."

Happening: Not doing so well on a math test.
Self-Talk: "I'm better at other things. Everyone is different and this test isn't the end of the world even if it was challenging. I am proud of me."

Happening: Being talked about behind my back.
Self-Talk: "I can choose whether I let this get me down or not. I am the best I can be. I have to accept myself. I am proud of what I am."

Appendix 4 Examples of Student Feedback: Accepting Myself (Bernard, 2013)

Write down what Accepting Myself means to you…

1. To know and be proud of who I am and to accept myself with my good qualities despite any troubles or issues I may have.
2. Accepting who you are and be proud to be you. Don't try to be like someone else just be yourself. It is good to be different, no one is perfect.
3. Even though I'm not perfect and different to others I am still me and I have unique things about who I am. Be proud of yourself and just be you.
4. You accept yourself as who you are, what you do, and not be ashamed if you are different from others.
5. To appreciate what I have got and to be myself the way I want to be.
6. Everyone has different qualities (good or bad) and you need to accept those qualities.
7. Being proud and happy for who you are because no one is the same or perfect.
8. Everyone has a right to be who they are even when they do something bad. Everyone is different with pros and cons and they can change.
9. If you're not good at something, you need to accept who you are and your bad qualities that you might need to improve in.
10. Accepting both the good and bad qualities about yourself even though you would prefer something different.
11. Being proud of who you are and believing in yourself no matter what happens.
12. Accepting all of yourself, the bad qualities and the good.
13. Accepting you and other people for who they are and with their different qualities.
14. I know I'm not good at some things but I'm not going to get angry with myself.

Appendix 5 Examples of Curriculum Lessons that Teach Self-Acceptance

Cool Cat (Vernon, 2006)—grades 1/2
Objective: To learn how to accept yourself for who you are.
Materials: A copy of the Cool Cat story.
Procedure

1. Read the following story to children.

   Cool Cat
   Once upon a time there was a black cat named Blackie. Blackie was a very unhappy cat and everyone knew it. When his mother would purr and tell him what a beautiful coat of black fur he had, Blackie would hiss, "Don't call me Blackie—I hate my color." So his mother stopped mentioning the color of his fur and instead, praised him for being such a good mouser. Blackie snarled at her and said angrily, "I'm not a good mouser—most of them get away." So his mother stopped commenting on his ability as a mouser, and instead told him how happy she was that he could jump so high. "That's no big deal… all cats can jump high," said Blackie. Her mother just shook her head. "Oh, Blackie," she said, why can't you accept yourself as you are? You're a cool cat and you can do lots of things. Sure, "there are things you can't do, but that's how it is for every cat. Isn't there anything you like about yourself?" Blackie meowed softly, "Well, I sort of like the white tip on my tail, even though I wish I had white paws too."
   "You are right—your tail is very pretty, but you can't change the fact that your paws aren't white. Does it make you happy to think about things like this that you can't change about yourself?" asked Mama Cat.
   "I guess not, but I just wish I could be a great mouser like Tom cat, and I wish I had tan fur like Toffee cat."
   "I understand that you might like to be different, but just like you can't change the color of your paws, you can't change the color of your fur. But, maybe you could learn to be a better mouser if you paid close attention to how Tom cat does it. But even if you aren't a great mouser, does that make you a bad cat?"
   "I suppose not," replied Blackie. "That's right," said Mama Cat. "It doesn't make you a bad cat, it just makes you a cat who can do some things better than others. And since you told me that it doesn't make you happy to think about what you can't do or how you don't think you are as cool as other cats, what can you do the next time you start thinking about the things you don't like?"
   "Well," said Blackie, I could…

2. Elicit responses from the children about what Blackie could do when he starts thinking about what he doesn't like about himself.

Discussion

Content Questions

1. What did Blackie like about himself?
2. What didn't Blackie like about himself?
3. What advice did Mama cat have for Blackie about accepting himself?

Personalization Questions

1. What are some things you like about yourself?
2. Are there things you would like to change? Invite sharing
3. If there are things you don't like about yourself, does that mean there is nothing good about you?
4. What can you tell yourself if you are acting like Blackie and only thinking about the things you don't like about yourself?

To the Leader

Emphasize the concept of self-acceptance—accepting oneself with positive as well as negative qualities.

A Lesson to Teach Self-Acceptance (Bernard, 2007; grades 5+)

Objectives

1. Students will be able to state a word (emotional vocabulary) for describing how they feel when something bad happens ("down").
2. Students will be able to identify their positive and not-so-positive characteristics.
3. Students will be able to state that all people are made up of positive and not-so-positive characteristics.
4. Students will be able to explain that it doesn't make sense to rate themselves as bad or hopeless when something negative happens.
5. Students will learn that if they want to get along with themselves and not feel so down when something bad happens, they can think Accepting Myself thoughts.

Materials
Handouts for Students

Notes

All children are vulnerable to negative events and circumstances that occur at school and home that involve rejection (e.g. being teased, criticized, yelled at, or laughed at, having a bad hair day or bad skin, being excluded) or lack of achievement (e.g. poor years on report card, many errors on a spelling test, "red" comments made by teacher on written assignment, losing at tennis, poor performance relative to peers).

In this session, you will be providing children with a form of resistance or inoculation so that when they encounter negative events, they have a self-protecting Habit of the Mind we call Accepting Myself. The natural instinct of most children when exposed to negative events (rejection, lack of achievement) is to think, "Because this

bad thing has happened, I am a loser and a failure." This pattern of thinking called Self-Downing leads to low self-acceptance if children are exposed to a sufficient number of bad events or a few intense negative events (e.g. harsh treatment by a parent, reading difficulties). In teaching Accepting Myself, you will want to help children to: (1) identify their positive and not-so-good characteristics; (2) understand that they do not lose their positives when something bad happens; and (3) understand that it doesn't make sense to ever think of themselves as totally hopeless when something bad happens or because they have one or more not-so-good characteristics.

The goal for children when confronted with a negative event is to think to themselves: "This is not so good, but it is not the end of the world. I am still me. I still have many terrific qualities. I am still capable of achieving." Accepting Myself is a powerful Habit of the Mind to combat the inevitable knocks all children experience.

Scripted Lesson

I. Introductory Discussion

A. If you are a new visitor to a classroom and students do not know you, introduce yourself as a psychologist, counsellor, social worker, or teacher and ask for someone to define what a psychologist/counsellor/social worker does. If you are a teacher, emphasize that teachers are interested in teaching students a whole range of skills for not only doing the best they can in their school work, but also in getting along with each other.

B. To develop rapport with the students ask them to state their name before responding to your questions. Rather than stand in the front of the class, circulate among the students so that you become more familiar to them. As well, determine from the students the class rule for responding to questions and listening to others so that students do not simply call out their answers and talk while others are talking.

II. Introductory Discussion/Activity: "Who Wants to Feel Down?"

A. Indicate that the purpose of today's session is to learn some new ideas about how to stay confident when you are not having a very good day.

B. Ask for a definition of Confidence. Provide a general definition including: not being overly concerned with what others think if you make a mistake or do your work, not being afraid to fail, not being too hard on yourself when you make mistakes in your school work, and having trust in yourself that you will be successful (e.g. predicting eventual success).

C. Distribute the Handouts for Students and draw students attention to the Emotional Thermometer worksheet. Indicate that it measures how upset someone gets.

D. In a humorous manner, display the emotion of feeling down (e.g. looking miserable). Say aloud what happened to you such as, "I've just been called a 'jerk' by four kids in my class and I feel _____," (ask students to guess the feeling). In displaying the feeling of being down, ask for different words to describe the feeling. Indicate that the word you would use to describe how you feel when someone is not nice to you or when things are not going well in your schoolwork is "down."

Happenings	Feeling
??	Very down (8–10°) Lose confidence

E. Using the chart above, ask for some examples of things that can happen at school and at home that can lead them to getting very down (point to the top part of the thermometer 8–10°). Ask several students to volunteer answers. As students provide answers, write them below the word "Happening." Look for the following: not being allowed to play, not getting invited to a class party, someone making a mean comment (teasing), not doing well in a test, classmates laughing at an answer given by a student to a teacher's question, and getting badly criticized for not doing homework. As students self-disclose a time/situation when they felt down, ask for a show of hands of other classmates who also get down when the same type of event occurs. Discuss how, when you get very down, you tend to lose your confidence.

F. Ask the silly question: "Who likes the feeling of being very down?" Gain agreement that it doesn't feel very nice. Explain that the specific purpose of the lesson is for students to learn what they can do when something bad happens to them so that they do not get so down and so they do not lose their confidence.

G. On the board, display the following summary diagram using examples provided by students of "happenings" that can get them down:

Happening ➔	Thinking ➔	Feeling
Being teased	??	Down (8–10°)
Being yelled at		Lose confidence
Not being allowed to play		
Getting a bad grade		

Ask the question: "When you get very down (7, 8, 9, or 10 on the Emotional Thermometer), what would you be thinking about yourself when something bad happens?" Acknowledge all answers, but write down in the "Thinking" column the answer that either a student (or you) provide: "I'm dumb," "I'm stupid," "I'm no good." Explain that the thinking illustrated in the next diagram is called "negative" thinking. Explain how it is their thinking—rather than the happening—that causes them to feel down and lose their confidence. Ask for students to explain this relationship until everyone in the class understands. You might also indicate that negative thoughts are not sensible, not true, and not helpful. (Depending on the age/cognitive maturity of the students, you can substitute the words "irrational thoughts" for "negative thoughts.")

Happening ➔	Thinking ➔	Feeling
Being teased	"I'm dumb"	Down (8–10°)
	"I'm no good"	Lose confidence
Being yelled at	"I'm hopeless"	
Not being allowed to play		
Getting a bad grade		

H. Explain that you will show students a way of thinking that will help them to not get so down—but rather, feel confident—when something bad happens to them.

Ask students, “Rather than feeling very down—8 to 10 on the Emotional Thermometer—what would be a better emotional temperature to have?” Gain agreement that feeling only a little down—say, 3 to 4—would be better.

Indicate that they will need to rip up their negative, irrational thoughts and substitute more positive rational thoughts. Explain that the next activity will help them discover more rational and positive things to think when something bad happens.

Illustrate these relationships as follows

Happening →	Thinking →	Feeling
Being teased	~~“I’m dumb”~~	~~Down (8–10°)~~
Being yelled at	~~“I’m no good”~~	~~Lose confidence~~
Not being allowed to play	~~“I’m hopeless”~~	
Getting a bad grade	??	A little down (3–4°) Still confident

III. “Complex You” Individual Activity

A. Draw student’s attention to the student worksheet Self-Wheel. Instruct students to fill in the appropriate wheel spoke (+) or (−) as you read aloud the following unfinished statements (emphasize that “I don’t know” or “Nothing” are not acceptable answers):

1. I am good at _____
2. I could improve in _____
3. One of the things I like best about myself is _____
4. One thing I would like to change about myself is _____
5. Other people think or say I am good at _____
6. Other people say I need to improve in _____
7. One very good thing I have done is _____
8. One mistake I have made is _____

B. Invite students who finish early to illustrate each spoke using markers, crayons, and pens to create pictures within each space.

C. Call on several students to share their wheels with the class, explaining the content of each spoke. Make the point that all people are complex, not simple, and that it is important for each of the students to be aware of their good points as well as those areas that could be improved on. Emphasize that people’s good qualities are not just trying hard and getting good grades in school. Lots of other characteristics of themselves are important too. Ask: “What’s more important, getting an ‘A’ in reading or being a good friend?” Answer: they are both good qualities to have.

D. Ask students if they would throw out a bicycle if they found that one of its wheels had a broken spoke. Ask them to explain their answers. Ask them whether it makes sense to think they're hopeless and negate their good points when something bad happens.
E. Ask for some suggestions about more positive ways to think about yourself when something bad happens at school or home, with friends or strangers, or even if you are simply having a bad hair day. Use the following diagram as illustration, including comments by students covering their new way of thinking.

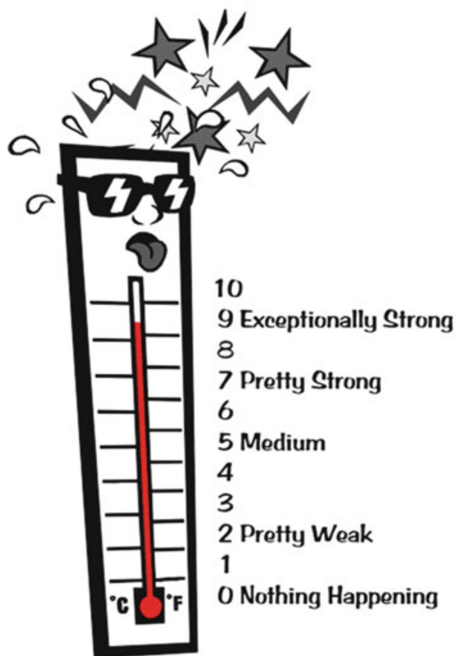
Happening ➔	Thinking ➔	Feeling
Being teased	~~"I'm dumb"~~	~~Down (8–10°)~~
Being yelled at		~~Lose confidence~~
Not being allowed to play		
Getting a bad grade	~~"I'm no good"~~	
	~~"I'm hopeless"~~	
	"Even though that thing happened, I'm still capable and people like me"	A little down (3–4°) Still confident

F. the activity by emphasizing that everyone has choices about how to think about themselves when something bad happens. Encourage students to think positive, rational thoughts.

IV. Homework Activity: Don't Think Negatively

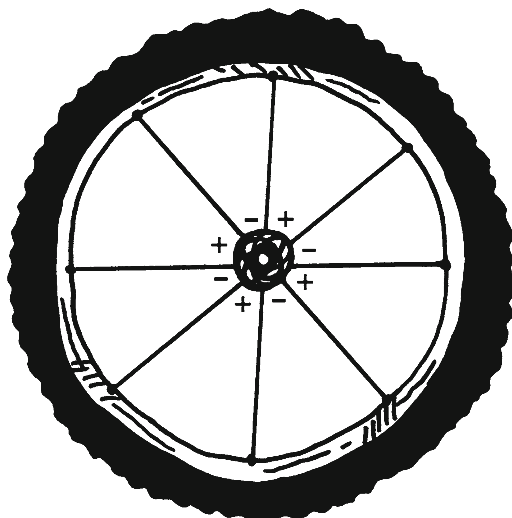
A. Draw students' attention to the worksheet Don't Think Negatively. Instruct students that for homework you would like them to draw a picture of some event that has happened to them at school where they ended up feeling down (7, 8, 9, or 10 on the Emotional Thermometer) or draw something that could happen at school where they would get to feeling down. Ask them to write down any negative thoughts that they had at the time or that would get them down (e.g. "I'm hopeless, dumb, no one likes me,"). Indicate that in the last activity, you will be asking students to substitute their negative thoughts for positive thoughts.
B. You will want to make the point that students (as does everyone) have a choice about what to think when something bad happens. Ask the question: "Who controls your thinking?" Reinforce the idea that we determine what we think, not our parents or teachers. This is our personal source of power to deal with the not-so-nice things that can happen.
C. Ask students to practise more positive and/or rational ways of thinking during the week if something bad happens.

Student Worksheet
The Emotional Thermometer



Directions: Fill in the spaces between the spokes of this wheel by completing the statements your teacher reads aloud.

Student Worksheet
Self-Wheel



Appendix 6 Self-Help Tips for Strengthening Your Self-Acceptance (Bernard, 2012b)

Self-Acceptance Boosters

- Starting the day with a positive mindset holding yourself in high regard and knowing that no matter what happens, you will accept yourself.
- Pat yourself on the back when you have completed something difficult. Do not take your success for granted!
- Take the time to think about how you look and how you come across to others—looking confident helps boost your self-acceptance.
- Have a positive and open attitude toward change—change of job, house, and friends.
- Relax in pressure situations like meeting someone new or doing something where you might not be successful at first.
- Think back to the last time you succeeded at doing something that was hard to do and remind yourself: "I've done hard things before, I can do this now!"
- Expressing your opinion knowing that others may disagree; being able to accept their disagreements as professional not personal.

Self-Acceptance Busters

- Getting down and taking things personally
- Blowing bad things out of proportion
- Needing people to approve of everything you do
- Having to do things perfectly
- Over-focussing on things that go wrong including people's opinion of you
- Ignoring positive events

Use Self-Accepting Self-Talk

"It is normally better to be liked by others, but disapproval does not make me a worse person."

"I accept who I am, even though I may not like some of my traits and behaviors."

"My performance at work—perfect or otherwise—does not determine my worth as a person."

"Mistakes and setbacks are inevitable. I will accept myself while disliking my mistakes and setbacks."

"No matter what, I accept myself."

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Self-Acceptance and the Parenting of Children

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Children can represent both a joy and a challenge to their parents that can be met with either acceptance, warmth, responsiveness, and sensitivity, or in unaccepting, unresponsive, insensitive, neglectful, and/or hostile ways (Rubin & Burgess, 2002). Successful parenting has multiple determinants, with growing empirical support for the relevance of parents' cognitions (Gavita, 2011a).

In this chapter, after basic considerations about parenting (i.e., its' role in child adjustment and the role of cognitions in parenting), we introduce a special type of parenting, namely *rational parenting*. Then we discuss the measurement of parental acceptance—a key component of rational parenting—and how parent education

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programs can implement rational parenting and parental acceptance. In the end, conclusions and discussions are presented.

Fundamentals of Parenting

In its broadest sense, parenting refers to everyday behavior of parents towards their children, including the parents' emotions, cognitions, behaviors (i.e., parental practices), and values (Bornstein, 2002). In a more narrow sense, however, parenting refers to the child-rearing and disciplinary practices of parents towards children.

Parenting and Child Adjustment

It is well documented (see Burke, Loeber, & Birmaher, 2004) that poor parenting practices relate to child psychopathology (e.g., Haapasalo & Tremblay, 1994), while positive parenting practices represent protective factors involved in child adjustment (McCord, 1991). Indeed, punitive discipline has been found to be a common risk factor for both internalizing and externalizing disorders (Burke et al., 2004). In this equation, harsh discipline is linked to child aggression, while low parental warmth/involvement is associated with oppositional child behavior (Burke et al.; Stormshak, Bierman, McMahon, & Lengua, 2000), and overprotection is reported in the cases of child internalizing disorders (Rubin & Burgess, 2002). However, it is difficult to identify specific effects; for example, parents of antisocial children tend to be simultaneously very harsh and very lax in their disciplinary practices (Baumrind, 1967; Serketich & Dumas, 1996).

Positive parenting in turn has been consistently associated with child adjustment (Petit, Laird, Dodge, & Bates, 1997). Children of positive parents can make good relationships with adults, siblings and friends, show better concentration, and are displaying lower levels of aggressive behaviors than children of less positive parents (Burke et al., 2004). Marked association of positive parenting with child educational attainment also was found by Desforges and Abouchaar (2003). They defined positive parenting as parents being involved with their children, taking part in joint activities with them (e.g., playing games), and involving them in activities of daily living (e.g., showing interest in homework set, communicating about what is happening).

Patterson and Fisher (2002) conceptualized parenting within a bidirectional model. Indeed, it seems that parenting styles and children's characteristic temperament depend on each other. It is well known that parenting strategies (e.g., reinforcement) and reactions (e.g., parental distress) are influenced by children behaviors (e.g., task accomplishment) and characteristics (e.g., child affect; Gavita, 2011b). However, research has also shown that whether, how, and how much parenting

influences the child depends on their individual characteristics (e.g., child's temperament; Belsky, Bakermans-Kranenburg, & van IJzendoorn, 2007). This suggests that the negative effects of parenting are heightened for children presumed "vulnerable" for temperamental and/or genetic reasons (Gavita, Capris, Bolno, & David, 2012; Gavita, David, Bujoreanu, Tiba, & Ionutiu, 2012). In the light of behavioral genetic research, it becomes even more important to document ways in which parenting can be improved.

Cognitions as Key Determinants of Parenting

Parenting itself has been found to have multiple determinants, including (1) circumstantial factors (e.g., everyday stress, lack of social support, negative economic conditions), playing the role of activating events (Burke et al., 2004), (2) parental emotions (Lovejoy, Graczyk, O'Hare, & Neuman, 2000), and/or (3) parental cognitions (Hoza et al., 2000). Moreover (parental) emotions are fueled by various cognitive mechanisms, and the impact of activating events is often mediated by our interpretations (e.g., cognitions); thus, cognitions play a key direct and/or indirect determinant of parenting (Gavita, 2011a).

Interest and empirical support on the impact of parent emotions and cognitions in parenting have grown in the past two decades (Gavita, 2011a). The cognition-based model of parenting behavior (Murphey, 1992) proposed that parents' cognitions are important predictors for emotional reactions and specific practices of the parents (Bugental & Johnston, 2000; McGillicuddy-De Lisi & Sigel, 1995).

In addition to the general cognitions that parents endorse (i.e., about career, life in general), it has been documented that parents can have specific cognitions about themselves in the parenting role, about their children, and/or about their parenting (Gavita, 2011a). Cognitive biases of parents have been associated with the use of specific parenting behaviors, which have been in turn related to child psychopathology (see MacKinnon-Lewis, Lamb, Arbuckle, Baradaran, & Volling, 1992).

Parents' cognitions about themselves vary at different levels: self-esteem, self-efficacy, and/or self-ratings of their worth (see Gavita, David et al., 2011; Gavita, DiGiuseppe et al., 2011 for an analysis of processing levels of parental cognitions). Cognitions that parents have about themselves can influence their use of efficient parenting and their level of effective participation in treatments for their children (Hoza et al., 2000). More specifically, Hoza et al. found that parents with low self-esteem and low self-efficacy enforced consequences less, especially when faced with resistance from their child. Dix and Meunier (2009) showed that mothers who think that they lack parenting abilities (i.e., low self-efficacy) were less responsive or reactive to difficult child behavior with negative feelings (e.g., anger, anxiety) and harsh control.

Interest in parental evaluative cognitions has been raised in the context of data underlying the importance of parental goals (see Bugental & Johnston, 2000). Bugental and Johnston proposed that the construct of parental goals includes the

evaluative and prescriptive component of values, and has the advantage of being more conceptually related to the actions that parents might take, being derivative from their values (see also Dix, 1991).

Thus, in order to explore the role of evaluative cognitions in parenting, we will focus in this chapter on the theory and practice of rational-emotive behavioral therapy (REBT). We will explore in detail a specific model of parenting, because REBT's theory and practice are one of the most advanced psychological approaches regarding the role of evaluation cognitions in parenting. Moreover, although most therapeutic approaches support the development of self-esteem as a cognitive resilience factor, REBT considers it a cognitive vulnerability factor, and thus has a unique alternative to self-rating (i.e., self-esteem), namely unconditional self-acceptance. Indeed, REBT constructs of rational and irrational beliefs have been conceptualized (see David, 2003) as evaluative beliefs that could be understood in the framework of appraisal theories of emotions (see Lazarus, 1991). Based on the view of these evaluative cognitions (e.g., rational and irrational beliefs) as important determinants of parenting, the concept of rational parenting has arisen within the parenting field, the early contributors to our understanding of rational parenting being Ellis, Wolfe, and Moseley (1966) in their book "How to Raise an Emotionally Healthy and Happy Child" and Hauck (1967) in "Rational Management of Children."

Rational Parenting

General Rational and Irrational Processes

The REBT framework (see Ellis & Bernard, 2006) conceptualizes rational beliefs (RBs) and irrational beliefs (IBs) of parents and children as relevant resiliency mechanisms (rational beliefs) and vulnerability factors (irrational beliefs) and as having an impact of parenting practice and psychopathology (e.g., Bernard & Joyce, 1984; DiGiuseppe & Kelter, 2006; Terjesen & Kurasaki, 2009). According to the ABC model of REBT (Ellis & Bernard, 2006), our behavioral and emotional reactions (C) are not determined by the activating events (A), but by the way we think (believe) about the activating event (B). Parent IBs represent unrealistic and absolutistic demands of themselves as parents, of others, such as their children, or of life. The REBT model places IBs into four categories (see DiGiuseppe, Doyle, Dryden, & Backx, 2013) demandingness (DEM; e.g., "My child must respect me at all times"), awfulizing/catastrophizing (AWF; e.g., "It is awful if my child does not respect me"), frustration intolerance (FI; e.g., "I cannot stand when my child does not respect me"), and global evaluations (GE) of human worth (i.e., self—"I am worthless if my child does not respect me", others—"My child is worthless if she does not respect me." and/or life—"The world is no good if my own child does not

respect me."). Self-downing (SD) is a special case of negative global evaluation of self-worth.

The corresponding RBs are expressed as flexible preferences rather than demands (PRE; e.g., "I would very much like for my child to respect me at all times, and I am making efforts to do get his/her respect this, but I accept that s/he might not respect me"); badness (BAD; e.g., "If my child disrespects me, it is bad but not awful") rather than awfulizing; frustration tolerance (FT; e.g., "I do not like when my child does not respect me, but I can stand it") rather than frustration intolerance; and unconditional acceptance (UA), rather than global evaluation/self-downing (GE/SD).

Global evaluation or self-downing is defined as an irrational belief because it lacks logical, empirical, and pragmatic support (Ellis, 1994) and thus, its cognitive restructuring (e.g., disputation) will focus on these points. Global evaluation is non-pragmatic because it prevents people from achieving their goals; is illogical because it does not fit logics to extend our identity to a role or behavior; is inconsistent with reality because often the empirical evidences do not support it. In turn, unconditional self-acceptance (USA) is (a) pragmatic, in that it helps people to achieve their aim; (b) logical, in that it respects logics; (c) reality based, in that it is consistent with reality (Montgomery, David, DiLorenzo, & Schnur, 2007).

Parental Rational and Irrational Cognitions

Ellis et al. (1966) underlined in "How to Raise an Emotionally Healthy, Happy Child" the role that parental IBs about their children can have on shaping their children's view of the world. Ellis et al. mentioned:

> The worst care parents can provide their children is that of blaming them for their mistake making and wrongdoing. Parents or other early teachers usually help a child plummet down the toboggan slide towards disturbed feelings and behaviors by doing two things when he (child) does something that displeases them: (a) they tell him that he is wrong for acting in this displeasing manner, and (b) they strongly indicate to him that he is a worthless individual for being wrong, and that he therefore deserves to be damned and severely punished for his wrongdoing (p. 107).

Although rational parenting involves all four categories of rational belies, unconditional self-acceptance is a key component. Indeed, Ellis (2005) had conceived "acceptance" as fundamental to resilience and mental health that can also be applied to the parenting field. For example, REBT proposes as an alternative to self-downing, or any type of self-rating, working towards unconditional self-acceptance, meaning that "the individual fully and unconditionally accepts him or herself regardless of how s/he behaves intelligently, correctly, or competently and whether or not other people approve, respect, or love him" (Ellis, 1977, p. 101).

Origins of Irrationality in Parents and Children: Biological, Developmental, and Intergenerational Explanations

Ellis (1994) asserted that humans are born with an innate capacity to think irrationally. He went further to approximate that 80 % of this tendency is biological and 20 % results from environmental influences (Bernard, 2004, 2008). According to Bernard (2008), in order to prevent mental health problems and promote child adjustment, parents can teach children to give-up rating their selves based on their behaviors and to separate judgments of their actions from judgments of self-worth. In terms of self-acceptance, it is important that children accept responsibility for changing their faulty behaviors, without evaluating themselves as bad human beings. In this way, parents can help combat children's tendencies towards Global Evaluation/Self-Downing, by

> reminding them they are made up of many good qualities (and some that are not so helpful) and that they do not lose their good qualities when bad things happen […], by explaining them that all human beings are capable and likeable in their unique ways and, therefore, it is good for children to accept themselves unconditionally without having to prove themselves (Bernard, 2008, p. 8).

Children can learn from their parents not to rate people by their actions and to make clear distinctions between the ratings of people's actions and the ratings about their self-worth. In this way, it is possible that the child dislikes another person's actions or traits (even their parents' behaviors) but avoids judging the whole of the person as bad (Bernard, 2008).

Parents can also communicate rational messages to their children implicitly, by manifesting self-acceptance and showing unconditional acceptance to their children in critical events. By using both implicitly and explicitly the language of unconditional acceptance parents can overcome their emotional difficulties and raise emotionally healthy children.

The impact of child- and parent-related cognitions, beyond the role of general cognitions, and of evaluative cognitions (i.e., appraisals) on parental feelings and actions is considered more and more relevant in the parenting field, based on the recent data in clinical cognitive sciences (Bugental & Johnston, 2000; McGillicuddy-De Lisi & Sigel, 1995).

REBT proposes that both IBs and RBs can be shared by parents and children within the family (i.e., family culture; Joyce, 2006). Furthermore, when children (and adults) of any age become emotionally disturbed, the thinking processes they are basing their conclusions on are characteristic of Piaget's pre-concrete stage of mental development (e.g., making global evaluations; Bernard, 2008). In other words, parents can induct their children into "shared ways of thinking that perpetuate irrational patterns across generations" (Joyce, 2006, p. 180). It becomes obvious this way how children can be taught within the family to develop either self-acceptance or self-depreciating processes.

Below we will focus on developing a special type of REBT's acceptance, namely parent's unconditional acceptance, involving both parents' self and child unconditional acceptance. We are doing this because most of the research in the field was focused on this component.

The Role of Unconditional Acceptance in Rational Parenting

Types of Parental Unconditional Acceptance

In the parenting field, REBT promotes several forms of unconditional acceptance, as alternative to global evaluation/self-downing, which can be directed towards self, others, and life conditions.

Parental (*unconditional*) *self-acceptance* (USA) means (see Ellis & Bernard, 2006) that (a) parents fully accept themselves whether they succeed at important parenting tasks, whether they have the approval of significant others or not, and, if appropriate, (b) parents aim to improve their own behaviors.

Parental (unconditional) other acceptance (UOA) (i.e., parent unconditional child acceptance) means that (a) the parent fully accepts (although not necessarily like) his/her child (and all other humans), whether they act fairly and competently or not, and, if appropriate, (b) parents aim to improve their child's (other's) behaviors.

Parental (*unconditional*) *life acceptance* (ULA) means that (a) parents fully accept life whether it is fortunate or unfortunate and (b) do their best to discover and enjoy their personally selected satisfactions and pleasures (Ellis, 2003, 2004).

REBT postulates that self-downing ("I am a worthless person"), and/or other rating ("You are a bad child"), and/or life rating ("Life is bad because is not fair") create most of human disturbance. Moreover, recent data shows that the same self-rating processes ("I am a good or bad parent") are responsible for parental distress, while parental unconditional self-acceptance is proximally related to parental satisfaction (Gavita, 2011a, 2011b). Hence, a therapeutic goal when working with parents and families would be to restructure the global evaluation/self-downing and develop a USA philosophy when working with parents.

Besides, these three types of unconditional acceptance relevant to parents, there is a similar triad corresponding to children's unconditional acceptance: child unconditional self-acceptance, child unconditional acceptance of parents (and other acceptance), and unconditional life acceptance by the child. As follows, we will focus on parental acceptance due to its intergenerational propagation and its implication in parenting and child outcomes.

The Impact of Parental Acceptance in Parenting: Models and Empirical Evidences

Although less empirically studied than other types of parental cognitions about the self (i.e., self-esteem, self-efficacy), some conclusive evidence points towards the important role that parent's acceptance plays in parent and child adjustment.

Bernard and Joyce (1984) documented that parental self-downing beliefs were associated with poor parenting. Hauck (1967, 1983) identified several distorted parental beliefs concerning child management that are irrational because

they are inaccurate and they lead to dysfunctional styles of parenting. In his book "The Rational Management of Children," Hauck (1967) identified different irrational beliefs of parents that lead to distinct adaptive or maladaptive parenting styles. The "unkind and firm" and the "kind and not firm" parenting styles are both maladaptive for child development and are based on a low level of parental self and child unconditional acceptance. The "kind and firm" parenting style is the preferred and skilled form of parenting and considered most adaptive. This style is based on both self and child unconditional acceptance. Hauck proposed the self-downing/global evaluation belief "My worth as a parent depends on my child's performance" as determining parental depression.

Bernard (2004) and Ellis (Ellis & Bernard, 2006) proposed that parents' evaluative cognitions have important consequences for parental emotions. Several studies have examined the relationships between parent irrational beliefs and dysfunctional negative emotions, based on the ABC model of the REBT.

REBT asserts that extremely demanding beliefs about the self in the parenting role and nonacceptance can lead to extreme emotions in parents, which, in turn, leads to non/constructive disciplinary action. Moreover, Joyce (2006) proposed that IBs can lead through different mechanisms to the "unkind and firm" pattern of parental behavior or the "kind and not firm" child-rearing practices. According to DiGiuseppe and Bernard (2006), parents' irrational beliefs can lead directly to behavior, without the intervention of significant emotional arousal. However, this hypothesis was not empirically investigated yet in order to document if parental behavior can be determined by inferences or by their emotional reactions (e.g., appraisals). Same authors mention that the self-downing/global evaluation, as more pervasive absolutistic belief (such as "To be a perfect parent and a worthwhile person, my child must be totally obedient at all times"), can generate high degrees of emotionality.

Consequently, unconditional self-acceptance (USA) is involved in the promotion of healthy feelings and adaptive behavior (Joyce, 2006). It was recently found (Gavita, 2011a) that parental USA mediates the relation between general self-acceptance and parental distress. 211 parents of healthy children aged between 2 and 17 years old participated to this study. The parents responded to questionnaires measuring their levels of distress, general irrational cognitions, and parental irrational cognitions, respectively parental self-efficacy. When both general and parent unconditional acceptance levels were introduced in the regression equation for predicting parental distress, both remained significant ($p<0.05$). These results suggest that although general irrational cognitive structures are representing vulnerability factors for parental distress, specific parental irrational cognitions are proximal to causing parental distress. In other words, parents holding irrational cognitions referring to self and the child will experience a higher level of distress. Furthermore, results obtained in the same study (Gavita) showed that parental rational cognitions (i.e., USA) are mediating the effect that parental low self-efficacy has on parental distress. This means that parental low self-efficacy affects parental distress when associated with low USA of the parent.

In terms of positive parental emotions, parental USA was found to mediate the impact of low parental self-efficacy on parental satisfaction (Gavita, 2011a). In other words, parents' USA plays a protective role for parental satisfaction in case of

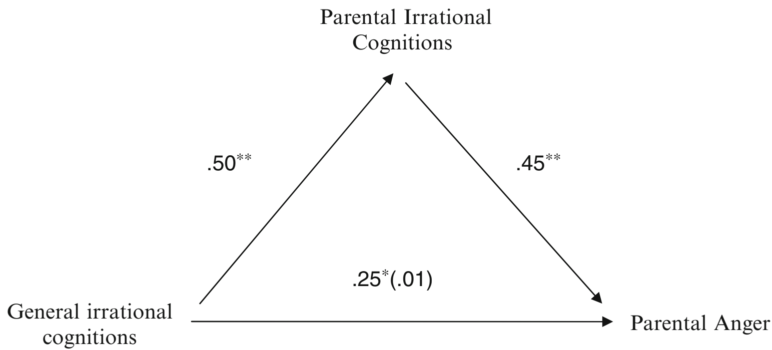

Fig. 1 Mediational diagram for models testing the interrelations among irrational cognitions, parental irrational cognitions, and parental anger. All values are beta coefficients. Values in parenthesis show relationships between predictor variable and the dependent variable when the mediating variable is included in the model; $^*p<0.05$; $^{**}p<0.01$. The value of Sobel test for this mediation is $z=3.98$, $p=0.00$

low self-efficacy in the parental role. These findings point towards a proximal role that parental USA has, as compared to other types of beliefs about the self, in causing parent's emotions, as proposed by REBT (Ellis et al., 1966). It seems that both a low level of self-downing and a high level of USA have been found to be protective for parental mental health, which has important implications for parental interventions.

Similar patterns were found for the parents of children presenting with disruptive behavior disorders. Specific parental IBs in this case to totally mediate (see Baron & Kenny, 1986 for the criteria for statistical mediation) the impact of general IBs in the case of parental anger (Gavita, 2011a). More precisely, general IBs activate parental specific IBs, which in turn cause parental anger (see Fig. 1). Parental self-downing/global evaluation was also documented to generate parent depression and guilt (Terjesen & Kurasaki, 2009).

Thus, empirical data suggests that parental USA is a key element in the architecture of parents' cognitions and have unique contributions to parental distress, which goes beyond the role of general cognitions or other types of cognitions about the self (e.g., inferential cognitions).

Measures of Parental Acceptance

Identifying the levels of unconditional self-acceptance in parents is not an easy process. However, this is an important component both in therapy and for research purposes (Chamberlain & Haaga, 2001).

In terms of specific beliefs of parents, there are currently two instruments developed within the field of REBT for measuring parental irrational cognitions, and

thus parental self-downing/unconditional self-acceptance too. Factorial analyses conducted on both scales yielded self-downing/global evaluation as a separate factor, showing that we can adequately measure specific parental self-rating processes.

The first measure of parental evaluative cognitions is the Parent Irrational Beliefs–Revised (PIB; Joyce, 1995). PIB is a 24-item revision of a previous scale developed by Berger (1983), which was called the Belief Scale. Self-Worth was one of the three subscales generated based on the validation investigations, together with the Low Frustration Tolerance and Demandingness subscales. The three factors that emerged were consistent with Ellis' (1994) REBT theory. The alpha coefficient for the revised scale was 0.75. According to Joyce (1995), the total Irrational Beliefs Scale scores and all subscale scores correlated strongly with various emotional measures (e.g., distress).

Although a good instrument, PIB fails to match the highest standard recommended for the measurement of rationality–irrationality; namely, that assessment instruments include separate scores for rational and irrational beliefs (see Lindner, Kirkby, Wertheim, & Birch, 1999).

To overcome this gap, Gavita, DiGiuseppe, et al. (2011), Gavita, David, et al. (2011) recently developed the Parent Rational and Irrational Beliefs Scale (P-RIBS). P-RIBS (see Appendix 1) is based on the perspective on the IBs and RBs as nonpolar opposites (DiGiuseppe, Leaf, Exner, & Robin, 1988) and on priming/triggering the activating events (see David, Lynn, & Ellis, 2010; Davison, Robins, & Johnson, 1983).

The structure of the scale is based on the RIBS-GF (Rational and Irrational Beliefs Scale-General Format; Montgomery et al., 2007). An equal number of statements reflecting rational and irrational processes were included, as measured by the Attitudes and Beliefs Scale (ABS-II; DiGiuseppe et al., 1988). Items in the P-RIBS reflect evaluative processes in two content areas relevant for parenting: (1) child behavior (Part 1 of the scale) and (2) parent-role (Part 2 of the scale; see Appendix 1 for item examples). Thus, the Global Evaluation/Self-Downing and Unconditional Acceptance each have two items, one referring to child and one referring to parent. Each of the items is rated by the parent in a 5-point Likert format, ranging from strongly disagree (1) to strongly agree (5). The instructions are included within the P-RIBS to (1) identifying a specific situation when the parent was confronted to a distressful situation; and (b) explaining the difference between "preferences" and "absolutist demands," in order to help parents avoid misunderstandings induced by the wording process.

The P-RIBS was found to be strong psychometrically (Gavita, David, et al., 2011; Gavita, DiGiuseppe, et al., 2011; see Appendix 1), showing acceptable internal consistencies and concurrent validity. The hypothesized factors, RBs and IBs subscales were supported by the exploratory factor analyses. The Global Evaluation factor emerged as separate from factorial analysis, with items phrased irrationally, showing the relevance of this irrational process in the parenting field. The Cronbach's alpha was adequate for the P-RIBS total, $\alpha = 0.73$, RBs Subscale, $\alpha = 0.83$, IBs Subscale, $\alpha = 0.78$, and GE Subscale $\alpha = 0.71$. The total score on P-RIBS registered high correlations with the Global Evaluation subscale, $r(285) = 0.64$, $p < 0.01$, the

IBs Subscale, $r(285) = 0.63$, $p < 0.05$, and the RBs Subscale, $r(285) = -0.59$, $p < 0.01$. The P-RIBS total and factor scores were each positively correlated with factor scores of measures of general rational and irrational cognitions and with measures of parental distress (Gavita, 2011b; Gavita, David, et al., 2011; Gavita, DiGiuseppe, et al., 2011).

The development and validation of the aforementioned instruments have a number of implications for parent and child USA research. Such measures support the advancement of knowledge concerning the parent and child shared unconditional self-acceptance/self-downing processes and their impact on their adjustment. For example, they allow further understanding into the parent reasoning in selecting different discipline tactics, such as over-reactive or dysfunctional responses. Moreover, parental and child USA measures are important to facilitate the understanding of the mechanisms of change following participation to parent management training or group therapy sessions.

Developing Parent Unconditional Acceptance

Parental IBs can be changed/modified in parent counseling or during the parent education classes by using cognitive restructuring (challenging/disputing/reframing; Gavita, David, et al., 2011; Gavita, DiGiuseppe, et al., 2011). One of the fundamental aims of cognitive-behavioral therapy—and REBT—is to help parents recognize the factors that prime or activate (As) their irrational beliefs. Once self-downing beliefs are identified, parents are helped to realize the effects these have on their—consequences [C] connection and to learn tools for cognitive restructuring/disputing. The main aim of cognitive restructuring is to help parents actively think in terms of acceptance.

In counseling and parent education, parents learn to adopt the unconditional self-acceptance philosophy, which means that they fully accept themselves as human beings, whether or not they succeed at important parenting tasks, and whether or not they have the approval of their children/significant people.

Another focus is on parents' unconditional acceptance of the child. Parents learn to fully accept (though not necessarily like) their child/children, whether or not they behave, respect/appreciate them or act competently (Ellis, 2003, 2004, 2005). In this way, parents learn to fully accept themselves and their children with all their imperfections, as human beings, but at the same time aiming to improve the specific problems (Gavita, David, et al., 2011; Gavita, DiGiuseppe, et al., 2011). The final goal is for parents to achieve a strong thinking–feeling–acting philosophy of unconditional acceptance (Ellis, 2005).

Based on the REBT theory, parental self-downing/global evaluation can be restructured by using different techniques that disputing and replace them. Besides cognitive techniques, USA thinking can be strengthen through emotive techniques (e.g., rational-emotive imagery, repetition of rational self-statements, metaphors, humor), and behavioral techniques (cognitive-behavioral rehearsal, homework

assignments, or shame attacking exercises). DiGiuseppe et al. (2012) provide a detailed discussion of all these interventions in REBT.

Moreover, REBT emphasize the importance of addressing secondary disturbances (i.e., parents feeling depressed about their anger with their children). This process of modifying secondary emotional upset through having parents eliminate self-downing and, instead, accepting themselves with their secondary emotional stress is similar to targeting the relation the parent has with her/his emotions, which is a central within the third wave approaches in cognitive-behavioral therapy (see Hayes, Luoma, Bond, Masuda, & Lillis, 2006). In this way, parents learn to accept their mental states—negative thoughts, and disturbing emotions—by changing their IBs about them (Gavita, David, et al., 2011; Gavita, DiGiuseppe, et al., 2011). This does not imply that they are giving up the efforts to experience pleasant feelings, but that they are willing to accept their negative ones in a rational manner (e.g., "The fact that I am feeling depressed does not mean that I am a bad parent or a worthless human being").

By endorsing USA as an alternative to self-downing/global evaluation, parents can change their dysfunctional/unhealthy reactions (e.g., anger and harsh discipline) into more functional/healthy ones (e.g., annoyance vs. anger and positive discipline vs. harsh discipline).

Targeting Parental Acceptance Within Parenting Programs

Parental interventions have been developed mainly to teach parents how to increase positive interactions with their children while reducing bad, poor, and inconsistent parenting practices. It is now accepted that parenting programs have an important role to play in supporting both parent and children mental health. Currently, parenting programs are among the most well-established treatments for child psychopathology (Kazdin, 2005; Lundahl et al., 2006), and cognitive-behavioral parent programs are treatment of choice for child disruptive behavior disorders (NICE, 2006). However, cognitive-behavioral parenting programs vary in the extent to which they address different parenting components, depending on their preventive or their specific treatment approach.

The extension of REBT to the parenting field has been referred by a number of terms: rational-emotive parent education (Joyce, 1994, 2006), rational-emotive behavior parent consultation (Vernon, 1994), enhanced parent program, and/or rational parenting program (Gavita, 2011a). REBT's approach to parent programs emphasizes the importance of helping parents reduce their emotional stress associated with parenting and teaching parents to handle child emotional or behavioral problems and foster their adjustment (Joyce, 1990, 1995). Since parents coming to treatment have strong views of themselves, how children must behave, how they should be treated, the REBT family and parental interventions are underlying the importance of disputing specific beliefs about child-rearing practices, in order to

maximize changes and prevent early dropout. Two of the main components targeted are parental unconditional acceptance and child unconditional acceptance.

Only a few parenting programs aiming at teaching parents USA strategies were tested, with the first of them using a nonclinical approach (see Joyce, 1995, 2006).

The REBT Parenting Program (Joyce, 2005). This program which was developed and evaluated by Joyce focused mainly on reducing parental emotional distress, through disputing IBs, developing rational problem-solving skills, and fostering rational thinking. This parent education program consists of nine sessions and is committed towards building USA of both parent and the child. In the program, parents are taught how to identify and dispute parental self-downing, build rational beliefs (e.g., non-blaming) concerning discipline methods (kindness and firmness). Another focus of Joyce's program was on teaching children rational beliefs including unconditional self-acceptance and unconditional other acceptance, non-exaggeration, and non-demandingness. The program of cognitive restructuring employed the following steps: (a) increasing self-awareness of IBs, (b) disputing of IBs, (c) substitution with RBs, (d) practice rehearsing rational self-statements, and (e) reinforcement (by leader, group, self) for RBs.

This program was evaluated using a comparison group of parents as a waiting list. Results showed that parents receiving the REBT parenting program reported significant reductions in child behavior problems, parent irrationality, parent guilt, and parent anger. At a 10-month follow-up, data suggested maintenance of these effects for child behavior problems and parental global evaluation/self-downing (Joyce, 1995).

The Rational-Emotive Family Therapy approach (Huber & Baruth, 1989; Woulff, 1983). In terms of the rational parenting interventions for the treatment of child psychopathology, DiGiuseppe and Kelter (2006) designed a sequential family intervention model for the treatment of families of children with externalizing disorders. Within this intervention, the intermediary goal for changing the child's problematic behavior is to change parents' IBs and emotional difficulties in order to enable them to adopt more effective parenting skills. The REBT family therapy model included the following steps (DiGiuseppe & Kelter):

- Conducting a detailed assessment of the child's difficulties, and family functioning.
- Developing an effective therapeutic alliance with the parents; working on a target behavior based on a functional analysis developed collaboratively with the parents.
- Assessing and developing parents' abilities to implement the plan (negative dysfunctional feelings, IBs, parenting skills).
- Assessing and building strategies to overcome parent's resistance with the treatment (through changing their IBs).
- Continuous assessment of child's progress and parents' compliance with the behavioral skills and adjustment the behavior treatment plan as needed.
- Individual therapy with the child to internalize gains made within the behavioral intervention.

The Rational Parenting Program (Gavita, 2011a, 2011b). More recently, Gavita developed the rational parenting program, using a group format, for the treatment of child externalizing disorders, focused specifically on parental self and child acceptance; the program expands on the video curricula SOS Help for Parents of Clark (1996b). This program has incorporated recent advancements in the clinical cognitive sciences in order to overcome important risk factors (parent–child shared vulnerabilities for emotion-regulation difficulties) and to enhance the effects of parenting programs in the treatment of child externalizing disorders (Gavita, David, et al., 2011; Gavita, DiGiuseppe, et al., 2011; Gavita & Joyce, 2008).

The rational parenting program consists of a component focused on building parent emotion-regulation skills, through teaching parental USA, and an intensive behavioral parent training component (i.e., the child management strategies). The program works first on developing parents' self and child unconditional acceptance, and then changing the practical problems (child behavior problems). Methods used are a combination of within-session exercises and homework assignments for building parental USA. Another focus is on the transfer of the rational thinking habits to the child, through activities together, handouts and self-examples, which are followed on the entire course of the program.

By involving parents in addressing their own emotion-regulation (i.e., through Global Evaluation/Self-Downing) before they apply newly learned child management strategies, the rational parenting program aims (1) to reduce parental vulnerabilities for over-reactive behaviors and (2) to use parents as emotion-regulation agents of change in children's disruptive behaviors. In the program, rational self-statements are prepared by parents, with the aim of "overriding" the impact of these irrational beliefs in the situations when they are confronted with adversity (i.e., child misbehaves) and they cannot be aware of their influences. Parents are afterwards taught to examine antecedents to noncompliance, the consequences they are applying for the unwanted behaviors, and to recognize their children's underlying cognitive and emotional difficulties.

The Rational Parent program was tested both as a short program (e.g., 1–5 sessions; see Gavita, Dobrean, & David, 2010; Gavita, Capris et al., 2012; Gavita, David et al., 2012), and as a full-length program (consisting of ten sessions; Gavita, 2011a).

The Short Rational Parenting curricula. A four-session structure was used in a short version of this Rational Parenting Program for reducing externalizing behavior disorders in foster children (Gavita, Capris et al., 2012; Gavita, David et al., 2012). The sessions are structured as follows: Session 1 focuses on building emotional-regulation strategies through unconditional self-acceptance and unconditional child acceptance. Sessions 2 and 3 aimed at building positive discipline methods; Session 4 was focused on developing problem-solving strategies and coping plans with potential risk situations. Throughout the sessions, the development of rational thinking was continually monitored through the monitoring forms. A follow-up session was conducted for monitoring the progress. Results supported the efficacy of the program, as compared to the waiting list, in treating child behavior problems, developing positive parenting skills, and reducing parental emotional distress (Gavita, Capris et al.; Gavita, David et al.).

The full-length Rational Parenting curricula. The newest version of the Rational Parenting Program was tested in a trial which compared to a standard cognitive-behavioral parent program and waiting list (Gavita, 2011a) in the treatment of child externalizing behaviors. The rational parent program was called an "enhanced" cognitive-behavioral parent program (Gavita, 2011a), in order to be able to better integrate it within the more general literature. Its' content was based on the previously mentioned programs within the REBT field, and the SOS Help for Emotions and SOS Help for Parents self-help curricula and video vignettes (for details, see Clark, 1996a, 1996b). Both parenting programs tested comprised of ten sessions, one each week, and had in common the focus on teaching parents positive discipline strategies. However, the rational parenting program had an adjunctive module integrated at the beginning of the rational parenting program.

The adjunctive curricula covered the content of two initial sessions (session 2 and 3), based on REBT theory which proposes working first on the emotional problems of parents, and taking as second step for changing the practical problems, in order to obtain long-lasting results (DiGiuseppe & Kelter, 2006; Ellis, 1994). Using the ABCDE model, parents were taught to identify and challenge their IBs about their child, themselves, child management routines, or other stressful situations (antecedent focused emotion-regulation strategies). Content of the module was (session 2) identify their stress cues, teaching parents the B–C connection, identifying and disputing own irrational thinking patterns (Ellis, 1994), and (session 3) enhancing own and child unconditional (self-) acceptance and teaching the child strategies for changing low frustration tolerance and self-acceptance; preparing self-statement coping strategies for stress, in the form of parental "psychological pills" (see Appendix 2). Sessions 4–10, covered building child management skills (same with the standard condition but constricted in less sessions), as follows: session 4 covered child attending skills and activities with child; sessions 5–7 were focused on monitoring child behavior, setting goals for change child management, and setting family rules; sessions 7–9 covered techniques for managing unwanted behaviors, time-out, teachers as collaborators, communication with the child, helping child express emotions, problem solving and coping with specific child behaviors. Session 10 covered issues of maintenance and closure. On average, the adjunctive rational parenting module constituted three of the 15 h of intervention provided to each participating parent. Active skills training methods included modeling through video vignettes (43 vignettes; SOS Help for parents), role plays, feedback, and the use of specific homework tasks. Parents were followed at 1 month after the programs.

The rational parenting program (i.e., enhanced version of cognitive-behavioral program) was found (Gavita, 2011a) to be superior compared to the standard program, as seen in more generalized and long-lasting changes in both child disruptive behavior and parent outcomes. Significant decreases were obtained in parent-rated child externalizing syndromes, in both standard and rational parenting programs, compared to the waiting-list condition after the programs (with high effect sizes) and at follow-up. At follow-up however, in terms of child aggressive and behavior, significant high range improvements were reported by parents participating in the rational

parenting program, compared to parents participating in the standard program and on the wait list. Furthermore, improvements in terms of teacher reported child oppositional behavior were registered only for the rational parent program at follow-up. Both programs were effective in improving parenting, but only the rational program reduced parental distress, depression, and irrational parental cognitions.

This trial (Gavita, 2011a) was the first one to investigate both the outcomes and the mechanisms of change, in terms of a full range of affective, cognitive, and parenting variables, for the parent programs. Although parenting was found as mechanism of change for the standard cognitive-behavioral parent program, parental distress partially mediated the effect of the rational parenting program had on child reducing the levels of child externalizing syndromes. This indicates the role that the emotion-regulation component, which was based on developing parental unconditional self and child acceptance, had on child outcomes, as proposed by the REBT framework (DiGiuseppe & Kelter, 2006; Ellis, 1994).

Thus, based on this data, we can conclude that there are structured, comprehensive and moreover evidence-based parental interventions in the literature, built around developing parental and child USA. Empirical data shows that the focus parental USA seems to be a valid approach both when working for augmenting child adjustment or for the treatment of child psychopathology. However, it is hard to isolate the effects of teaching USA and our results should be interpreted accordingly.

Conclusions and Future Research

Parental acceptance, as a rational cognition, in the form of parent and child acceptance, is a key mechanism involved in good parenting and parent and child mental health and well-being (Ellis et al., 1966). Indeed, as it was documented in this chapter, parental acceptance plays role as proximal determinant of both parental negative emotions (e.g., distress, anger, depression, guilt) and parental satisfaction (Gavita, 2011a). Thus, based on the empirical data and theory presented in this chapter, we can conclude that parental acceptance can be considered as a core parental resiliency mechanism. Working towards parental unconditional acceptance within parent programs carries the potential of being a key component in the process of developing parent child adjustment. However, as it was mentioned in the introduction, at this moment less is known about the role of parent life acceptance and child unconditional acceptance in parenting. Therefore, future studies should explore these lines of research.

Recently, the concept of unconditional acceptance was extended at both theoretical and empirical the level. David (in preparation) makes distinction between the philosophical and psychological USA. He indicated that being a parent can be conceptualized as a part of the self, based on the role a person would play at a time. Philosophical unconditional acceptance refers to avoiding making ratings of ourselves based on our behaviors or performance in various valued domains of our lives and/or in general (i.e., human worth). An example of this belief relevant to parental role is "I accept and do not rate myself as mother and/or as a human being no matter how I am behaving

towards my children and try to improve my behaviors." Psychological unconditional acceptance, however, allows ratings of the self in different roles, as long as the person does not extend this to the global rating of the self. In other words, the person might think "I am a bad mother" but if she still accepts herself unconditionally, without rating herself globally (ex. "This does not make me worthless or a bad person and I will make do the best I can to improve my parenting"), this will not result in psychological disturbance. Until now, no distinction was done in the REBT literature between the two stances, both types of self-ratings (general and/or domain specific) being considered irrational (because of the overgeneralization) and both types of unconditional self-acceptance being considered rational. Although this distinction is made at the theoretical level, this might have direct important implications on the ways we conceptualize parental unconditional acceptance and its impact on feelings and behaviors. However, future research is needed to further investigate the role of parental psychological and philosophical unconditional acceptance in specific child and parental disturbances, and to further test the efficacy of parental interventions focused on developing parent and child unconditional acceptance on child and parent outcomes.

Appendix 1: The Parent Rational and Irrational Beliefs Scale (Gavita, 2011a; Gavita, DiGiuseppe, et al., 2011)

General instruction: This scale has two parts. Please follow the specific instructions as follows.

Instructions: *Please think about a situation when your child(ren) disobey or disrespect you. Try and recall the thoughts that you have had in such situations.*

When faced with adverse situations, some parents tend to think that situation absolutely must be the way they want (in terms of absolute must). In the same situation, other people think in preferential terms and accept the situation, even if they want very much that those situations do not happen and even they might try to change it. In light of these possibilities, please estimate how much the statements below represent the thoughts that you have in such situations.

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

No.	Items	Factor	Process
2	If my child disobeys me, it doesn't mean that I am a worthless person.	RBs	UA-S
7	I can stand when my child disobeys me, although it is difficult for me to tolerate it.	RBs	FT
9	I really do not want my child to disobey me, but I realize and accept that things do not have to always be the way I want them to be.	RBs	PRE
10	It is unpleasant and unfortunate to be disobeyed by my own child, but it is not terrible.	RBs	BAD

(continued)

(continued)

No.	Items	Factor	Process
12	When my child disobeys me, I accept them as being worthwhile despite her/his poor behavior.	RBs	UA-O
14	If I am not a good parent, it doesn't mean that I am a worthless person.	RBs	UA-S
19	I can stand to be a bad parent.	RBs	FT
21	I really do want to be a good parent, but I realize and accept that I may not always be as good at parenting as I want to be.	RBs	PRE
22	It is unpleasant and unfortunate to be a bad parent, but it is not terrible.	RBs	BAD
24	When I am not a good parent, I can accept my children as being worthwhile and not condemnable.	RBs	UA-O
1	My child absolutely must respect and obey me.	self	DEM
3	I think it is awful to be disobeyed by my own child.	IBs	AWF
5	It is unbearable to be disobeyed by my own child.	IBs	LFT
13	I absolutely must be a good parent.	IBs	DEM
15	I think it is awful to be a bad parent.	IBs	AWF
17	It is unbearable to think of myself as a bad parent.	IBs	LFT
11	When my child disobeys me, I think that my children are bad, worthless, or condemnable.	GE	GE-OD
23	If I am not a good parent, I think that my children are bad, worthless, or condemnable.	GE	GE-OD
16	If I am not a good parent, it means that I am worthless.	GE	GE-SD
4	If my child disobeys me, it means that I am worthless.	GE	GE-SD
6/18	I am always optimistic about my future.	–	Control
8/20	It is important for me to keep busy.	–	Control

Note. *IBs* Parental Rational and Irrational Beliefs Scale–Irrational Beliefs Subscale; *RBs* Parental Rational and Irrational Beliefs Scale–Rational Beliefs Subscale; *FT* frustration tolerance; *PRE* preferences; *BAD* badness; *DEM* demandingness; *AWF* awfulizing; *LFT* low frustration tolerance; *GE* Parental Rational and Irrational Beliefs Scale–Global Evaluation Subscale; *UA-S* unconditional acceptance-self; *UA-O* unconditional acceptance-other; *GE* global evaluation; *GE-SD* global evaluation-self-downing; *GE-OD* global evaluation-other-downing

Appendix 2: "Psychological Pills" for Parents (Developed by Gavita & David)

- I can accept myself as a parent even when my child does not obey or respect me.
- When my child does not obey, I accept him/her despite this behavior.
- I can accept myself even if sometimes I consider that I am not a good parent; I will do everything in my power to change my inefficient behaviors.
- When I am not a good parent, I can accept my children as being worthwhile and not condemnable.
- When my children do not appreciate or respect me, I can accept that it does not influence my self-worth, their worth in any way and it does not mean that my life is completely bad.
- When I have difficulty parenting, I can accept that it does not influence my self-worth in any way.

- I very much want to be obeyed by my child, but I accept that things do not have to always be how I want.
- I very much want to be a good parent and I am doing everything in my power for this, but if I do not manage to be a good parent all the time, it does not mean that I am worthless; it just shows that I had a poor behavior which can be improved in the future.
- It is preferable to be obeyed by my child, and I am doing efforts for this, but when I do not manage this, it is very bad but not awful, and I can stand it.
- I want very much to be appreciated and respected by my children, and I do my best to get it, but I accept that just because I want and/or worked hard for this, it does not mean that it necessarily must happen.
- It is very bad and unpleasant if my children do not appreciate or respect me, but I can stand it, and search for solutions, positive alternatives, and/or ways to cope.
- I can stand when my child disobeys me, although it is difficult for me to tolerate it.
- It is unpleasant and unfortunate to be disobeyed by my own child but it is not terrible, and I can search for solutions, positive alternatives, and/or ways to cope.

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Self-Acceptance and Successful Relationships

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Albert Ellis most simply defined unconditional self-acceptance (USA) as "accepting yourself as a person regardless of whether or not you perform well or others approve of you." Ellis had a similar view of "unconditional other acceptance" (UOA), which he defined as the accepting of someone else without preconditions such as how they behaved, or how they view or treat you (Ellis, 1994). In Ellis's view, it is their behavior, of course, that is subject to rational evaluation and non-acceptance. With respect to relationships, Ellis, with his trademark consistency, proposed that the quality of most serious marital difficulties is the irrational belief of each partner (Ellis, 1986). Thus, according to Ellis, the main ingredient of a successful relationship would be two logical thinking partners, who accept themselves and each other unconditionally. I believe that is certainly a good start. However, the mission of this chapter is to expand that premise a bit farther and define the challenges partners face according to their levels of maturity.

Throughout my career, helping single people overcome their emotional obstacles in order to find a suitable long-term relationship has been a specialty of mine. In *The Art of Living Single* (Broder, 1990), I strongly argued that the key to both finding and maintaining a successful love relationship is to solidly accept oneself—without ambivalence—as a single person and thus learn to cherish the freedom and solitude of this lifestyle. Then, it will be unlikely for one to give up the single life

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for a relationship that is destined to become dysfunctional, which is often the case for singles—who lack a sufficient degree of self-acceptance—with unmistakable signs from the very beginning.

Another area I am known for is helping couples and individuals determine whether their marriage or love relationship is viable. In promoting my book, *Can Your Relationship Be Saved? How to Know Whether to Stay or Go* (Broder, 2002). I was often asked, if there is one criteria that stands out above all else when asking oneself that viability question. Conventional wisdom would say it's how one feels about his or her partner. That's certainly important, but in my experience, not nearly as telling as how the partner who is exploring this question feels about himself or herself in the relationship and in the presence of his or her partner. Thus, self-acceptance is a crucial ingredient here as well.

The treatment for relationship issues, whether as an individual or couple, represent an area where REBT and various forms of CBT can potentially have some of their most innovative and successful applications. In my approach to addressing these issues, self-acceptance is one of the most important considerations. However, the extent to which a cognitive behavioral approach can meet the standard of permanently and effectively resolving any issue in treatment depends on how precise we are at identifying and reframing underlying dysfunctional cognitions or irrational beliefs. When working with couples, for instance, our task is to have a protocol to do this for each partner (Baucom, Epstein, Sayers, & Sher, 1989; Dryden, 1985; Ellis, 1986; Moller, Rabe, & Nortje, 2001). This is a practice that has been empirically validated (Addis & Bernard, 2002). However, it has long been my observation that irrational beliefs are too often identified through a "one-size-fits-all" mentality. In addition, developmental implications which define maturity in a given life area such as one's relationship issues are often ignored—sometimes merely as part of REBT/CBT's "anti-psychodynamic" brand.

In my latest book, *Stage Climbing: The Shortest Path to Your Highest Potential* (Broder, 2012), a model is proposed for closing these gaps. The Stage Climbing model is simply a straightforward CBT-based system designed to identify the beliefs and attitudes typical of different developmental life stages in adults that help explain or identify obstacles to resolving present day issues. I am suggesting that blending REBT/CBT with aspects of this developmental theory can produce a more effective treatment result. By drawing on some aspects of the developmental theories of Erikson (1963), Kohlberg (1987) and Sullivan and Grant (1957), I have found that a cohesive and consistent set of beliefs and behaviors in which to understand why an individual or couple may be consistently acting in self defeating ways can be identified. This model then takes it a step further and provides a roadmap and set of choices to help one break through an impasse by selecting a new set of beliefs and behaviors that are more consistent with therapeutic goals. In addition, we are taking development theory a step further by suggesting that self-defeating beliefs and behaviors characteristic of dysfunctional couples, give evidence of one or both partners operating from a *stage of development* or level of maturity in that aspect of the relationship that is different from what would be optimal given their presenting issues and therapeutic goals.

An important part of using this model then consists of picking a *target stage* along with deliberate strategies to integrate new and effective cognitions consistent with therapeutic goals. This chapter will illustrate the basic premise of this working model along with its implications for self-acceptance in the relationship area of life.

A *stage* is defined as a level or plateau of maturity that characterizes a cluster of behaviors, cognitions, and/or motives. Stages then become the *lenses* through which one sees life and all of its challenges. The Stage Climbing model contains seven ascending stages, conveniently numbered from one to seven. Most adults can recognize parts of themselves in each stage with respect to one or more aspects of life. Moreover, it is normal to choose—whether or not deliberately—to cope with different situations by viewing them via the beliefs characteristic of a unique blend of stages. Thus, one can be operating at a different stage with respect to various aspects of love relationship(s) in a career, as a parent, socially, spiritually, or with respect to one's view of oneself, etc.—all at the same time and without obvious contradiction.

The stage that is most consistent with how one normally (though not always) functions in a given area of life is what I refer to as the *default stage*. Think of a default stage as the "principal operating position" in that life area. One's default stage can be drastically different with respect to his or her career than it is as a parent or spouse, for example.

In the terminology of Stage Climbing, a *hook* is a belief, feeling, or behavior that is *uncharacteristically* typical of a stage higher *or* lower than one's default stage. Some hooks are beneficial, while others can be extremely counterproductive. In therapy, we spend much of our time treating the hooks that hold our clients back. Self-defeating behavior that is Axis ll in nature is normally differentiated by operating at a lower default stage *without* conflict. Hooks to higher stages can be thought of as the seeds for personal growth.

The Stage Climbing approach simply challenges clients to identify where they are now vis-à-vis the stage from which they are operating vs. where they want to be regarding their therapeutic goals in that life area. This can be done by focusing on present day issues and which stage(s) typify their present day functioning. (Note: It is no more necessary with this approach to spend an inordinate amount of time on childhood or other history, than any other cognitive behavioral approach would require.) Once the present and target stages are established, the next step is to select clear strategies to make the shift. The seven stages below illustrate this.

The Seven Stages

Stage 1: Only possible stage during **infancy**; later can potentially render one profoundly dependent upon others with varying degrees of feelings of inadequacy. Characteristic lack of taking initiative can increase the severity of depression, anxiety, and most other disorders resulting in feelings of inadequacy and victimhood.

Common beliefs about self at Stage 1:

- “I must be taken care of”
- “I am inadequate”
- “I am helpless”
- “I am a victim with no ability or potential to turn things around”
- “I am incapable of change or taking the initiative to better my life”
- “I must be certain that some (or any) decision I make be the right one or I will not be able to decide (and/or handle the consequences)”
- “What’s happened to me in the past (e.g., my childhood, etc.) makes it impossible for me now to live a happy and fulfilling life that I can take charge of”

As the above list clearly indicates, self-downing is rampant at Stage 1 and is the main focus of any cognitive restructuring.

Intervention objectives for Stage 1 issues: Address chemical/medical problems, anything to empower client to take the initiative toward reaching therapeutic goals and improving self-defeating and self-downing cognitions/irrational beliefs regarding victimhood, powerlessness, hopelessness, and poor self-evaluation.

Cognitive restructuring to a customized version of these beliefs is essential to mature beyond a Stage 1 default and to overpower Stage 1 hooks:

- “I can do it/handle it and *I will*”
- “I am tired of being dependent and relying on others. I now want to and will begin taking charge of my own life”
- “Certainty does *not* exist, therefore I *choose* to become comfortable with uncertainty”
- “‘Too hard’ implies impossible, which it isn’t. ‘Difficult’ is merely a challenge I can handle”; “I choose to be free of my past, wherever it limits me”
- “It is now up to me to make my life what I want it to be”

Stage 2: **Normal for toddlers**; thereafter, a life without internalized limits can result in **primitive** and **undisciplined** behavior, extreme self-centeredness, the tendency to act out and create much chaos for oneself and others, narcissism, sociopathic behavior, and/or acting out. Twos see themselves as omnipotent and above it all.

Common default beliefs about self at Stage 2:

- “I must have/be able to do whatever I want, regardless of the effect I (or my actions) have on others (or even the *long-term* consequences I may cause to myself)”
- “I don’t want to change … everyone but me is wrong”
- “I will be/do whatever I have to be/do to get whatever I want (or get anything or anybody that prevents me out of the way of what I want) at any given moment”
- “Life, and especially any aspect of it that I am concerned with should/must be easy”; “I must always be treated well; and anyone who doesn’t is just asking for revenge”

The cognitions associated with Stage 2 clearly illustrate an exaggerated sense of USA with little or no UOA.

Intervention objectives for Stage 2 issues: Behavior modification and other concrete forms of counseling to change errant habits that threaten security, desired relationships, or freedom; effectively (often forcefully) driving home the self-defeating nature of Stage 2 behavior and cognitions; helping client learn limits and frustration tolerance as well as to learn from mistakes.

Cognitive restructuring to a customized version of these beliefs is essential to mature beyond a Stage 2 default and to overpower Stage 2 hooks:

- "Being excessively self-absorbed has thus far not gotten me what I thought/hoped it would, what I truly wanted or satisfaction around what I have gotten"
- "Nobody has *everything* they want"
- "I can't always control how people treat me, only my reaction to them"
- "Life is not always easy and I choose to accept that"
- "There are long-term benefits *to me* in treating others as I would like to be treated"

Stage 3: **Normal throughout middle and late childhood**; thereafter can morph into an authoritarian personality often with extreme rigidity and inflexibility about rules, ideas, or people (including prejudicial beliefs).

Common default beliefs about self and others:

- "I/you must fit in by doing only what I/you should do and by being what I/you should be—that which is expected of me/you—or some dire consequence will result"
- "Situations are either black and white" … "People are either good or bad, right or wrong"
- "Others should/must do (and even believe) things my way"

At Stage 3, one's self-acceptance is generally tied to the acceptance they receive from others whose rules they are or feel compelled to follow.

Intervention objectives for Stage 3 issues: Challenge beliefs that lead to rigidity (especially black-and-white/all-or-nothing thinking); help awaken openness to new ideas, people, and experiences outside of comfort zone and "book of rules."

Cognitive restructuring to a customized version of these beliefs is essential to mature beyond a Stage 3 default and to overpower Stage 3 hooks:

- "I am ready to start examining the unquestioned rules I have lived by (and/or that I have demanded others live by), and to consider being more flexible and open to new ideas that are now a better fit for me and my life"
- "Fitting in and doing things the old way is only one of many choices that are available to me"
- "Other people have the same wide array of choices regarding how to live their lives as I do"

Stage 4: **Normal during adolescence**; as an adult, can result in anxiety, depression, self-doubt, alienation, shame, and a wide variety of neurotic and/or approval seeking behaviors.

Common default beliefs about self:

- "What (some other person or people that in the grand scheme of things don't really matter) thinks of me is crucially important"
- "Rejection by someone else is unbearable and even a reason to reject myself"
- "I must be loved or approved of by others (specific person, group or people in general) and meet their expectations"; "I can only accept myself to the degree that I am accepted by others"
- "I must do well at everything I do. Anything less than perfect is totally unacceptable"
- "Failing at something (e.g., a relationship, a job, an exam, a sexual performance, or to meet a goal) makes me a total failure (to myself, in the eyes of others, or both)"
- "________, (fill in the name of someone specific) must love me in the exact way that I require and show it consistently or our relationship is unfulfilling and perhaps even untenable"

At Stage 4, self-acceptance is most typically tied to ones performance and the acceptance of others whose approval they seek. Unlike at Stage 3, the challenge at Stage 4 is to be accepted for the traits and areas of life where one is unique. Self-downing can be chronic and automatic here until the above cognitions are challenged and restructured.

Intervention objectives for Stage 4 issues: The mastery of any technique that leads to self-acceptance (especially in dealing with real or perceived failure or rejection) is crucial here; anger, depression, and anxiety management, cognitive restructuring to override the tendency to catastrophize; learning to handle discomfort anxiety. (Note: REBT is known more for the treatment of Stage 4 issues than any other stage.)

Cognitive restructuring to a customized version of these beliefs is essential to mature beyond a Stage 4 default and to overpower Stage 4 hooks:

- "People who won't accept me for who I am are no longer worth my time and attention"
- "There is much more to life than putting boundless energy into fitting in and/or the hope of getting others to admire and/or envy, love and/or approve of me"
- "Love and approval from certain people may be nice, but not as essential as I have told myself it is"
- "I give *myself* unconditional acceptance regardless of who else does"
- "I can only do my best, and I hereby let go of all versions of that impossible standard called perfection"
- "Failing at something does not make me a failure"
- "I can handle things even when I don't like them"
- "How anyone else feels about me is out of my control"

Stage 5: **Normal adult in our society**; where the definition of self ("who you perceive yourself to be") becomes the sum of all one's life roles. Indeed, Fives often think of themselves as role jugglers. Characteristic view of life at this stage is often comfortable, dispassionate, or neutral. Stage 5 can also be a source of the ideal

attitudes and frame of mind to function best while doing or coping with what is merely necessary in order to live life in the higher stages. While a Stage 5 frame of mind is important to have at times with respect to certain relationships and activities, it often results in disappointment when you expect higher degrees of fulfillment than this stage can deliver.

Common default beliefs about self:

- "I can't (or I don't want to) handle (fill in the blank_____) in my life right now—I am overwhelmed"
- "I cannot tolerate being unglued, overwhelmed, or underwhelmed"
- "I feel trapped with no way out"
- "I must keep all aspects of my life together and in balance and step up to the plate with respect to all of my roles (e.g., spouse, breadwinner, parent, member of the community, etc.), regardless of whether or not they provide me feelings of satisfaction or gratification"
- "I 'have it all', but still feel unfulfilled"

Self-acceptance at Stage 5 is often and most typically contingent upon optimally meeting and performing well in one's roles.

Intervention objectives for Stage 5 issues: Handle overwhelm and role ambiguity, make lifestyle choices and decisions regarding life changes, learn to rise above one's roles in order to identify sources of passion and intrinsic motivation. Challenge the logic of merely replacing a lost (or unfulfilling) relationship or job with another, without a thorough examination of what will work best in the long term and/or learning to tolerate a void without giving in to the resulting discomfort anxiety.

Cognitive restructuring to a customized version of these beliefs is essential to mature beyond a Stage 5 default and to overpower Stage 5 hooks:

- "I want to be doing what I love and to feel rewarded internally (as well as externally)"
- "I can handle being overwhelmed, and resolve to use those times when I *feel* overwhelmed as learning experiences that can act as insight to draw upon when deciding whether to take things on"
- "Satisfaction and gratification are nice to have, but I realize and accept that there are many things I choose to have in my life that don't provide them to the extent I wish they would"
- "I now take responsibility for putting into my life that which will fulfill me long term"

Stages 6 and 7 are the **target stages** to which most people aspire and view as life at its very best. *It is at the target stages where one feels the very best—that is the most accepting—about himself or herself*. The target stages generally represent the frame of mind for optimal functioning.

Stage 6: **Mature adult capable and committed to transcending roles**. At Stage 6, whenever possible, one solidly operates according to his or her own intrinsic or internally generated values and passions. This is the first of two target stages in which one

genuinely and maturely loves, enjoys, excels, and creates in his or her own distinctive way. To the extent that one is operating at Stage 6, his or her view of that aspect of life is passionate, happy, loving, and most importantly—self-accepting.

Common default beliefs about self:

- "I prefer to have passion and to feel *personally* gratified by whatever I do in every important area of my life"
- "Life and each aspect of it is to be lived to the fullest and enjoyed"
- "Any answers I am seeking regarding myself lie only within myself"

It can be argued that self-acceptance is the gateway to the target Stages 6 and 7.

Intervention objectives for Stage 6 issues: Both to learn and practice ways to deepen one's access to internal sources wisdom, mindfulness, passion and intrinsic motivation; to install self permission for living in accordance with one's own definition of what is life at its best—governed by unique values, desires, and interests. This can be done through whichever method is most effective in transcending one's ego in order to access one's necessary inner resources, e.g., meditation, prayer, yoga, or any method (or unique combination thereof) that best helps a given individual turn inward for guidance or direction. Often a chosen mentor or coach who serves as a role model in the specific area one needs help, who is personally beyond the specific problem or challenge one is facing—can be helpful.

Stage 7: **The highest target stage**. To the extent that one has hooks or a default in Stage 7, he or she is beyond the need for self-gratification as per Stage 6 and lower; fulfillment is achieved by one's benevolence, unique contribution to the world and/or others (no matter how large or small it may be) and to how he or she can change it for the better. Any hooks in Stage 7 propel one's purpose that is "larger than yourself" which now has more importance as an intrinsic motivator than "self-interest." Some extremely common examples of Stage 7 endeavors are contributions of time or money to charity, and the best attitudes that underlie the role of parenting and giving to others in love—as well as other types of—relationships *without regard to what comes back*. At Stage 7, one's purpose *outside* of oneself has more importance than self-interest. Gratitude, determination, caring, and selflessness are all traits consistent with a Stage 7 frame of mind.

Common default beliefs about self:

- "It is a mission/pleasure to contribute to or be of benefit to_______ (fill in person or cause, for example)"
- "Gratitude for what I have and/or my commitment to a person or cause motivates me to want to give back"
- "There are larger, grander, bolder, and more challenging missions to undertake than merely pleasing myself"

At Stage 7, self-acceptance as well as the unconditional acceptance of others is a given. Sevens are by definition beyond their own gratification and life drama in favor of the needs of something or someone beyond themselves.

Intervention objectives for Stage 7 issues: Similarly to Stage 6, whatever is most effective in helping introspection in order to clarify one's mission or level of commitment.

Relationships by the Stages

Conventional wisdom has long recognized the role of maturity (of each partner and the type of involvement they have with each other) as having an effect on most aspects of a marriage or love relationship. This model can help the therapist to assess maturity and the specific role it plays when treating a couple. The basis for the relationship and how partners relate to each other, as well as what a partner believes about the other partner by the various stages, can provide valuable clues for selecting the best intervention strategy. The following breakdown of love relationships by the stages could apply to the relationship itself, the default stage of one or both partners or simply a hook of one or both partners. What is most important is the connection of a presenting problem to the stage it typifies.

Here is How Partners Typically Relate to Each Other by the Stages

Stage 1: The current basis of the relationship (and often the foundation or reason it even came to be) is security, dependency, and neediness (e.g., emotional or financial, etc.). One or both partners is often experienced (and seen) by the other as a "bottomless pit" and/or may be preoccupied with being taken care of. At the extreme, a person at Stage 1 can be the "powerless" recipient of abuse (or has the self-perception of powerlessness). Partner is seen as, and expected to be a need satisfier (or "parent"), without reciprocity.

Common relationship beliefs of person operating at Stage 1:

- "I'm trapped in this relationship and would not be able to make it on my own"
- "I have no choice but to remain in the unfulfilling (or even abusive) situation I am in"
- "He/she owes me and/or must take care of me"
- "We always have to be together (or you always have to be accessible to me)"

Stage 2: Usually, one partner strongly dominates the other and/or uses the relationship as a vehicle to act out in a variety of ways. Abuse is often melded out and deception is, the substitute for intimacy (what is not felt can be lied about). For example, "Twos" often demand that their partner be faithful while they are not.

Common relationship beliefs of person operating at Stage 2:

- "I must have things my way"
- "I'll stay as long as my needs are getting met"
- "Men/women are expendable"
- "The name of the game is to take as much as possible without giving anything back"
- "I don't want to change and if he/she doesn't like 'it', too bad"

Stage 3: Both the foundation and climate for the relationship are grounded in dictums (often clichés or stereotypes) that are usually based on long standing rules and traditions of the family of origin, religion, or "society"; but in any case were not

willfully chosen (e.g., how one meets a mate, religious or ethnic background of anyone who could be considered for involvement, who works, who stays home, the nature of their sex life, religion, fidelity, etc.). Disagreements often focus on who's most compliant with whatever rules form the basis of their relationship. When the relationship works, it's usually because their "book of rules" settles control issues and other conflicts as well, often with some form of black-and-white thinking.

Common relationship beliefs of person/couple operating at Stage 3:

- "_______ (fill in the blank) is the way a marriage (husband, wife, parent, sex, etc.) should/must be"
- "In any conflict, there is one partner who is right and one who is wrong"
- "Disagreement or conflict is a sign of a bad marriage/relationship"
- "Rigidity is preferred to changing the status quo"

Stage 4: Partners look to the relationship and each other as a source of love, validation, and approval. There is often an inordinate degree of jealousy and insecurity. Emphasis is on *being* loved (receiving) and validated as opposed to loving (giving). "Fours" often try to please partner as a way of getting back as much or more affection and validation. When they say, "I love you," it can mean, "I want you to love me." Fours may often ask partner, "Do you love me?" and obsess on that question and it's perceived implications.

Common relationship beliefs of person operating at Stage 4:

- "I should/must get more personal validation from my partner"
- "_______________ (fill in the blank) means he/she does not love me"
- "I should/must please my partner in order to be loved"
- "There is nothing as important in life as *being* loved"
- "Jealousy is not merely an insecurity, being jealous means you really care about your partner"

Stage 5: Each partner honors his or her commitment to the other and (perhaps dutifully or dispassionately) fulfills the other's spouse/relationship slot and all that it entails (e.g., sex partner, companion, friend, co-parent, confident or someone with whom to be intimate, share finances, travel companion, etc.). Partners are not necessarily governed by passion or strong attachment that transcends their roles in many areas of the relationship. In the case of a relationship such as a marriage that stays together mainly for practical reasons such as financial, social, political, or lifestyle considerations (e.g., "the children"); Stage 5 could be a couple's target stage. In other words, for some couples, this is as good as it will get. Arguably, a marriage grounded in a Stage 5 default is what most marriages become over time; and thus represent a norm in our society.

Common relationship beliefs of person operating at Stage 5:

- "We are comfortable in our lives together"
- "We enjoy each other's company and have much in common"
- "Being 'in love' is something that happens in the beginning of a relationship or when you're young and is not practical (realistic or necessary) later on"
- "I love him/her but I'm not *in* love …"

Stage 6: In this model, Stage 6 is considered a goal or target stage that most couples (and those who are seeking a love relationship) aspire to. Partners look to each other as a person they wish to love and support as opposed to someone from whom love, sex, support and validation is merely expected or reciprocated. There is genuine caring, intimacy, passion (perhaps, but not necessarily sexual) and respect that is not predicated on reciprocity. Thus, when "Sixes" tell partner, "I love you," they mean just that, without consideration for what their partner feels toward them.

Common relationship beliefs of person operating at Stage 6:

- "This is the person that I want to be with (for the rest of my life)"
- "When I am with him/her, I feel very good about myself"

Stage 7: This is the highest target stage. Couple becomes a team who selflessly work together in a common mission outside of themselves (e.g., their children, their community, a cause, etc.). Either partner can easily put the other partner or partner's desires or mission above his or her own without distain or expecting a quid pro quo. Disagreements are resolved by reaching consensus on whatever represents the highest good. Stage 7 couples are beyond being attached to and governed by expectations.

Common relationship beliefs of person operating at Stage 7:

- "My pleasure is in providing gratification to my partner"
- "We can strongly disagree without either of us being wrong"
- "Our relationship is grounded in respect and support"
- "I can be happy for my partner even though his/her good fortune does not necessarily benefit me"

Protocol

First have couple identify the stages and corresponding cognitions or variations of irrational beliefs (B) that underlie a relationship issue. Then identify a target stage (generally Stages 5, 6, or 7), along with the desired attitude and cognitions (E) for optimal functioning within the relationship. This can be selected and installed both individually and with the couple working together as a team, by using a variety of well-established CBT/REBT techniques. It is important to stay realistic regarding what is possible in a given relationship. Striving for what is ideal instead of what is optimal is akin to helping a client set themselves up for failure. A client friendly handout to help with this process can be downloaded at http://www.StageClimbing.com/calibrations/couples.

As I have pointed out elsewhere (Broder, 2002), I believe that the optimal attitude for any therapist working with couples is complete neutrality as to whether the relationship stays together or partners recognize that the relationship has run its course.

Often when partners become aware of the stages through which they both relate to each other and view themselves within the context of the relationship, they realize that a lack of motivation to operate at a higher or target stage means the relationship is no longer viable (at least as their expectations had previously defined the relationship to be) or at the very least, they need to change their expectations. On the other hand, couples who can identify with the stage or lens through which they each see the relationship, themselves and each other, often experience an enhanced motivation to restructure the beliefs that govern their involvement. It is that mutual motivation for a couple to move forward after seeing what's possible, that I have found to be the essential ingredient to stay on the path of making a troubled relationship viable once again. Success stories, for example, can include a couple who agrees to lower their expectations and accept that a Stage 5 marriage—without the demand for passion that's not there—will work for them, a couple who accepts that their sex life needs to be worked on can climb to Stage 6 together—at least in this area of their relationship or a couple who agrees to abandon their Stage 3 motivated goal of having children find that they can experience deeper feelings of appreciation for each other—resulting in a level of fulfillment that was heretofore missing.

Conclusions

In the Stage Climbing model, the definition of self-acceptance is quite different at each stage. At Stage 1, self-downing resulting in feelings of inadequacy is the biggest obstacle to self-acceptance. At Stage 2, "self-acceptance" is mostly an illusion that results from putting others down. At Stage 3, "group think" is often disguised as self-acceptance. At Stage 4, self-downing is back in the picture, mostly regarding one's performance and obsession with the acceptance coming from others. At Stage 5, self-acceptance itself is less of an issue, until a crisis such as the breakup of a relationship or a job loss puts a crucial role in jeopardy. However, self-acceptance is part of the definition of the target Stages 6 and 7. It is USA alone that allows one to trust his or her internal resources as the best sources of wisdom and guidance.

With respect to relationships, I believe that in reality there is no such thing as a happy marriage (or love relationship), only two individual partners who experience varying and often different degrees of happiness within a given relationship. After more than three decades of treating couples, I have come to define this as each partner's degree of self-acceptance in that part of his or her life. By privately assessing, each individual partner's subjective view of how he or she views himself or herself as part of a couple as well as all the related and relevant aspects of life (e.g., sex, parenting, etc.), the most effective intervention strategy usually becomes obvious in the shortest time possible.

In addition to those typically encountered in relationship therapies as discussed in this chapter, the Stage Climbing model can be applied to virtually any therapeutic issue. The variable of maturity suggests a new way of seeing personal, career, family, and organizational issues.

I also present the model as a new dimension to the understanding of emotions, motivation, and values. All of its potential applications encourage clients to recognize where they are presently operating and then choose a target stage as a way of defining their goal and selecting the best strategy to get there.

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Self-Acceptance in Women

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It is not unusual to open the daily newspaper to see headlines "Female stars relegated to the underclass" referring to the "…discrimination that resulted in Australia's women Olympic basketball players flying to London in economy class, while the men travelled in business class" (The Age, July, 20, 2012, p. 1). Then two pages further on, "Most women say 'I do' to husband's name". Reporting on a recent study by sociologist, it was stated that the vast majority of women take their husband's name at marriage with 90 % of children also having their father's, not their mother's, surname (The Age, July, 20, 2012, p. 5). Then a week later, "Women's work never done and pay still lousy". Reporting information from the Bureau of Statistics, the headline pointed out that "Men are better paid, but women are better educated. Men dominate the top executive jobs, at least in business, while women do most of the unpaid work at home" (The Age, July, 28, 2012, p. 5). One cannot but wonder what this differential treatment of men and women in our society can have on women's self-image and their self-acceptance. History and the research literature in fact paint a complex picture of gender self-image and self-acceptance.

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Development of Gender Self-Image and Self-Acceptance

Wolfe and Naimark (1991) presented a model outlining the way attitudes about gender roles, many of which are very subtle, became part of a woman's automatic repertoire of cognitions and, thus, influenced her self-acceptance and behaviour, frequently in a detrimental and often debilitating manner. In their model, the process of gender-role stereotyping starts with the messages the young infant, toddler, child, and adolescent girl receives from her social context (Step 1). These messages begin at a very early age and have an influence even before the child develops language (Wolfe & Naimark). Parents, siblings, teachers, members of the social milieu, and the media transmit these messages (Fodor, 1990). The messages tended to be taken for granted and are rarely questioned. The way boys and girls are handled and dressed, toys and activities provided, and behaviour tolerated differ for the two genders.

Wolfe and Naimark (1991) suggested that these messages were internalised by women by the time they reached adulthood and developed into a belief system (Step 2). In terms of rational emotive behaviour therapy (REBT) theory (Ellis, 1962), these beliefs can be irrational or dysfunctional as they are frequently in the form of absolutistic demands regarding how the woman should behave, talk, feel, look, and think in order to be accepted, valued, and appreciated (Wolfe & Naimark). Since the beliefs were internalised, they influenced the women's self-perception and self-acceptance.

These internalised demanding beliefs often create feelings and behaviours that are dysfunctional for women (Step 3). Thoughts associated with poor self-acceptance, anxiety about behaviour that deviated from the gender norms, and depression over lack of control were cited as frequently present in women seeking therapy. Women also presented with self-defeating behaviours including procrastination, lack of assertiveness, and failure to follow through with self-generated goals (Wolfe & Naimark, 1991).

In Wolfe and Naimark's (1991) model society's reaction to women completed the cycle (Step 4) with institutions and programmes reinforcing the presence of sex-role stereotypes. They asserted that both institutions and individuals reacted negatively to woman's deviations from the sex-role norms. The burning of St Joan of Arc for taking up arms and the placement of Zelda Fitzgerald, Scott Fitzgerald's wife, in a psychiatric hospital because she, too, liked to write have been claimed to be extreme examples of the treatment of women who deviated from gender stereotypes (Chesler, 1972).

In this context self-acceptance by women, or lack of it, was therefore considered to be a mirroring of the way they were treated by those around them and society in general.

What Is Self-Acceptance?

Defining self-acceptance is complex, particularly given the different understanding of what the concept "self-acceptance" means and, hence, how it might be measured.

Cognitive Behaviour Theory and Self-Acceptance

To cognitive behaviour therapists, self-acceptance, while related to self-esteem, is not the same; self-acceptance being based on a philosophical concept regarding how an individual sees himself or herself. Self-esteem is seen as how an individual values himself or herself based on characteristics, behaviours, and achievements as well as approval from others. It is basically how the individual rates himself or herself. The problem with such rating is that we feel good and rate ourselves positively if we have desirable characteristics, behaviours, achievements, and approval from others but feel down and rate ourselves poorly if these features are lacking. Self-esteem is therefore conditional.

Self-acceptance, on the other hand, is unconditional with all ratings of the self, either positive or negative, considered to be erroneous. While it has been suggested that people both biologically and socially tend to rate themselves and their characteristics, behaviours, thoughts, feelings, and achievements, it has been suggested that they can learn to omit self-rating and rate only their performances (Ellis, 1992/1994). It has furthermore been suggested that "…people will undo much of their self disturbance if they rate and evaluate their thoughts, feelings and actions in regard to their goals and purposes and if they refuse to measure their global 'selves' or 'beings'" (Ellis, 1995, p. 213).

This view of self-acceptance is based on a humanist and existential position that people create their own world with an emphasis on full and unconditional acceptance of self and others. People can choose not to prove themselves but to be themselves and enjoy themselves. Emotionally healthy people are glad to be alive and accept themselves just because they are alive and can enjoy themselves. They do not measure their worth based on achievements or what others think of them (Ellis & Whiteley, 1979). In essence self-acceptance is a philosophical decision to accept the self unconditionally and not play the rating game.

Following the writing of Ellis, others (Walen, DiGiuseppe, & Wessler, 1980) have pointed out that there is no scientific way to prove conclusively that one human being has more or less worth than another. It therefore follows that all people are of equal worth. However, the notion of worth also leaves it open for the opposite to apply that of worthlessness. In eliminating the notion of worth, Ellis proposed the concept of unconditional self-acceptance. Self-acceptance is, therefore, not based on an assumption of worth related to a behaviour, characteristic, achievement or support, or approval from others. Rather it is a choice to accept oneself. Instead of rating oneself as a bad (or good) person, it is seen to be more helpful to accept oneself as a person who does some bad things (Ellis, 1994).

What then is the self? A simple way to see this is to regard the self as the experiential being at the core of a person; that which sees, hears, dreams, thinks, feels, and becomes sexually excited (Franklin, 1993). Rather than there being one "I" or self it has been suggested by Franklin that the self is composed of many "i"s. There is the i that watches a sunset, the i that plays tennis, the i that works as a gardener, and the i that cares for children. The whole self is then not put down if one i is faulty.

Existential philosophy is not the only basis for self-acceptance. Other common philosophies also espouse this notion. In the Christian New Testament, Jesus was asked "What was the most important commandment?" He responded, "Thou shalt love the Lord thy God with all thy heart, and with all thy soul, and with all thy mind. This is the first and great commandment. And the second *is* like unto it. Thou shalt love thy neighbor as thyself. On these two commandments hang all the law and the prophets" [Matt22:37–40]. This gives a clear message of the need for self-love or self-acceptance.

In Buddhist writing self-acceptance is also espoused. "Self-acceptance is the ability to rejoice in one's own good qualities and be at peace with and tolerant towards one's faults". In Buddhist psychology the terms attapiya (Dhp.157), attakāra (S.I,75), and attakāma (A.II,21) mean "self-appreciation", "self-respect", and "self-love" and are always used by the Buddha in a positive sense. In the practice of loving-kindness meditation, the first step is to develop love towards oneself. It is considered that we can hardly love, respect, and care about others unless we have such feelings towards ourselves. As the Buddha says: "One who truly loves himself will never harm another" (S.I,75) (Dhammika, 2006). No doubt there are other philosophies that espouse similar messages.

Cognitive behaviour therapists other than Ellis also were aware of the concept of self-acceptance. Beck (1991), as a result of his empirical research was aware of the lack of self-acceptance in his depressed patients who tended to negatively reproach themselves, suffer self-blame and self-castigation.

In Ellis's Rational Emotive Behaviour therapy (Ellis, 1962; 1994), Ellis considered that absolute shoulds, musts, and oughts were the primary source of disturbance, for example, "I must do all I can for my family". He also referred to three evaluative cognitive processes in the form of awfulising, for example, "It is awful if I don't do all I can for my family", low frustration tolerance, for example, "I can't stand it if I don't do all I can for my family" and globalising, for example, "I'm no good if I don't do all I can for my family". This last process of globalising reflects a global, negative evaluation of self based on one feature, characteristic or behaviour which Ellis would say reflects lack of self-acceptance.

That self-esteem and self-acceptance differ is supported by research. In a study to examine the relationship between the two concepts and their effect on psychological health different patterns were evident for self-esteem and self-acceptance. "Self-esteem was more closely associated with affect, with higher levels of self-esteem being indicative of lower levels of depression. Self-acceptance appeared to be more closely associated with general psychological well-being and to be more helpful when undertaking clinical work for general psychological problems" (Macinnes, 2006, p. 483).

Within the cognitive behaviour therapy school, a number of scales have been developed to measure beliefs that reflect core unhelpful beliefs relating to demands for affiliation, achievement, and comfort as well as the processes of demands, awfulising, low frustration tolerance, and global rating of self and others. Some of the scales actually focussed on the negative aspect of negative self-rating or lack of self-acceptance such as the Attitude and Belief Inventory (Burgess, 1986). However,

the General Attitude and Belief Scale (DiGiuseppe, Leaf, Robin, & Exner, 1988) included items that reflected self-worth or self-acceptance and lack of self-acceptance. This scale was further developed by Bernard (1990) to include negative evaluation of others and a sorter version, the SGABS, was further developed (Lindner, Kirkby, Wertheim, & Birch, 1999). The Unconditional Self-Acceptance Questionnaire was also developed (Chamberlain & Haaga, 2001).

The author also developed a scale, the Women's Belief Scale, specifically to measure the gender beliefs of women focussing on the demands a woman places on herself, along with awfulising, low frustration tolerance, and negative self-rating or lack of self-acceptance if these demands are not met (O'Kelly, 2011).

Self-Acceptance and Well-Being

Another approach to the conceptualisation and understanding of self-acceptance comes from the research on well-being. In fact, a recent literature search revealed more articles in this area than any other area of research with regard to the term self-acceptance.

In contrast to the mental health literature that typically focusses on the negative end of psychological functioning, Ryff (1989a, 1989b, 1989c) focussed on psychological features that account for positive functioning and well-being; the presence of wellness rather than the absence of illness. Ryff (1989a, 1989b, 1989c) was critical of the lack of theory guiding research in this area of well-being. As a result, she reviewed the literature in this area, teasing out the major features associated with well-being. Based on the multiple frameworks of positive functioning, such as those suggested by Erickson, Neugarten, Maslow, Allport, and Rogers, she developed a multidimensional model of well-being. The six dimensions were positive evaluation of one's self and one's past life (Self-Acceptance), a sense of continued growth and development as a person (Personal Growth), the belief that one's life is purposeful and meaningful (Purpose in Life), the possession of quality relations with others (Positive Relations with Others), the capacity to manage one's life and surrounding world (Environmental mastery), and a sense of self-determination (Autonomy). Self-acceptance was therefore seen by Ryff (1989a, 1989b, 1995) as a major contributing factor to well-being.

Having explored the theory of well-being, including the dimension of self-acceptance, she constructed a scale that has come to be known as the Psychological Well-Being Scale (PWS) (Ryff, 1989b). Knowledge of the development of this scale helps to understand more fully her conceptualisation of the term self-acceptance. Scale definitions for each dimension were developed reflecting bipolar high and low scores. Self-acceptance was defined in the following ways:

> *High scorer*: Possesses a positive attitude toward the self; acknowledges and accepts multiple aspects of self, including good and bad qualities; feels positive about past life.
>
> *Low scorer*: Feels dissatisfied with self; is disappointed with what has occurred in past life; is troubled about certain personal qualities; wishes to be different to what he or she is. (Ryff, 1989b, p. 1072)

Three item writers were instructed to write self-descriptive items that were consistent with the definitions. Thirty-two items, half positive and half negative, were finally used for the scale. Shorter versions of the scale have also been developed with as few as three items in the Self-Acceptance Scale (Carr, 2002). Examples of the items in the Self-Acceptance Scale are (1) I like most parts of my personality, (2) When I look at the story of my life, I am pleased with how things have turned out so far, and (3) In many ways I feel disappointed about my achievements in life (reverse coded) (Carr).

While this approach to self-acceptance reflects cognitive statements about self, they are evaluative. In this sense they differ from the approach of the cognitive behaviour therapist such as Ellis who was critical of any form of evaluations and ratings of self and stressed the need for unconditional self-acceptance. Ryff's conceptualisation was based on psychological theory while that of Ellis was based on philosophical foundations shared with others.

What the Research Tells Us About Self-Acceptance in Women

It was considered productive in this chapter to explore self-acceptance issues that relate to significant issues that women in general have to deal with rather than self-acceptance issue for women with mental health issues. In this regard the topics explored below include self-acceptance and the difference between men and women, self-acceptance in multirole women, and self-acceptance and violence towards women.

Gender Differences

From the time of her early work on well-being, Ryff and her colleagues explored gender differences (Ryff, 1989b; Ryff & Keys, 1995; Ryff & Singer, 1996). The results regarding overall differences between men and women on the PWS dimension of self-acceptance are of interest and have been consistent. In her early study of well-being in 321 men and women across the life span, divided among young, middle-aged, and older adults, a number of gender differences were evident in the six dimensions of well-being. These differences occurred on the measure of positive relations with other, on which women scored higher than men. The difference between men and women on the measure of personal growth approached significance, again with women scoring higher. That was it. There was no difference between men and women on the self-acceptance measure for any of the age groups (Ryff, 1989b). In a study relating parents' well-being and that of their adult children, again no significant difference was found between self-acceptance of the mothers and the fathers although women did score higher on personal growth and positive relations with others (Ryff, Lee, Essex, & Smutte, 1994). Similar results were again obtained in a later, larger study with a sample size of 1,108, which was

also divided into the three age groups. The only scale that showed significant gender differences was the Positive Relations Scale. There were no differences with regard to self-acceptance nor did self-acceptance differ across the age groups (Ryff & Keys, 1995). These results support the belief that women are more focussed on interpersonal relationships while men are tied to individualism and autonomy as was suggested a number of years earlier (Gilligan, 1982).

It is particularly interesting to note that in a number of the studies reported by Ryff and her colleagues (Ryff, 1989b; Ryff et al., 1994; Ryff & Keys, 1995) there was a consistent pattern of negative associations between well-being and several measures of depression. These were accompanied by consistent positive associations between the measures of well-being and positive affect, happiness and satisfaction. Of the measures of well-being the strongest relationships were present for self-acceptance and environmental mastery.

These results tend to create a dilemma. It has been well documented that women, from early adolescents and throughout adulthood, are twice as likely to experience depression, as do men. This is the case across different cultures and ethnic groups. It is true whether it is subclinical symptomatology or diagnosed depression. Lifetime prevalence of depression of 21.3 % has been cited for women in contrast to a prevalence of 12.7 % for men (Nolen-Hoeksema, 2001). What then do we make of the fact that women in Ryff's studies did not show differences between men and on self-acceptance yet self-acceptance was one of the two scales of the well-being scale that was most highly negatively related to depression. A possible reason for this lack of gender differences is that the samples in Ryff's studies may have been selective. Individuals suffering from depression may have opted not to take part in the "well-being study". The participants in the studies might therefore not have truly represented the range of well-being. The studies may be focussing on individuals, both men and women, who are more at the positive end of the mental health spectrum. Measurement issue may also impact on this lack of gender difference. For all subscales of the PWS information tends to concentrate in the midrange. Score precision therefore diminishes at the high and low levels of well-being and therefore the high and low levels of self-acceptance (Abbott, Ploubidis, Hubbert, Kuh, & Croudace, 2010).

The heritability of self-acceptance in men and women has also been studied. Self-acceptance, as measured on the PWS (Ryff, 1989b), is considered one of the most important aspects of psychological functioning that accounts for the heritability of resilience. In a major twin study, from the National Survey of Mid-Life Development in the United States (MIDUS), men and women did not differ with regard to self-acceptance. In men, however, environmental mastery, involving the ability to maintain a sense of empowerment and competency, along with a positive view of oneself in the face of psychosocial stressors, both contributed to psychological resilience. When there were statistical controls for self-acceptance, the heritability for men was only reduced by 33 %. In women, however, the one significant psychological resource of self-acceptance contributed most to heritability. Controlling for this one factor in women reduced the heritability by 70 % (Boardman, Blalock, & Button, 2008). It seems from this study that when it comes to heritability of resilience in women one factor, that of self-acceptance, is significant whereas

men are not solely dependent on this one factor but derive additional benefit from environmental mastery. This is a possible reason why the incidence of depression is lower in men.

To date there has been no study reported exploring gender difference on the various measures of beliefs, in particular self-worth or self-acceptance beliefs, within the CBT framework. It seems that this is an area where further research is warranted to get a fuller understanding of gender difference and self-acceptance.

Self-Acceptance and Multiple Roles

It has been suggested that the differential environmental factors, such as women's social roles and the high incidence of violence and sexual abuse in women, might also contribute to the higher incidence of poorer emotional well-being in women in comparison with men (Nolen-Hoeksema, 2001) although more research in this area is warranted.

The lives of women have changed considerably throughout the twentieth century. Prior to World War II, the majority of women were involved in full time, unpaid, domestic duties: cooking, washing, cleaning, and nurturing their husbands, children, and the elderly. External pressure associated with World War II led to many women entering the paid workforce, initially through necessity, to replace men who were serving in active combat in the armed forces. Following the war women's participation in the paid workforce continued to increase. Women's representation in positions of leadership and in professions also increased (Chesney & Hill, 1988).

Although women took on paid work outside the home, they continued to do most of the domestic work, working longer hours in combined workforce employment and household tasks than did their male partners (Bittman, 1991; Cowan, 1983; McBride, 1990; Rexroat & Shehan, 1987). This was the case regardless of income, education, social background, employment, or age. This increased workload for multirole women was presumed to have a deleterious effect on their health and well-being (Bittman, 1991).

While it may not be the ideal for women to carry a double load, to date there is in fact little empirical evidence supporting the contention that a double workload has a negative effect on women's physical or emotional health. A number of cross sectional and longitudinal studies have reported an association between employment and good physical health (Haynes, Eaker, & Feinleib, 1984; Verbrugge, 1982, 1983, 1986; Waldron & Herold, 1986; Waldron & Jacobs, 1988, 1989; Woods & Hulka, 1979). The nature of the association between paid employment and women's emotional health is not as clear as for physical health. No studies, however, have found women in paid employment to be more distressed than women who were not in paid employment (Warr & Parry, 1982).

In modern society gender roles are not clearly defined with the result that both men and women juggle multiple roles, for example homemaker, worker, partner, parent, career for an aged parent, and voluntary worker. It appears that a greater

number of roles enhances well-being in both men and women. In fact increased role involvement that is the more roles a person had, was among other measures, associated with more positive self-regard. In this context, however, the self-acceptance of women was lower than that of men (Ahrens & Ryff, 2006). This result is in contrast to other studies of well-being and self-acceptance in women suggesting that self-acceptance in women may be influenced by context.

Women with young children adapt to work and family demands in different ways. Some stop work altogether for some time, others reduce their work hours, and others may move into work that complements the maternal role. Making these adjustments impacts on a woman's career. They have access to less on-the-job training, less work experience, and fewer promotions with resulting reduced income, erosion of earnings, prestige, and mobility in the labour market (Carr, 2002). These work-family trade-offs impact on how a woman evaluates herself. Again using data from the MIDUS study focussing on the PWS (Ryff, 1989b), it was shown that these factors impacted on self-acceptance differentially for men and women. Income was positively related to men's but not women's self-acceptance; however, a college degree had a greater impact on self-acceptance for women than it did for men. Furthermore, for women, the impact of work-family trade-offs varied depending upon the cultural norms of the cohort or peer group. For all age groups women who changed jobs or reduced their work hours did not differ in self-acceptance from those who remained full time in the workforce. However for those women born between 1931 and 1944 stopping work to raise children was a large positive predictor of self-acceptance. In contrast women born between 1960 and 1970 who stopped work to care for their children reported significantly lower self-acceptance (Carr, 2002). It is well known that the feminist revolution has led to a change in gender-role behaviour and attitudes from the late 60s and thus the two groups of women mentioned above are likely to have had very different expectations with regard to gender-role behaviour. It appears that adhering to cultural norms or specific sub-cultural norms for gender-role behaviour enhances a woman's self-acceptance (Carr, 2002). When the impact of unpaid work, such as childcare, housework, voluntary work, and caring for elderly or ill relatives, was explored in a more recent study, similar results were obtained. Unpaid work was negatively associated with self-acceptance (Lindfors, Berntsson, & Lundberg, 2006). We cannot, however, assume that in current times being out of the workforce causes a woman to have low self-acceptance. It could be that women with low self-acceptance opt to stay out of paid employment while those with high self-acceptance opt to work in paid employment. The impact of cultural norms for gender-role behaviour is again relevant.

Restriction in the number of roles may also be a factor in women who opt not to work in paid employment as a commitment to multiple roles has shown to be related to life satisfaction and self-acceptance. Managerial women in particular who are committed to a variety of roles have a very strong sense of self-worth (Ruderman, Ohlott, Panzer, & King, 2002).

Self-acceptance and self-efficacy, being the belief a woman has in her ability, are also related in women in paid employment. Women with higher self-acceptance

have higher self-efficacy. This is the case across a range of work sectors and is particularly so for the health and industrial sector (Srimathi, Kumar, & Kiran, 2011).

The demands multirole women placed on themselves and then how they evaluated themselves were also explored in a large research project exploring stress and well-being in multirole women conducted by the author (O'Kelly, 1999). All the women working at a large teaching hospital were asked to take part in the study. Of the 2,562 questionnaires sent out 974 (44 %) were returned completed. Of the 974 women 422 were living with a male partner, had children living at home, and had a household to maintain in addition to their paid employment. The main measure taken was the Women's Belief Scale (O'Kelly, 2011). This scale was developed for the purpose of this study and was created to explore gender-role beliefs. It was based on REBT theory with subscales of demands, awfulising, low frustration tolerance, and negative self-rating. It is this last subscale that is of particular relevance to this chapter as it is indicative of lack of self-acceptance.

The multirole women who rated themselves negatively also had high score on the global severity index of the brief Symptom Inventory, a measure of emotional distress. They also reported that they felt stressed overall with life in general. They experienced more negative affect and less positive affect and reported less satisfaction with life as a parent, worker, and with life in general. The relationship between self-acceptance or negative self-rating and well-being however differed with occupational status and education. Professional and managerial women were less inclined to rate themselves negatively in comparison to blue-collar workers such as kitchen hands and cleaners. In addition those with a higher level of education also had lower scores on negative self-rating in comparison to those with lower levels of education. It is not surprising then that those with a lower level of education, having left school before the end of their secondary schooling, rated themselves lower than those with a postgraduate degree.

It is of interest that the relationship between stress and well-being and self-acceptance as measured by negative self-rating varied for different occupational groups and levels of education. For blue-collar and clerical workers there were no relationships between negative self-rating and their Global Severity Ratings, their positive and negative affect and life satisfaction measures. So it seems that the higher level of stress in these women is not related to their view of themselves. The managerial and professional women as well as the nurses were however more stressed, as measured by the Global Severity Rating, if they rated themselves negatively. For the managerial and professional women higher score on negative self-rating were also related to lower positive affect and higher negative affect as well as lower quality of life and life satisfaction measures. If the nurses had high negative self-rating, they also had low positive affect and low measures of life satisfaction. Likewise it was only for those with higher levels of education that there were relationships between negative self-rating and the Global Severity Index, with those with a tendency to rate themselves negatively being more stressed.

This research again suggests that context is important in exploring the relationship between self-acceptance and well-being in women. The blue-collar and clerical women are basically continuing to work in roles that are traditionally female roles.

There is therefore not a conflict between the demands placed on them in the workforce and their gender-role beliefs. Hence their self-acceptance is not challenged. For the more highly educated managerial and professional women and to a lesser extent the nurses, the demands of the workplace may require them to take on roles that are traditional male work roles and have demands on their time that detract from their role as wife, mother, and homemaker. Such pressures may challenge their self-acceptance as a woman leading to greater stress.

Abuse of Women and Relationship with Self-Acceptance

Gender-based violence towards woman has been noted by the General Assembly of the United Nations as a worldwide issue. It is a major contributor to poor physical and emotional health of women (United Nations, 1993). Such violence not only includes physical and sexual abuse but also psychological, social, and economic abuse. The World Health Organisation (2005) study reported that across a number of countries more than a quarter of women reported that they had been physically or sexually assisted since the age of 15 years with the incidence being as high as 50 % in some countries. In the study the extent of physical or sexual violence or both by an intimate partner over a lifetime varied from 15 % in urban Japan to 70 % in provincial Ethiopia. The statistics indicate the great extent to which violence is a part of a partnered woman's life in many countries. There were variations, with more highly educated women reporting a lower level of violence, and a higher incidence of violence in rural areas rather than urban sites. While intimate partner violence was the most common, non-partner perpetrators were most often the woman's father or other male or female family members. Controlling behaviour by males was strongly related to the physical and sexual violence as well as other forms of controlling behaviour such as controlling access to health care, wanting to know where she is at all time and being angry if she has contact with another man. In the WHO study it was assumed that power and control are the motivators underlying men's violence towards women and that they use a range of strategies to assert that power and control. For many women home was not a restful sanctuary.

In addition to intimate partner violence high incidence of childhood sexual abuse of women was reported. Across different countries incidence ranged from 1 to 21 %. Strangers and male family members posed the greatest risk. Many women reported that their first sexual experience was by force, often before the age of 15 years. It is possible that both the figures regarding childhood sexual abuse and the life time experience of abuse actually are under reported as a percentage of women regard the abuse as normal or justified. The status of women in society was seen by the WHO as a key factor in the prevalence of violence towards them.

In the WHO study the consequence of violence towards women was of concern as violence has a major impact on the women's physical, mental, sexual, and reproductive health. With regard to their mental health, women who had experienced violence were more likely to contemplate and attempt suicide. The experience of

past violence was also related to the report of mental distress in later life. Of particular concern was that violent, controlling men often kept women from sources of help. Women also were reluctant to seek help as a result of fear of retaliation from their abusive partner and stigmatising reactions from other. Also the women's own beliefs were highlighted, namely, feelings of shame and self-blame. One cannot but assume that such treatment would have an impact on a woman's self-acceptance. There is, however, little research exploring the relationship between violence towards women and self-acceptance.

A study of Jordanian women has explored the relationship between violence against women and self-acceptance. In a large sample with 915 women, it was evident that women who had been educated at school were less likely to be abused by their partner, with higher reports of abuse in women who had not received school education. Of more significance was the relationship between abuse and self-acceptance. Both environmental mastery and self-acceptance, as measured on the PWS, were significantly negatively correlated with all forms of marital abuse; physical, psychological, social, and economic. Of the two PWB measures, self-acceptance had the higher, negative correlations with psychological, physical, and economic abuse. The authors assumed from this data that women with a high level of self-acceptance are less likely to be victims of marital abuse (Hamden-Mansour, Arabiat, Sato, Obaid, & Imoto, 2011). It is, however, also likely that women who have positive attitudes towards themselves do not tolerate abuse or manage situations in a manner that do not lead to abuse, possibly due to an accompanying sense of environmental mastery. Such a sense of mastery gives them competence in managing their environment, controlling a complex array of external activities, and making effective use of opportunities. However, in such a correlational study it is hard to know the direction of causality. It is also likely to be the case that women who are respected and not abused by their partners have a higher level of self-acceptance than women who are abused. All we can say is that a negative relationship exists between abuse and self-acceptance. Working with men to develop different perceptions and attitudes towards women and more effective communication strategies would undoubtedly enhance the well-being of women in addition to programmes to educate women and develop their sense of self-worth.

A number of studies have also explored issues associated with self-acceptance in women who were sexually abused as children. A study of factors contributing to resilience in women who had been sexually abused as children but who had subsequently gone on to college indicated both risk and protective factors. In this study three subscales of the PWB were used as indicators of resilience; positive relations with others, environmental mastery, and self-acceptance. It was surprising that there was a positive relationship between severity of abuse and both self-acceptance and environmental mastery. The women who had experienced several different abusive incidents, and yet got to college later in life, in fact were more accepting of themselves and felt more competent in managing their lives than others. Women would no doubt have to have self-acceptance to survive such experiences to the extent that they could achieve academically. Family conflict was, however, negatively related to self-acceptance. In those homes where the trauma occurred in the context of negativity and where

depreciation and disapproval was common, the child would understandably mirror a negative view of self (McClure, Chavaz, Agars, Peacock, & Matosian, 2008).

On a more positive note development of self-acceptance and even passionate self-acceptance (Payne, 2010) was seen as a key factor in healing the impact of childhood sexual abuse in adult survivors. Several studies used qualitative methods, consistent with the feminist approach and philosophy to explore women's experience of therapy. The women spoke about their feeling of self at the start of therapy, being characterised by self-loathing and shame and seeing themselves as victims. As a result of the therapy process, they were able to not only see themselves as survivors but also progress to regard the abuse as just an experience and not defining who they are. In contrast they learnt to be self-accepting and appreciate themselves with all the different facets of their lives: women, mothers, lovers, friends, teachers, dancers, artists to name a few roles (Phillips & Daniluk, 2004). Disengaging and externalising the trauma or abuse experience enabled the women to see it as an experience in their life and not self-defining. They saw the responsibility for the abuse shifting from the abused to the abuser and hence shifting the blame and with it shifting their negative attributional patterns (Saha, Chung, & Thorne, 2011). Problem-focussed coping strategies were considered to enhance favourable mental health outcomes being characterised by social support, psychological interventions, cognitive reappraisal of the abuse, and self-acceptance (Phanichrat & Townshend, 2010).

What Is the Self That Women Need to Accept?

Taking gender into account creates a complex picture when one explores the importance of self-acceptance in women. What is the self that is actually being referred to or what self needs to be accepted? Gender self-confidence, gender self-definition, and gender self-acceptance are all terms used in the literature (Hoffman, 2006). Gender self-confidence refers to the strength of a woman's belief that she meets her own personal standard of femininity. Whereas gender self-definition takes into account how strongly her femininity contributes to her identity and gender self-acceptance refers to the degree of comfort a woman has as a member of her gender (Hoffman, Borders, & Hattie, 2000). The picture is even more complicated given that, on the one hand, a woman may simply adopt and define her femininity by internalising external and societally based roles and values regarding womanhood, while others may develop their own perception of what it means to be a woman with their own values, beliefs, and abilities (Ossana, Helms, & Leonard, 1992). This later concept has been referred to by earlier writers and researchers as gender schema. Bem (1981a) used the term gender "schema", a schema being "…a cognitive structure, a network of associations that organises and guides an individual's perception" (p. 355). Her gender schema theory proposed that children internalised society's sex typing and linked preferences, attitudes, behaviours, and personal attributes to their own sex and ultimately to themselves. This supposedly developed "…an internalized

motivational factor that prompts the individual to regulate his or her behaviour so that it conforms to the culture's definition of maleness and femaleness" (p. 355). This is a similar view to that of Wolfe and Naimark (1991) mentioned previously.

It has been suggested that a person's gender schema, with a corresponding set of demands and expectations on behaviour, influences his or her well-being. Historically it was assumed that development of gender-typed behaviours and characteristics congruent with those considered appropriate and even dictated by society for each gender was essential for good mental health (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970). Women therefore needed to develop a feminine gender identity with self-acceptance being associated with acceptance of traditional feminine traits. It is evident from examples mentioned earlier, namely, Joan of Arch and Zelda Fitzgerald, that woman have been treated badly if they did not accept their traditional feminine role.

While it was traditionally believed that congruence between physical sex and gender schema was advantageous for the individual, in more recent decades research has proved this not to be the case for women. Androgynous individuals, having both masculine and feminine qualities, are often psychologically and physically healthier and less stressed than others (Bem, 1975; Shaw, 1982; Thornton, Leo, & Alberg, 1991). That this applies more to women rather than men suggests that it is the taking on of masculine characteristics that gives an advantage rather than the incorporation of feminine characteristics (Roos & Cohen, 1987). There are suggestions that psychologically feminine women have learnt to be more helpless than others, particularly androgynous women (Baucom & Danker-Brown, 1979, 1984). In a broader sense, it is possible that women who are androgynous have a more diverse repertoire of behaviours that are acceptable to them and are therefore more flexible in responding to a range of demands. This leads to them having a greater range of coping skills (Patterson & McCubbin, 1984). For a woman to be psychologically robust she needs to incorporate traditional masculine qualities into her sense of self. Masculine qualities of achievement and competency orientation as well as self-assertion, leadership, individualism, and dominance are valued more by society than feminine traits. The presence of these traits has also been shown to be positively related to self-acceptance in women. In contrast the feminine traits of nurturance involving self-sacrifice, compassion, understanding, and support of others are not related to self-acceptance (Long & Goldfarb, 2002).

In modern society conflicts can arise for women if their culture and context places expectations on them that differ from their self-defined expectations associated with their role as a woman. Conflicts could occur between their self-acceptance as a worker, which may require the adoption of traditionally masculine characteristics, and their self-acceptance as a woman particularly if in their gender definition they value traditional nurturing roles of wife and mother. That managerial and professional women as well as nurses, more so than clerical and blue-collar women, were more distressed and had poor self-acceptance if traditional gender-role demands were not meet (O'Kelly, 1999) can be explained by this conflict; the assumption being made that the workplace demands were not consistent with their gender-role expectations. A similar conflict was evident in Israeli Jewish women

living in a culture with strong historical and religious traditions with regard to gender role. Professional women juggling the workplace demands, with a view of self as the worker, and the personal demands, with a view of self as nurturer, also had poor self-acceptance in comparison to women from cultures that were more flexibly regarding gender role (Long & Goldfarb, 2002).

Culture and context therefore creates a complex picture with regard to self-acceptance for women. Lewin (1984) argues that women should develop their femininity and gender confidence based on personal and idiosyncratic views of themselves rather than stereotypical, societally dictated views. The transcendence of gender roles, characterised by the ability to perceive and express qualities as human rather than masculine or feminine (Rebecca, Hefner, & Oleshansky, 1976), would appear to free women from unhelpful gender-role conflicts and enhance their self-acceptance.

Conclusion

Self-acceptance in women undoubtedly has an impact on the lives of women. Historically it was considered to be in the best interest for a woman to develop a view of herself that internalised societal expectations for feminine behaviour and characteristics. Research, however, has shown that this is not a healthy view for women to take of themselves as the traditional passive behaviour of women predisposes them to poor mental health. On the contrary, to enhance their well-being, women need to develop a sense of self that accepts the inclusion of traditional masculine qualities.

While self-acceptance is not a panacea for women, self-acceptance has been shown to enhance resilience and hardiness in modern women. The research referred to in this chapter clearly shows that women with high self-acceptance manage better with juggling the complex multiple roles that many women now deal with as they pursue careers like their fathers yet bear and nurture children like their mothers. They are also better able to manage the abuse that is directed their way in male-dominated societies. It has been suggested that women benefit the most if they transcend gender self-acceptance and focus on self-acceptance as an individual.

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Self-Acceptance and Chronic Illness

Jennifer A. Gregg

Keywords Depression • Anxiety • Self • Self-concept • Functional contextualism • Hayes • Relational frame theory • Perspective taking • Mindfulness-based stress reduction • ACT

Diagnosis with a chronic medical condition can be an extraordinary stressor. As an individual adjusts to living with a chronic illness, often his or her understanding of self changes and evolves to include this new element. Psychologically this may present an intense challenge to adjustment, which may then impact how the illness is managed and perhaps the course of the disease itself. In this chapter, the concepts of self and self-acceptance within the context of chronic illness will be described. This description will be embedded in psychological, contextual science in order to examine the factors that contribute to self-acceptance in chronic illness, with an eye toward ways in which psychological interventions may improve functioning and self-acceptance in individuals with chronic disease.

Chronic Illness

Chronic diseases are defined as "illnesses that are prolonged, do not resolve spontaneously and are rarely cured completely" (Centers for Disease Control and Prevention (CDC), 2003). Currently the World Health Organization (WHO) reports that chronic medical conditions are the leading cause of global deaths, responsible

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for more deaths than all other causes combined. These illnesses, which encompass all non-communicable diseases but are primarily represented by cardiovascular disease, chronic respiratory diseases, diabetes, and cancer, are responsible for approximately 63 % of deaths worldwide (World Health Organization, 2010). These rates are predicted to rise as populations age and as lifestyle factors increase the incidence of these illnesses.

While mortality is an important factor in any analysis of illness, death is certainly not the only cost of chronic illness. Financial costs to treat chronic illnesses and loss of work related to chronic illness impact the global economy tremendously, and the psychological costs to individuals who live with chronic illnesses are incalculable. Before embarking on an analysis of self-acceptance in the context of chronic illness, it is useful to consider the psychological factors and mechanisms present.

Psychological Factors and Chronic Disease

In order to understand the psychological impact of a chronic disease, we must consider the pathways through which psychological functioning can impact, and be impacted by, specific illnesses. Studies have long demonstrated a high degree of impairment and distress experienced by many individuals following a diagnosis with a chronic medical condition (e.g., Michael, Kawachi, Berkman, Holmes, & Colditz, 2000; Wells, Golding, & Burnam, 1988) More recent studies have shown that this relationship may exist in both directions; chronic illness may impact the severity and course of psychological symptoms, and psychological symptoms may affect health outcomes among those diagnosed with chronic illness.

For example, in a review of studies conducted with individuals already diagnosed with cardiac diseases, an increase in disease morbidity and mortality was associated with even minimally elevated depressive symptoms (Frasure-Smith & Lespérance, 2005). Additionally, Todaro, Shen, Niaura, Spiro, and Ward (2003) reported that depression and anxiety symptoms predicted the development of heart disease, even when controlling for metabolic and central nervous system variables. A depression diagnosis has been associated with lower glycemic control and more complications in individuals with diabetes, as well (Lustman et al., 2000). Not surprisingly, medical care costs are estimated to be up to 50 % higher for individuals with chronic medical conditions when depressive symptoms are also present (Katon, 2003).

Psychological adjustment to chronic disease may be impacted by many factors, such as disease severity, functional impairment, degree of self-management involved, disease prognosis, and even the level of symptoms experienced, and it should be noted that there is a high level of heterogeneity among individuals with chronic illness along these dimensions as well as in adjustment (Stanton, Revenson, & Tennen, 2007).

Behavioral Mechanisms

One mechanism through which psychological factors impact chronic illness relates to the behavioral management required by many chronic diseases. These lifestyle behaviors constitute an area where psychological and behavioral functioning may directly improve or worsen physical health. For instance, health behaviors such as eating a healthful diet, exercising, and getting adequate sleep all may impact physical disease processes for disorders ranging from heart disease to chronic pain. The burden of self-management behaviors varies by disease, but often requires responsibility for day-to-day management to be carried about by the patient.

Take for example the case of the individual diagnosed with diabetes. Diabetes Mellitus requires a large degree of self-management to be carried out by the patient outside of direct medical intervention. This self-care is difficult to adequately adhere to and requires patients to maintain a high level of motivation over a long period of time. Specifically, the average day for an individual with type 2 diabetes involves the administration of oral medications and/or injected insulin, careful attention to diet and carbohydrate intake, regular exercise and weight loss where advised, management of stress response, adequate sleep, consistent checking of eyes, feet, and other body parts that may be susceptible to impairment, and regular doctor visits. All of this must be performed daily, frequently within a context of fear, stigma, frustration, and longstanding patterns of behavior that differ significantly from these requirements. Not surprisingly, these self-management behaviors are often not implemented consistently, and adherence to medical recommendations does not seem to be as related to a lack of knowledge of how to take care of one's diabetes, but rather to psychological factors such as motivation, denial, avoidance, and fear (Norris, Engelgau, & Narayan, 2001; Peyrot & McMurry, 1985).

Biological Mechanisms

Another mechanism through which psychological factors may impact chronic illness involves the more direct impact of stress on these processes. Although there is much that we do not yet know about stress and its biological impact on the body, there are clear relationships between the experience of chronic high stress and many chronic diseases. If we take the example of diabetes above, there are also physical mechanisms through which psychological factors such as stress may play a role. For instance, when an individual encounters a stressor in the environment a biological chain of events is started through which a signal is sent from the hypothalamus in the brain to the pituitary gland, to the adrenal gland, where a corticosteroid is released into the bloodstream. This neuroendocrine response allows for increased glucose to enter the bloodstream, providing energy for possible increased demands on the body produced by the stressor. A mechanism is built in to this system to "turn off" the process when the stressor is removed. However, in the case of chronic

stress, this feedback loop may not function properly. If the stressor is the demands placed on the individual by a diabetes diagnosis, the stress response is chronically engaged, providing for excess glucose availability, thereby potentially increasing the potential for excessive glucose and diabetes-related complications. This, then, creates a new stressor for the individual.

Whatever the mechanism, it is clear that psychological factors impact chronic illnesses and adjustment is related not only to physical features of the disease but psychological elements such as lifestyle behaviors and stress as well. The concepts of self and self-acceptance are inextricably tied to our experience of our health and vitality and these factors are, in turn, greatly impacted by psychological factors.

A New Understanding of Self-Acceptance and Chronic Illness

Self-acceptance has been formally studied for decades, and is often defined as the evaluative element of the self-concept (Shepard, 1979). Other chapters in this volume will focus on a more detailed definition of self-acceptance than there is room for here, but in order to apply this construct to chronic illness, it is necessary to note that the concept of self entails many dimensions, including our physical health and functioning. Thus, when applying an evaluative eye toward our self-concept, disease and functioning are clearly implicated.

The diagnosis of a chronic illness can greatly impact how an individual views his or her life, self, and future. This impact has been called a "biographical disruption" (Bury, 1982), suggesting a connection between the meaning of the experience and the context in which it occurs. This meaning has been further defined by Bury (1988) as related to the consequences of the illness, as well as the significance of the illness and what it may mean for the long-term view of one's life.

There are two ways that self-acceptance as a construct is typically considered, and can be evaluated in the application to chronic illness. The first asserts that self-acceptance is the *outcome* of interest. In other words, self-acceptance may be the goal sought by individuals with chronic illnesses, regardless of illness characteristics. This would entail that although the chronic illness may not be curable, accepting oneself as an individual, or an individual with this illness, would be the higher order goal. Most existing studies that have examined the relationship between self-acceptance and chronic illness have relied on this more traditional understanding of self-acceptance as part of a larger construct of well-being. Notably, self-acceptance is a subscale of a well-known measure of psychological well-being (PWB; Ryff & Singer, 1996), indicating that it may be an element of PWB, and thus a goal in and of itself.

The second is that self-acceptance is the *process* of interest, and it serves as the pathway through which one might improve along some dimension. That dimension may be adjustment, functioning, or illness variables, but self-acceptance would provide for the improvement. Although these two pathways are the typical way of understanding the impact of self-acceptance on chronic illness, both have their

limitations. Below is a description of these limitations, along with a functional, contextual analysis that discusses self-acceptance as neither process nor outcome, but rather a by-product of living a vital, meaningful life.

Functional Contextualism

Functional contextualism is a branch of science that defines the goals of science as prediction and influence of behavior. From this point of view, causal mechanisms lie in the context of an individual, rather than in the individual. Thus, thoughts and feelings do not cause behavior, and behavior can be predicted and changed without needing to change internal mood, thoughts, or feelings.

Such an understanding may be particularly useful in understanding the psychological response to illness. Consider for example, the individual diagnosed with prostate cancer. When caught early, this type of cancer is often considered a treatable condition (Mettlin & Murphy, 1998). At diagnosis, however, patients often still respond with fear for their lives, as well as worry and anxiety about treatments, impairments in sexual functioning, side effects, and diminished evaluations of masculinity. All of these thoughts are aversive and highly self-related once the diagnosis has been "attached" to an individual.

Human beings behave remarkably consistently in the face of such negatively evaluated, self-related thoughts and feelings: we attempt to avoid them. This makes self-acceptance as either an outcome or process goal very difficult. Importantly, the *topography* of these behaviors may be quite distinctive. Some people do this through maladaptive means of abusing alcohol, shutting down, or neglecting to go to physician's appointments or follow recommendations. Others attempt to avoid it through more "adaptive" means, such as focusing on the positive, eating more healthfully and exercising to prevent more such news, or actively coping by seeking support or reassurance.

The *function* of these behaviors as avoidance, however, remains the same. Experiential avoidance has been defined as purposeful attempts to reduce or eliminate negative experiences, such as thoughts, feelings, urges, memories, and bodily sensations (Hayes, Strosahl, Follette, & Gifford, 1996). Experiential avoidance has been demonstrated in many studies to have harmful effects in contexts ranging from pain to anxiety disorders (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Not surprisingly, Roesch et al. (2005) conducted a meta-analysis of 33 studies (3,133 subjects) of men with prostate cancer and found that men who used avoidance coping reported lower mood and physical functioning.

In a study of symptomatic HIV + men who have sex with men (N = 211), Penedo et al. (2003) showed that use of avoidance coping strategies was related to higher levels of psychological distress, even when controlling for losses and HIV symptoms. Holland and Holahan (2003) demonstrated that avoidance coping strategies were negatively related to PWB in young, early-stage breast cancer survivors. In a study of individuals with Huntington's Disease, avoidance coping was a predictor for poorer overall well-being (Helder et al., 2002).

Particularly difficult, perhaps, is the avoidance of negatively evaluated thoughts and feelings about the self. If I have been diagnosed with heart disease, I may have many unwanted thoughts about myself such as, “I have this because I have allowed myself to become obese” “I deserve to have a heart attack” “I am going to die because of my weight” “everybody will know that I don’t take care of myself now” “everybody will think that I deserve this.” These thoughts, no matter how awful and unwanted, are not easily avoided. In fact, attempts at avoidance in such a context may actually create more negative self-evaluations rather than less.

Relational Frame Theory

In order to fully understand how experiential avoidance may function to increase rather than decrease psychological struggle, it is necessary to first describe how one comes to know oneself through this perspective. This entails a discussion of relational frame theory (RFT; Torneke, Hayes, & Barnes-Holme, 2010). A brief description here will allow for a clearer understanding of this relationship with chronic illness.

RFT is a psychological theory of the development of language and cognition in humans. Although RFT can be technically complex, the basic principles are quite simple. Essentially RFT asserts that relating objects, ideas, words, and situations together is what forms their meaning and definition in human language. This relating starts in infancy with one of the first and simplest relations being those between an object and its “name” as children are learning to speak. For example, a child learning English may learn that the sound “ball” is *the same as* the round object in front of them. From there, she may eventually learn that the written word “B-A-L-L” is *the same as* the sound “ball.”

Human beings learn this relating quickly and easily once we start, but it would still take a prohibitively long time to learn each and every relation there is to learn in the world directly. Luckily, a defining characteristic of this type of relating in humans is the ability to *derive* additional relations. In the example above, then, once the child had learned that “ball” is the same as the round object, and “B-A-L-L” is the same as “ball,” she could derive backwards that “ball” is the same as “B-A-L-L,” and that the round object is the same as “B-A-L-L,” even though these relations were never directly taught.

Importantly, this behavior of relating an object and its name is a behavior that is subject to the same principles of other types of behavior. Just like other types of behavior, relating is sensitive to the context. Within a context it can be reinforced or punished, thereby increasing or decreasing, respectively, the future probability of it occurring in the future. If a very small child says the word “ball” in the presence of a ball for the first time, often her parents will respond with excitement or enthusiasm. Not only has this increased the probability that she will say the word “ball” in the future in the presence of a ball, but also the behavior of relating things in this way likely has been strengthened as well.

Once relations of sameness have been learned in this naming context, other relations emerge. Opposite, bigger than, better than, and every variation one can generate begin at an early age. Relational networks develop, and the complexity of these relations become more and more elaborate as objects, ideas, and all of their functions transfer and transform though this derived relational responding. Often this responding is related to our sense of self. Merwin and Wilson (2010) found that an individual's ability to form and response to equivalence (or *the same as*) classes containing both self-referents and both positive and negative evaluation terms was influenced by that individual's preexisting verbal construction of self. In this study, individuals who had indicated high distress and low "self-esteem" had a more difficult time matching indicators of self (me, I) with positive stimuli and descriptions.

The ability to relate in this way is thought to be a distinctly human ability. Nonhuman animals cannot predict a future that they have not yet experienced and cannot therefore prepare and plan for contingencies the way humans can. However, humans can also compare their experience to an imagined past or future and evaluate it negatively as *worse than*, thus transforming the reinforcing properties of an event or experience without any change to the natural environment. RFT helps us understand why an individual who has watched a loved one die of a chronic illness, such as Huntington's Disease or Chronic Heart Failure, can feel terror as though the dying is occurring HERE-NOW upon being diagnosed with the same illness, and how it would be the case that following such a diagnosis the self would be *the same as* these frightening labels. It also then becomes more understandable why, in this circumstance, an individual might avoid doctor's appointments or other reminders of being ill.

Vahey, Barnes-Holmes, Barnes-Holmes, and Stewart (2010) used the Implicit Relational Assessment Procedure (IRAP), a method for assessing relational responding between groups of stimuli, to examine what they call implicit self-esteem. University students, convicted prisoners in a high security area, and convicted prisoners in a low security area responded to a series of relational tasks that paired the relation of "similar" and "opposite" to positive or negative target stimuli paired with "Participants Name" or "Not Participants Name." Half of the trials contained a contextual cue for "Consistent" and the other half were "Inconsistent." As predicted, students and prisoners in the lower security area demonstrated shorter latency during self-positive relations (Consistent) vs. self-negative relations (Inconsistent) compared to higher security prisoners. In other words, humans can find a way to create misery and a negative evaluation of self verbally, and attempts to avoid this content are futile, since relational networks cannot be intentionally subtracted from even in the direst of circumstances.

Perspective Taking

It is through this network of relations that one knows oneself from a functional contextualistic perspective. Within this context, self can be defined as "verbal responding

to one's own responding" (for a book-length treatment of the self and perspective taking, see McHugh & Stewart, 2012, quote p. 24). The term "verbal" here refers to the process of relating described above. As relational networks become more and more complex and more types of relations are added, it is easy to see how a child would come to "know herself" in this context. For example, it is through this relating that a child may "know" that she is *bigger than* a sibling or *worse than* other children in the context of learning to read. She may learn that a child who eats all of their dinner is *better than* a child who does not, and then quickly derive that she is therefore not better than (or is *worse than*) other children when she does not eat.

Among the relations that establish early in this network of responding is a set of relations called "deictic frames." Key within these are the relations of I-YOU, HERE-THERE, and NOW-THEN. Obviously the relation of I-YOU is important in the development of verbal self-knowledge. As children are learning to relate, those around them are constantly asking them questions to develop these relations: "Where are YOU now?" "What are YOU doing (THERE)?" "What did YOU do (THEN)?". These questions, and the answers generated, develop the relational networks of these frames. This forms the basis for perspective taking: "what did YOU THERE do THEN?"

The ability to take multiple perspectives on the self relates directly to the deictic frames described above (McHugh & Stewart, 2012). Importantly, the first-person perspective we experience as we look out into the world from our eyes is always from the HERE-NOW perspective—it is not possible to see the world in the present from a THERE-THEN perspective. However, your psychological content (your thoughts, feelings, beliefs, etc.) can be located HERE-NOW or THERE-THEN.

Senses of Self

From this perspective of HERE/NOW and THERE/THEN, there are multiple senses of self that emerge. When considering the self it is helpful to conceptualize the multiple ways of identifying and connecting with the self that humans utilize. Three of these that have traditionally been described in a functional contextualistic model are: self as content, self as process, and self-as-context (McHugh & Stewart, 2012).

Self-a-content. One characteristic of the way in which language develops in humans is the ability to categorize ourselves based on the direct and derived relationships. These categorizations are rooted in the complex relational networks generated of our thoughts, feelings, evaluation, comparisons, and understandings of our preferences, abilities, and weaknesses. Take for instance, the thought/belief/evaluation that "I am a good listener." This conceptualization of self provides a quick shortcut when understanding the self and can be a powerful regulator of behavior as one seeks to remain coherent with such a categorization.

This conceptualized self occurs as a description of something that occurred THERE/THEN as being a HERE/NOW without the touchstone of the ongoing

present moment. It typically lacks multiple perspectives and functions as a rigid rule to follow. Consider the example of an individual with chronic pain who evaluates that, "I am a person who doesn't exercise because of my back pain." Understanding oneself this way greatly reduces the likelihood of engagement in exercise behavior, and differs dramatically from the ongoing noticing that one doesn't like to exercise. Additionally, it describes an understanding of oneself based on past experiences (THERE/THEN) as though they are stable, important, and immutable in the present (HERE/NOW).

Self-as-process. Self as Process refers to the verbal self-knowledge of thoughts, feelings, bodily sensations, and other experiences we have throughout the day as they occur. Also called "the knowing self" or sometimes "self-awareness," this aspect of the self is key in mindfulness traditions and allows an individual to "know" what they are experiencing in the present moment. The ability to be aware of and label psychological internal experiences not only gives individuals the ability to predict and take care of their needs, but also allows others to respond effectively with regard to them.

Self-as-process is also important in the management of health-related behaviors. Take again the example of the individual with back pain. From a self-as-process perspective, he may notice, in an ongoing, HERE/NOW way that he *had the thought* that he did not want to exercise, or had a lack of interest or a sense of fear associated with exercise and hurting himself, without it becoming a defining characteristic. Importantly, he would not need to change the content (i.e., make himself like to exercise) in order to notice this, but rather would just have the self-awareness that this was his experience.

Self-as-context. Self-as-context refers to the observing self that notices not only the ongoing stress of experience, but also the fact that this is content to be noticed. This differs from self-as-process in that it entails an almost transcendental observation; noticing the noticing.

Self-as-context, or ongoing perspective taking, conceptualizes the self as the part of our experience that has an awareness not only of our perspective, but also that there are multiple perspectives not only of our verbal interactions or thoughts and experiences, but also of our experience of self. This perspective provides a high level of psychological flexibility. Take again the example of the individual with chronic pain who dislikes exercise. From a self-as-context perspective, he could not only notice that he was having the thought that he did not want to exercise, but could also notice that he was noticing that thought and *had the ability to move toward exercise with that dislike and fear*. Noticing the noticing allows for a range of behavioral momentum that is not governed by his private thoughts, feelings, or bodily sensations but rather by his higher intentions.

This concept of the "self as context" as a way of understanding self provides multiple advantages. First it reduces the need for an individual to avoid his or her own negative content. As noted above, experiential avoidance has been shown to produce increased difficulty across domains and problems, and generally interferes with the ability to cope with, and take care of, chronic illnesses. From this other

perspective, the need to eliminate negatively evaluated thoughts and feelings about self is reduced.

Second, it provides another element to the definition of self-acceptance described at the start of this chapter. Specifically, the term “self” does not apply to an entity or being as much as a perspective. Perspective taking or an observational stance allows for behavioral changes without corresponding changes in thoughts and feelings.

In order to illustrate this difference, consider again the example of the individual with chronic pain discussed above. A traditional approach to treatment may treat the pain, and also encourage the patient to have more positive thoughts and feelings about himself as a person and about exercise in order to engage in more exercise and improve overall mood and functioning. A functional contextualism perspective, on the other hand, would seek to untie the connection between self-evaluations and exercise/thoughts and feelings, whether they are positive or negative. From this approach a goal of therapy would not be increase self-acceptance, or increase self-acceptance in order to improve along some other dimension, but rather to increase perspective taking and allow the individual to mindfully notice negatively evaluated thoughts about him or herself while disconnecting those thoughts to behavioral action. This allows the flexibility for behavioral action to be generated in line with personal values, rather than elimination of thoughts and feelings. From there, self-acceptance would change naturally as a function of living a vital, more meaningful life, but this would not be the overt goal.

Facilitating Perspective Taking in Chronic Illness

In recent years there has been an increased attention to interventions and conceptualizations of human suffering that focus on the goal of mindful noticing of difficult content, rather than symptom reduction. Mindfulness- or acceptance-based approaches generally provide this focus, although specific interventions vary in the degree of focus on perspective taking or mindfulness. Below is a description of two interventions that seek to facilitate this approach: mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1990) and acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999). ACT has been generated from RFT and functional contextualism, while MBSR and other mindfulness-based traditions evolved from a spiritual tradition that was then applied in a medical setting. Although MBSR and ACT come from different roots, they have many of the same core principles.

Mindfulness Based Stress Reduction

MBSR was developed in the early 1980s at the University of Massachusetts Medical School by Jon Kabat-Zinn, and was originally started as a program to assist medically ill patients for whom medical intervention had not been successful. The program

administered to these patients was standardized, trained, and exported, and has now been delivered to thousands of people in countries around the world.

Mindfulness has been defined as the "self-regulation of attention so that it is maintained on immediate experience, thereby allowing for increased recognition of mental events in the present moment" and "adopting a particular orientation toward one's experience in the present moment, an orientation that is characterized by curiosity openness, and acceptance" (Bishop et al., 2004, p. 232). These two characteristics are key in MBSR; patients are taught to bring their attention to the present moment without evaluation through training in specific meditation techniques (Kabat-Zinn, 1990).

According to Baer, Smith, Hopkins, Krietemeyer, and Toney (2006), there are five main facets that, when combined, describe the process often referred to as mindfulness. These facets are: (1) observing, or the noticing of internal or external stimuli, (2) describing, or mentally labeling these stimuli to oneself, (3) acting with awareness, or attending to what one is doing, rather than acting absent-mindedly, (4) non-judging of inner experience, or refraining from negatively evaluating one's experience, and (5) non-reactivity to inner experience, or allowing one's thoughts and feelings to come and go without reaction. Mindful self-acceptance, then, refers to nonjudgmental stance with respect to the self in the past, present, and future regardless of positive or negative evaluation (Ryff & Singer, 1996).

This understanding of mindfulness, and MBSR specifically, have been studied in a variety of ways to explore the mechanism and outcome of mindfulness interventions. Problems including chronic pain, anxiety, heart disease, depression, cancer, as well as other, nonclinical groups have been studied, and recent reviews have demonstrated the efficacy of MBSR (Baer, 2003; Grossman, Niemann, Schmidt, & Walach, 2004).

In terms of medically related problems, Tapper, Shaw, Ilsley, Hill, and Moore (2008) examined the efficacy of a weight-loss intervention for women based on principles of mindfulness. Sixty-four participants were randomized to either four 2-h workshops or asked to continue their normal diets. Assessments at 6-months post-intervention indicated significant increases in physical activity for those in the mindfulness intervention compared to control participants. When participants who reported not utilizing the skills from the workshop were excluded ($n=7$), both physical activity and BMI were significantly different in the mindfulness group (in the desired direction) compared to the control group. In another study with chronic illness, Hesser, Westin, Hayes, and Andersson (2009) demonstrated that mindful noticing of tinnitus early in treatment (session 2) predicted improvements in tinnitus-related distress following treatment, even when existing improvement before session 2 was controlled for.

An important question with any intervention involves whether treatment gains are associated with the proposed mechanism of change. Carmody and Baer (2008) examined whether participation in MBSR led to changes in mindfulness across the five domains of the mindfulness described above, whether this increase in mindfulness is related to formal practice of mindfulness, and finally whether this increase in mindfulness mediates the relationship between practice and home practice. Results

indicated that changes in mindfulness were observed following mindfulness training, that increases in all facets of mindfulness except describing were related to increased time of home practice, and that increases in mindfulness mediated the relationship between meditation practice and improvement in psychological symptoms and perceived stress.

There is a clear relationship between the ability to mindfully notice one's thoughts and feelings without judgment and self-acceptance as it has been discussed in this chapter. In a study with college students, Jimenez, Niles, and Park (2010) found that higher levels of dispositional mindfulness were associated with higher levels of mood regulation expectancies, and higher levels of self-acceptance, which were then negatively related to depressive symptoms. Additionally, Cohen-Katz, Wiley, Capuano, Baker, and Shapiro (2005) demonstrated that an 8-week Mindfulness Based Stress Reduction program increased qualitative reports of self-acceptance by the fifth week of the program, in addition to self-awareness and self-care in a group of 25 nurses.

Acceptance and Commitment Therapy

ACT (Hayes et al., 1999) is an approach to human struggles that targets two processes: the acceptance of negative thoughts, feelings, urges, or bodily sensations and the clarification of and commitment toward values that are deeply meaningful to an individual. ACT, like MBSR, relies heavily on mindfulness as a pathway toward value-based living, and unlike many more tradition approaches, does not have the explicit goal of the reduction of symptoms. Importantly for the present discussion, ACT is an intervention rooted in functional contextualism that utilizes this understanding of self and perspective taking as a core element to facilitate mindfulness and meaningful behavior changes.

A key goal of ACT is to increase psychological flexibility (see Chap. 5). Psychological flexibility is the ability to make full contact with the present moment, including reactions to it, and persist or change behavior in relation to personal, chosen values. For example, if an individual who has recently been diagnosed with diabetes walks past a bakery and has the thought, "it's not fair that other people can have cake and I can't" and experiences corresponding feelings of sadness, pain, and loss, he or she may choose to go into the bakery and order a piece of cake in order to stop having these thoughts and feelings. A more psychologically flexible approach, on the other hand, would be for the individual to notice that he or she is having these thoughts and feelings, from the perspective of the present, and check to see what his or her values are in that moment and choose to go into the bakery or not based on those values rather than the control of negative thoughts and feelings.

Key to the concept of psychological flexibility is the two, connected processes of noticing one's ongoing experience in the moment from a defused, nonjudgmental space, and noticing a sense of detachment or distinction between those experiences and oneself. In other words, moving between the state of self-as-process to

self-as-context (Foody, Barnes-Holmes, & Barnes-Holmes, 2012). The goal is to operate from a space of transcendent noticing, and moving between that and experiencing, in order to be noticing the experiencing as well.

The efficacy of ACT as an intervention has been investigated across a range of disorders. Efficacy has been demonstrated in dozens of randomized controlled trials to date, although ACT is still a somewhat new treatment approach. In a recent meta-analysis of ACT studies, Powers, Zum Vörde Sive Vörding, and Emmelkamp (2009) reported significant effect sizes for ACT comparisons against wait-list controls and treatment-as-usual groups.

In an early randomized controlled trial relating to chronic illness, Dahl, Wilson, and Nilsson (2004) examined the efficacy of a brief ACT intervention for the prevention of sick-leave taking among public health employees in Sweden. They found that after a brief intervention utilizing this approach participants used significantly less sick leave and had significantly lower medical utilization than participants in the treatment-as-usual condition. More recently, Lundgren, Dahl, Melin, and Kies (2006) evaluated the effects of a brief ACT intervention combined with seizure management training significantly reduced seizure frequency, duration, and quality of life compared to supportive therapy. Importantly, this study demonstrated a change in seizure frequency from a baseline of nearly four seizures per month to less than one seizure per month from posttreatment through 1-year follow-up, and no change at all in seizure frequency over that time in the supportive therapy condition.

ACT has also been applied to areas focused on metabolic and weight-related problems as well. Lillis, Hayes, Bunting, and Masuda (2009) examined the effectiveness of an acceptance-based intervention with 84 obese individuals who had completed a weight-loss program. Results indicated that 3 months after a 1-day workshop incorporating principles of acceptance and values clarification, participants had significant reductions in stigma, weight, and other negative effects of obesity than individuals who had not participated in the workshop. This is significant given that the intervention itself did not target weight loss, but rather targeted the mindful noticing of distressing thoughts and feelings about obesity, as well as self-stigma. Forman, Butryn, Hoffman, and Herbert (2009) found that in an open trial of an acceptance-based intervention for weight loss for obese and overweight women ($n=29$), weight loss averaged 6.6 % of overall body weight for those who completed the treatment ($n=19$) and nearly 10 % at 6-month follow-up ($n=14$). In diabetes, similar results have been found, with significant changes in self-management behaviors and glycemic control 3 months after a 1-day ACT group compared to education alone (Gregg, Callaghan, Hayes, & Glenn-Lawson, 2007). In all, both MBSR and ACT, as well as other acceptance- and mindfulness-based approaches to chronic illness, provide a new framework for understanding these problems from a perspective other than that of symptom reduction. This is crucial in this area, since often the reduction or elimination of symptoms is not possible in chronic disease, and attempts to negate the psychological effects of these problems may instead exacerbate them.

Conclusion

Self-acceptance in the area of chronic illness is a complicated domain. Being ill with a disease or disorder that is long term by its nature requires a high degree of psychological resources, and often the ability to cope with these illnesses impacts not only quality of life, but also the illness itself. From a functional contextualistic framework we form an infrastructure of how the sense of self develops, and how this sense of self contributes to both the ability to accept oneself fully and without judgment and the ability to exacerbate suffering. New interventions developed to address this dilemma provide hope for moving forward a meaningful life with chronic illness.

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Self-Acceptance and Aging: Using Self-Acceptance as a Mediator of Change in CBT with Older People

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Keywords CBT • Emotional regulation • Negative age stereotype • Dryden • Albert Ellis • Unconditional self-acceptance • Kindness • Neff • Compassion-focused therapy • Mindfulness • Depression • Anxiety • Self-depreciation • Wisdom • Positive emotions • Resilience

In this chapter, a brief overview of the current demographic transition facing the world is provided so that readers can appreciate a contemporary account of aging. As this chapter is written to appeal to clinicians and researchers who may not feel 'expert' in working with older people, a brief outline of the prevalence of depression in later life and the efficacy literature for cognitive behaviour therapy (CBT) in late life depression as well as a brief consideration of CBT as a treatment option for older people is provided as context for what follows.

This review provides the basis for an examination of the utility of promoting compassionate self-acceptance (CSA) as a clinical aim in working with older people. Perhaps, self-acceptance may be thought of as an outcome of emotional growth and development over the lifespan in the respect that emotion regulation competence appears to increase as a person ages (Urry & Gross, 2010). Thus, increased emotion regulation is likely to entail developing a more positive constructive self-view. Enhanced skill in emotion regulation can develop for either dealing with emotionally challenging scenarios or in managing emotional distress proactively. Rather than older people being more expert at regulating emotion following events, older people appear to be skilled at anticipating and, therefore, avoiding emotionally negative situations (Scheibe & Carstensen, 2010). However, experience and managing to deal with situations over a lifespan must play a role too. 'There is no doubt that experience plays a central role in improvements in emotion regulation across the

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life course, and every reason to think that experience is largely beneficial' (Cartensen, Fung, & Charles, 2003, p. 108).

Increased competence in emotion regulation may flow from changes in values where older people selectively optimise the present moment rather than focusing on the future, consistent with the theory of socioemotional selectivity theory (SST: Cartensen, Isaacowitz, & Charles, 1999). As people age, the perceived finite boundary to their lifespan results in changes to values so that people preferentially invest in more emotionally meaningful goals that results in better emotional balance and the achievement of intimacy with a few valued others (Cartensen et al.). In addition, older people prefer to focus on positive emotions rather than negative emotions.

As SST suggests, there is rich emotional development in later life. Change and growth are possible at any age and this must be an important core value for therapists working with older people. To therapists unused to working with older people, they may fear older people to be rigid and less able to flexible in achieving change. This is most likely to be a myth or a negative age stereotype not necessarily born out in psychotherapeutic work with older clients. As Knight (2006, p. 24) notes, 'The more traditional, largely pessimistic, view has been that adult development and increased experience make people rigid and set in their ways. Yet some clinicians working with the elderly have felt that the effect is quite the reverse: that growth and experience teaches adults to be more flexible, less dogmatic, and more aware that there are different ways of looking at life'.

Considering CSA within a CBT framework when working with older people with depression and anxiety may be most important when problems are chronic or complex or when the individual may be considered to have treatment-resistant depression or anxiety.[1]

Compassionate Self-Acceptance

CSA attempts to integrate two separate but linked concepts; compassion and self-acceptance. Dryden (2013) in this volume provides a very precise and helpful definition of unconditional self-acceptance based on the work of Albert Ellis that is adopted in this chapter. Unconditional self-acceptance is a stance that a person adopts towards oneself as complex and unique yet fallible and flawed individual; however, there is no rating or value judgement made about oneself, indeed there is a very strong absence of self-judgement. The acceptance of oneself is very simply unconditional.

[1]Treatment resistant anxiety and depression is difficult to define as there is limited consensus on agreed definitions but may encompass clients who have failed to respond to different first line treatments such as psychological therapy and medication (Lannouette & Stein, 2010). Other approaches consider such factors as age of onset of problems, comorbidity, illness severity and chronicity as indices of treatment resistance (Kornstein & Schneider, 2001).

There is a lot of overlap between the concepts of self-acceptance and self-compassion. This author presents clinical work here that is sympathetic to the work presented by Dryden where self-compassion and unconditional self-acceptance are integrated in order to make them a richer therapeutic change agent. CSA incorporates the tenets of unconditional self-acceptance and integrates two aspects of self-compassion; namely kindness towards oneself and an appreciation of common humanity, in that '…being human means being flawed and imperfect and learning from one's mistakes' (Neff & Vonk, 2009, p. 26). This latter element incorporates self-acceptance where the self is accepted as complex, unique but flawed. The third aspect of self-compassion (Neff & Vonk) is an emphasis on mindful approach to thoughts. While this is intriguing and likely helpful, the non-judgemental stance of self-acceptance seems more pragmatically helpful in integrating within CBT. In working with a clinical population the acknowledgement of the reality of the situations facing individuals maintains an active focus on symptom reduction.

There is some limited overlap with the work of Gilbert (2009) in his development of compassion-focused therapy in that there is an explicit focus on helping clients treat themselves more compassionately in moments of distress; however, the elements of mindfulness are de-emphasised in the approach outlined here.

The concept of CSA is enacted in therapy using the following assumptions.

1. The client comes to accept that being harsh and critical towards themselves in times of stress or distress is unlikely to be helpful in how they emotionally and practically cope at that time.
2. The client recognises that automatically/instinctively they are compassionate towards others when they are dealing with difficult or upsetting situations, and judgement/comparisons are also unhelpful and undermining in many cases.
3. The client starts to apprehend or appreciate the reality of the situation they are dealing with and that they may not be a right or obvious correct decision to make.

Thus, CSA is an integration of self-compassion and self-acceptance and uses each to promote symptom change and positive psychological growth.

Demographic Change and the New Experience of Aging

If not already, we will very soon, be faced with an entirely new cohort of older people with different values, needs and expectations that challenge persistent age stereotypes (Cuddy, Norton, & Fiske, 2005), characterising older people as warm but low on competence. Global population aging witnessed today is unprecedented in the whole of human history (UN, 2011). In the UK, life expectancy at birth is increasing so that by 2011 it had reached its highest ever level in the UK with life expectancy of 82.1 years for a female child born today and 78.1 for a male child born today (Source: Office of National Statistics—ONS, 2011). Life expectancy at age 75 is now approximately 11–12 years. Older people may experience their aging significantly different from that of their parents and especially their grandparents.

In the developed and developing world increasing longevity is a phenomenon (Kinsella & Wan, 2009). To illustrate this, consider that in 2012 there were 810 million people aged 60 years or older, but by 2050 there will be two billion older people alive representing 22 % of the global population UN (2011). This equates to two people celebrating their 60th birthday every second around the globe UN (2011).

It is the oldest-old section of society that evidences the largest relative population growth with global projections estimating a percentage increase in numbers of people aged 85 plus of 301 % between 2005 and 2040, whereas for those aged 100 plus, a percentage increase of 746 % is estimated, over the same time period (Kinsella & Wan, 2009). In 1950, 1 % of the population were aged 80 years and above, but by 2050 8 % of the global population will be aged 80 years plus.

A consequence of this demographic change is that many more psychotherapists are going to come in contact with older people seeking help, and in all probability the issues older people bring into therapy will change as longevity increases (Laidlaw & Pachana, 2009). Therapists must be prepared to embrace the psychological needs of a 'greying society' with therapists knowledgeable about longevity statistics and demographic change arguably better equipped to see the benefits of working with people who may have more life years experience in comparison to their therapists. Engaging effectively with older people entails identifying and challenging *erroneous* age-related negative cognitions (e.g. growing older is depressing) that may seem understandable and factual to people who are depressed or realistic to therapists inexperienced in working with older people (Laidlaw & McAlpine, 2008).

Prevalence of Depression in Later Life

Depression in later life is a major public health issue as it is linked with increased morbidity, mortality and reduced quality of life (Fiske, Wetherell, & Gatz, 2009). Depression and anxiety are major causes of mental health problems in later life, but rates of depression and anxiety in later life may be lower than rates reported for younger or middle-aged adults (Blazer, 2010; Jorm, 2000).

In a systematic review of community-based studies assessing prevalence of late life depression, Beekman et al. (1999) calculated an average prevalence rate of 13.5 % for clinically relevant depression symptoms. More recently, McDougall et al. (2007) reported findings from a large epidemiological study looking at the prevalence of depression in people aged 65 years and older from across England and Wales and estimated depression prevalence among older people to be 8.7 %, with a prevalence rate for severe depression of 2.7 %.

Recent evidence suggests that while anxiety disorders in later life may be very common (Bryant et al., 2008) and disabling, nevertheless anxiety symptoms remain neglected and under-treated in primary care (Vink et al., 2008).

While medical illness may increase rates of depression in later life, with a greater burden of illness resulting in an increased risk of depression the majority of older people who develop physical problems do not develop depression (Blazer, 2010).

Nevertheless medical illnesses complicate the recognition and treatment of depression and anxiety Charlson & Peterson (2002).

Depression is also increased in the presence of cognitive impairment and dementia with a consequent impact on treatment responsiveness (Wilkins et al., 2010). While rates of major depression in later life may be relatively low, subsyndromal or 'subclinical' depression (subclinical depression is the presence of significant symptoms of depression that don't fully meet DSM criteria for major depression) prevalence is much higher in older people Lyness (2008). As subsyndromal or subclinical depression can become chronic, it is likely to have an adverse impact on the quality of life and relationships in the older person's life. Lyness (2008) notes a strong association of increased mortality in older people with subclinical depression and the naturalistic outcome is poor for subclinical/subsyndromal depression on its own (Lyness, 2008).

Efficacy of Psychosocial Treatments for Late Life Anxiety and Depression

The overall conclusion about psychotherapy with older people is that there is good evidence that psychotherapy is effective for depression and anxiety (Pinquart, Duberstein, & Lyness, 2007) although the literature on psychotherapy outcome with the oldest-old is insufficient. The most systematically evaluated psychological therapy with older people is CBT and consensus from outcome studies, systematic reviews and meta-analyses concludes that CBT is an efficacious treatment for late life anxiety and depression (Hendriks, Oude Voshaar, Keijsers, Hoogduin, & van Balkom, 2008; Wilson, Mottram, & Vassilas, 2008). Recent randomised controlled trials (RCT) in the UK also attest to the efficacy of CBT for late life depression in primary care settings (Laidlaw et al., 2008; Serfaty et al., 2009).

Treatment efficacy for more chronic presentations of depression and anxiety, however, may report poorer outcomes. Conditions such as anxiety may follow a chronic course and although CBT may be efficacious for this condition in the short term, at longer term follow-up there may be further episodes of relapse (Durham et al., 2005). Depression and anxiety frequently overlap and usually a mixed presentation will also result in poorer treatment prognosis (Diefenbach & Goethe, 2006). Generalised anxiety disorder (GAD) frequently co-exists with depression but whereas depression may have a recurrent course, GAD may present as a single chronic episode lasting years or even decades (Lenze et al., 2005). McCullough (2012) comments that people with chronic psychological conditions receive poor treatment and rarely receive the understanding and support they need. It may be especially important that this very vulnerable group of clinical patients receives a compassionate treatment approach.

CSA may be a fundamentally important clinical aim in CBT in that a person may not be able to contemplate the possibilities for meaningful change unless they start to work towards unconditional self-acceptance of themselves. This is a developing

clinical idea, but put more simply, unless a person can start to accept that they are as human and flawed as all of us, but that they also have strengths and positive attributes, then a person may become focused on a deficit position, and that negates growth and possibility for change.

CBT with Older People

CBT is particularly appropriate as an intervention for older adults because it is skills enhancing, present-oriented, problem-focussed, straightforward to use and effective. It is an active, directive, time-limited and structured treatment approach whose primary aim is symptom reduction (Laidlaw, Thompson, Siskin-Dick, & Gallagher-Thompson, 2003).

Cognition–emotion interactions are important for understanding how it is that people find experiences or situations personally troubling or challenging. Behaviour is equally important as actions based upon erroneous negative mood-congruent cognitions may maintain, and in many cases, amplify the individual's problems or difficulties. It is seen often in people with depression who become overwhelmed by demands that feel they cannot meet. The negative cognition may be that the person is unable to cope. This generates affect that either decreases a person's mood or increases their anxiety level or both. In a depressed or anxious state, a person may act in ways that can cause them further difficulties.

An example of this is Archie aged 82, who experiences medically unexplained pains in his legs. He has had multiple consultations and examinations but no cause has been identified. Archie is convinced that he will end up in a wheelchair. This negative cognition is plausible and compelling to him and generates a great deal of affect. He becomes sad at the prospect but also anxious as he lives in a large home alone. At the height of his anxiety he was convinced that he needed to sell his house. This action may be justified but it was made at the very peak of anxiety and he looked for a quick fix. If he had sold his house and moved into a small managed apartment some way from his current house, this would have had potential consequences for Archie. He would become remote from his neighbours and he would lose having room for all his personal possessions, and there was no guarantee that this would improve his overall situation, nor whether it was required at that moment. Some months later, Archie, whose leg pains seemed to have neither worsened nor improved, significantly expressed relief at not having acted when he was anxious. Therefore, the nature of a person's difficulty can be determined through an analysis of their behavioural responses. Archie was able to see that worry and anxiety can be maintained or made worse by the way we respond to our anxiety and that sometimes no action is better when a person is having an anxiety attack. Thus helping clients to see their actions as understandable, but as (dis)stressed behaviours, may be necessary when evaluating behavioural and emotional responses.

When a person is in distress what they need is support and encouragement, not criticism. In analysing behaviour one can discern how the person treats themselves.

Do they adopt a kind, accepting approach or a hypercritical one? The utility of either approach can be examined in the session and appropriate homework tasks agreed.

The basic conceptual idea behind CBT is elegantly simple to grasp and is illustrated by the example of the stoic Epictetus who noted that people are disturbed not by things but by the views they take of things (Mansell & Taylor, 2012), in that a situation is neither good nor bad, but it is how a client perceives a situation or experience that determines its impact, it is in effect in the eye of the beholder. Likewise, the inferences and attributions that a person holds about themselves may not be entirely factual but be influenced by cognition-mood biases where depressed individuals have a specific pattern of selective biased processing of emotional stimuli such that it intensifies attention to negative stimuli and inability to disengage from negative stimuli that results in emotion dysregulation (Gotlib & Joormann, 2010). Hence, the inability to develop self-acceptance as a result of mood biased cognitive processing may become a primary contributor to depression.

CBT recognises the idiosyncratic nature of a client's problems, in a non-stigmatising way and individually tailors treatment so that the client and therapist experience a unique therapeutic exchange that is focused on achieving symptom-relief. The CBT practitioner asks questions using a specific 'Socratic' style and maintains the focus in sessions on a changeable 'here and now' timeframe. This can be very daunting for therapists working with older people whose psychiatric history may be longer than the individual therapist's lifespan, especially as the client may believe that the cause of their problems, based in the past are key to finding a resolution. More likely the way that people can be helped is to understand the past as contributory but not necessarily essential for 'cure' (Dryden, 2009); it is the maintenance of problems rather than the cause of problems that is the focus in CBT (Laidlaw & McAlpine, 2008).

CBT aims to be empowering of individuals and seeks to promote self-agency as it adopts a non-pathologising stance to understanding how a client's problems may have developed (Zeiss & Steffen, 1996). Empowering individuals to become their own agents of change suggests self-acceptance as an important outcome in CBT.

Self-Acceptance and Aging

Self-acceptance may become more potent as one develops the capacity for self-compassion (for differentiation of self-acceptance and self-compassion see Dryden, this volume). By developing CSA, perhaps, people can develop the competences they need in order to become resilient in the face of age-related and other life challenges.

There should be no illusion about the challenge of developing CSA in clients, including older people. As an example, Tom who is 70 years old becomes infuriated with himself when he perceives his memory to let him down. His emotional responses (anger, frustration) to perceived memory failings tend to overwhelm him

at a time when he is already distressed. This has increased his sense of incompetence and corroded his view of himself. In therapy when discussing his latest ‘failure’ he was asked whether he could try being more accepting of his memory difficulties and more compassionate towards himself so as to reduce his catastrophising. His response was: ‘Beating yourself up is a passive process. It’s so easy, you fall into that trap so easily. It’s such as bloody effort to be compassionate [to oneself] because it’s alien. It’s not a natural process. It’s a struggle [to be compassionate]’. After a short pause for reflection, Tom added ‘I have lost confidence in my own strengths’. Thus, when working with clients we ought to bear in mind that a goal in therapy may be enabling our clients to develop self-acceptance as a skill that enables them to become their own therapists. Clients need to develop a more realistic sense of their capabilities and possibilities within therapy if they are to maintain their within-session treatment gains, or even make further progress. Thus seeing CSA as a competence and a skill rather than as a personality trait means that it can be increased by learning and experience. Thus homework tasks based around selective actions specified in advance can be scheduled in order to develop self-acceptance over a number of trials. As a person becomes more self-accepting, the person may require to engage in therapy as he or she has started to become more effective in managing his or her own emotion regulation.

Depression and emotional distress is not an inevitable outcome of old age. As Blazer (2010) notes, the paradox of low relative rates of depression in the presence of challenges associated with age may be explained in terms of three protective factors associated with aging such as mature emotional regulation competence, increased wisdom (Baltes & Smith, 2008) and resilience. Older people cope better with stressful events as Blazer (2010) notes these are events experienced as being ‘on time’ (p. 172).

People tend to have some sort of normative timeframe for certain life events, and if these are ‘on time’ with cultural expectations, they may tend to manage these better. Hence an older person may cope with the death of a spouse better than is anticipated or expected. Echoing this, Sadavoy (2009) notes rates of depression are surprisingly uncommon when considering the challenges that can be posed by old age. When older people are asked about life satisfaction, they report high levels of life satisfaction. This apparent contradiction of high levels of life satisfaction at the stage of life most associated with cognitive and physical decline is termed the ‘aging paradox’ (Carstensen & Lockenhoff, 2003).

Empirical evidence suggests older people report better emotional stability and are apparently more competent in emotional regulation in comparison to adults of working age (Cartensen et al., 2011). As one may assume that self-acceptance and better emotion-regulation skill are complimentary, increasing self-acceptance as an outcome of aging may be a ‘cohort norm’ experienced by the majority of older people and a desirable outcome of longevity.

Perhaps non-depressed older people develop a natural relativism in their thinking in that they may not like the physical health changes as one ages, but compared with other peers who may develop more chronic limiting conditions or diseases like dementia, they may feel comparatively well off. Thus, when working with older

people, it is important that the therapist approaches the client with an open-mind about their attitudes and experience of aging. As older people may become more skilful in emotional regulation, this is an intriguing idea for anyone wishing to work therapeutically with this client group as it suggests *older people may make better candidates for psychological therapy*. In short as we age, our habitual ways of making sense of the world and how we have appraised how well we feel we have dealt with the challenges we have faced over our lifespan are likely to predict whether a person is self-accepting and self-compassionate.

Yet the 'cohort-norm' of increasing self-acceptance may not be the case for older people who report emotional problems such as depression and anxiety. Clearly there can be 'barriers' to self-acceptance. These 'barriers' may be symptomatic of conditions such as depression with a lack of CSA contributing to the maintenance of depressive affect. Poor self-acceptance may manifest as a negative and overgeneralised autobiographical memory in depression, or in shame attributions, or may be the consequence of a lifelong history of recurrent episodes of depression.

Compassion requires empathic awareness of suffering and a desire to alleviate this distress. This is how Neff (2012, p. 79) describes compassion, 'It entails feelings of kindness, care, and understanding for people who are in pain, so that the desire to ameliorate suffering naturally emerges. Finally compassion involves recognising the shared human condition, fragile and imperfect as it is'. Obviously self-compassion entails the same qualities except this time they are directed inward towards the self (Neff). Perhaps, kindness and understanding is easier to direct outwardly as it can make us feel virtuous as we act kindly and attentively towards our fellow man, but may feel indulgent and egotistical when directed at ourselves. Thus being compassionate to others may enhance our sense of well-being, doing the same for ourselves seems to provoke a number of possible negative mood states. Thus when working with clients who are depressed or anxious, a discussion about the advantages of self-acceptance has to be conducted in session prior to the scheduling of any homework tasks.

Case study: Jennifer is a 73-year-old retired widowed librarian who has a long history of contact with psychiatric services for anxiety and depression stretching back decades. She has been told by one of her doctors that her problems are linked to her personality, and this was unlikely to resolve. Her medications do not fully resolve her levels of distress, and she has experienced a recent trial of a number of different medications to try to improve her functioning. She lives alone and when her mood is low she calls the Samaritans helpline and may do so up to 5–7 times per week. The more that she does this, the worse she feels about herself in that she experiences shame and a reinforcement of her self of helplessness. Jennifer presented with combination of anxiety and depression symptoms. Diefenbach and Goethe (2006) note that this may result in poorer treatment prognosis and there is a lack of psychological treatment trials of mixed anxiety and depression in later life.

In early sessions with her therapist, Jennifer stated, 'During my life when things have gone wrong, instead of addressing them I've turned to help from others'. And 'What a mess I make of my life. I make these decisions and I can't cope with them'.

These statements lack acceptance and compassion and perhaps contribute to her sense that she is unable to cope with distressing emotions by herself; hence the reason she will frequently call the helpline. Jennifer has a tendency to make negative self-comparisons, in that she often appraises her actions as deficient in comparison to how she believes others would cope. Her self-worth appears contingent upon external outcomes or social comparisons. As Neff and Vonk (2009) note, 'Although people typically value being kind and compassionate to others, they are often harsh and uncaring towards themselves (p. 26)'. This perfectly describes Jennifer and there was a great need to help her reframe her view of herself in a way that was self-accepting and compassionate. Over a short period of time, by asking herself, *what is a compassionate way to understand this situation*, Jennifer stopped calling the Samaritans and has maintained this change in her behaviour over a series of crises. Self-compassion reduces emotional reactivity and negativity (Neff & Vonk) and this may appear to explain the positive change in this single element of behaviour.

Jennifer tends to feel quite frustrated with herself meaning she puts herself down—she self-depreciates, and this has a consequent negative impact on her mood level. Her level of self-acceptance would appear to be markedly low. Having such a focus is manifestly self-defeating. By engaging in punitive self-rating, Jennifer never develops optimal coping strategies and she does not engage her problem-solving abilities, nor does she develop a sense of resilience to deal with future challenges. It is unsurprising, therefore, that she has an external locus of control when it comes to managing her problems as she has a view of herself as inadequate. As will be seen later, Jennifer is on the contrary a strong resilient individual who has overcome much adversity over her lifetime. Perhaps, one of the greatest tragedies when working with people with chronic histories of depression and anxiety is that people develop narratives of themselves as either 'cursed' or as 'failures' and yet these self-same individuals often have survived by coping with high levels of distress.

CSA seems an appropriate as a therapy aim for Jennifer given the chronic nature of her anxiety and depression history and the fact that evidence suggests self-compassionate individuals are able to moderate distress in difficult situations and may even be better able to self-soothe in negative situations. But most importantly, self-compassionate individuals are better able to accept responsibility for actions without inducing high levels of negative affect (Leary, Tate, Adams, Allan, & Hancock, 2007). By this mechanism, CSA may generate resilience and wisdom as individuals do not need to sign up to a view of themselves as excessively positive or unrealistically perfect (Neff & Vonk, 2009). Thus a realistic aim of accepting oneself as imperfect but 'a work in progress' (an example of self-acceptance) may be an optimal approach for Jennifer to adopt in order to afford change.

An important goal is for Jennifer to start to appreciate that by making judgmental ratings or comparisons she is on a rollercoaster of swinging emotions. In situations where she can say to herself she executed a task better than others may have done in distressing situations, she may experience short-term elevations in mood. For the short-term, she may feel good about herself by engaging in judgement and valuations based on external criteria. Helping people to become self-accepting is an important step in therapy as it means, in part, adopting the view 'I accept myself no

matter what' and it requires an individual to, as much as possible, elect to work consciously to not self-evaluate their individual worth based on their achievements, opinions of others and other external criteria (Bernard, *personal communication*). This is the work being undertaken by Jennifer in the final relapse-prevention stage of therapy.

Early on in the CBT sessions, Jennifer's therapist asked her to complete a timeline as part of a homework exercise early on in therapy. In CBT the idiosyncratic appraisal of the individual is data to be used in understanding how one makes sense of one's problems.

The timeline can be located on a vertical line that connects the client's birthdate at the start of the timeline with the current date at the end of the timeline, drawn as horizontal lines at either extreme end of the vertical 'timeline'. The therapist can ask the client to put all notable events from life on this 'timeline'. By employing this simple technique, the therapist gains an 'edited' and highly idiosyncratic summary of the high and low points of an individual's life. Bauer and McAdam (2004) note themes arising in an individual's personal narrative are likely to reflect the things that are personally meaningful and relevant to them.

When individuals are able to become self-forgiving, their attributions and emotions about themselves become less negative and more positive. 'Simply, self-forgiveness disinclines people to attribute negative qualities to the self' (Wohl, DeShea, & Wahkinney, 2008, p. 8). Intriguingly, Wohl et al. note that when people become more self-forgiving they think and act more constructively towards the self and the positive attributes are associated with less depression. Self-forgiveness entails accepting one's responsibility for one's actions and is associated with well-being. Wohl et al. further conjecture that self-forgiveness may be a catalyst for personal growth (p. 10). When reviewing a life using the timeline, there is often a need for self-forgiveness, a concept compatible with unconditional self-acceptance, and this may be associated with better emotional well-being. In a recent study Wohl et al. report a strong association between self-blame and depression. Thus, when using the timeline, reflection, rather than blame upon past events, is the main focus.

In line with work by Watkins, Baeyens & Read (2009), it is recommended that when reviewing negative events from the past on the timeline a concrete and specific focus is adopted so as to avoid a biased and overgeneralised negative bias in recall of past events. The therapist needs to remain focussed on how difficult experiences from the past can be reviewed for their utility in helping people.

It is in taking these elements from the timeline that wisdom gained from life's experiences (good and bad) can be put to good use. First, personal wisdom depends on learning from experience, but it is also evident in the execution of judgement in ambiguous situations (Sternberg, 2012). Personal wisdom is evident when one learns from experience and elements that are registering on an individual's personal timeline will be important and personally meaningful. In order to learn from previous experiences or situations in which there is a degree of shame or a perception of failure, the development of CSA seems an important prior step. Second, compassion and wisdom are interlinked (Siegel & Germer, 2012), thus developing one begets the other. Compassion and wisdom are not traits but skills that can be

developed and enhanced (Siegel & Germer) and as CBT is a skills-enhancing approach to managing distress, utilising CSA towards an outcome of increased personal wisdom would appear to be an appropriate target for therapy.

Wisdom can be enhanced by explicitly asking people to reflect on difficult life experiences in a structured way to see if they can identify anything good that may have come out of difficult experiences from the past and what they might use from this new learning to equip themselves better to deal with current difficulties. McAdam (2006) talks of individuals developing 'redemptive sequences' where a bad experience or event can be transformed into a growth experience by the individual.

From her timeline, it was evident Jennifer was not given a sense of herself as competent and loveable when growing up. Despite this, Jennifer married and had two children whom she has brought up in an atmosphere of unconditional love. Jennifer's husband died in midlife, leaving her to struggle to bring up her children alone, and she did this by going back to work and providing for them. In her 50s, Jennifer developed breast cancer and had a mastectomy. She has also experienced a number of other physical illnesses and in the main has had to cope for a large part of her adult life on her own.

The therapist worked with the timeline and helped Jennifer to challenge her cognitions about helplessness weakness and self-depreciation. It was evident that Jennifer was very empathic and accepting of other people. Using cognitive distancing, Jennifer was able to stand back and view her experiences as if through the lens of another viewer and started to develop a cognitive reframe of herself as a resilient survivor. Thus, a new frame of reference of 'survivor' was accepted by Jennifer when asked if she could apply the view she had for others to herself. This was a first step towards a more self-accepting and self-compassionate narrative.

Neff (2012) notes that sometimes self-compassion may be misunderstood as self-indulgent or self-pitying. As such, understanding and acceptance may not be as easy or feel as deserved when directed at ourselves. After recovering at home following a knee operation, Jennifer experienced a relapse in her anxiety and depression. Consequently, she stopped doing all the effective tasks she had been doing previously to manage her mood. She telephoned her therapist and tearfully exclaimed she had failed him and let him down. She was distraught and in crisis, her levels of shame were overwhelming. The therapist encouraged Jennifer to focus on what she could do in that moment to help herself feel better and between them a set of behavioural experiments were discussed to be completed as homework until they could meet for their next face-to-face session. Jennifer did her tasks and did it to good effect. At the next appointment, the therapist and Jennifer focussed on how it felt when she negatively self-evaluated herself for feeling unwell. Jennifer spoke out as she was concerned that 'taking it easy' on herself when she was struggling was likely to mean she would end up in a worst position. She said, 'I'm frightened that too much kindness would make me fold up' and 'Being too kind/soft could have damaged my resolve'.

This became the focus of a new homework task, to contrast the two ways of treating herself and to consider the emotional, cognitive and behavioural consequences of being hard, or being compassionate when she was in distress. Jennifer recovered

her equilibrium quite quickly and this was seen as a positive development. It showed that Jennifer was reducing her self-blaming behaviours and adopting a more CSA that meant she was able to focus on what she could say to herself that was more helpful to her in the moment. However a crisis engulfed her grand nephew, Conor. He had just started college in a town near to where Jennifer lived. This meant that Conor was living away from home for the first time in his life. He travelled home at the weekends. On a Friday evening, Jennifer was surprised to have a visit from a bedraggled, distraught Conor. He had got lost changing buses on his way home from college. Confused he didn't know where to turn except for his great Aunt (Jennifer). He was full of apologies for disturbing her and constantly berating himself for his perceived stupidity. Jennifer, took him in, was kind to him, empathic to his pain and distress and sought to ameliorate this. She did a very good job of being compassionate. When the therapist heard about this experience in the session he took the opportunity to address Jennifer's view about being kind was likely to mean people wouldn't learn from their mistakes, or that it was a mistake to be too kind as it would mean that people slide away further. The therapist role played a harsh response to Conor, Jennifer was able to see that this approach is cruel and unproductive and can only make things worse. Compassion rather than chastisement is the most useful approach to adopt here.

This is potentially important as an individual in distress makes sense of the world in an automatic rigidly-inflexible mood-congruent biased way via schemata (Gotlib & Joormann, 2010). They generate compelling idiosyncratically credible but punative self-lacerating views. These cognitions and schemata powerfully disconnect a person from a compassionate, understanding and accepting self-view. They castigate themselves for their perceived failings, develop guilt and shame for their acts of commission and acts of omission. Once an individual engages in negative appraisals, it can be hard for them to disconnect from negative processing (Gotlib & Joormann) and as such they may lose sight of a realistic view of themselves and ruminate rather than reflect upon a situation or stimuli. Quite literally the person may find it difficult to live with themselves.

CSA is seen as an important step towards increased personal wisdom and perhaps an enhanced ability to cope with further adversity as positive emotions may predict increased resilience (Cohn, Fredrickson, Brown, Mikels, & Conway, 2009). CSA may be especially important when working with chronically depressed and anxious older people as it allows them to change their internal idiosyncratic focus from a negative non-productive self-view to one that is more productive in addressing the realities of challenges facing them. In this case example with Jennifer, change is promoted in an individual who has experienced a long psychiatry history and in whom had developed a negative and hopeless self-view that mitigated against possibilities for change. While this new approach is not yet secure, it provides hope for further growth change and development.

A central tenet of this approach is that when a person is experiencing a difficult set of circumstances, or is in distress, being self-attacking and blaming is unlikely to be helpful or to bring about an improvement in any perceived shortcomings (Neff, 2012). What clients may find difficult to accept first is that by developing

CSA towards themselves when facing a crisis or difficult circumstances, it actually achieves what they assume can only be achieved by a focus on castigation, self-criticism and blame. The situation is more likely to be learned from as well as a better outcome achieved and with a lower propensity to repeat costly mistakes, if the person can become attuned to using CSA. By doing so, the individual can focus on the most optimal actions in a realistically difficult scenario. By focusing on what one can do and without self-judgement or blame, this keeps the individual focused on utilising best of themselves.

Despite the commonly held assumption correlating wisdom with age, wisdom is not an outcome of age, but personal wisdom may develop through recognising uncertainty, ambiguity and responding in as optimally effective way as possible as the prevailing circumstances dictate. Sternberg (2012) suggests that personal wisdom requires a desire on the part of the individual to change and to develop the skills inherent in personal wisdom, such as openness to experience, willingness to reflect and then learn or profit from experience. As older people experiencing emotional distress have a lifetime frame of reference, there are great opportunities and rich possibilities for people to use and profit from their life experiences. This will only develop if the therapist explicitly works with their clients to help them mine the richness of their life experiences and histories so as to use these insights to help people find more effective ways of coping with current difficulties.

Using wisdom of one's years is integrating all that one has learned about the world and about oneself and using that to its best advantage. Thus in the clinical domain, when working with older people, the relevance of self-acceptance and self-compassion may be to help people in emotional distress achieve better emotional regulation skills, reframing personal narratives of failure or ineptitude into a more helpful frame of reference of resilience or 'survivorship' in the face of challenges, so that people consequently achieve a better treatment outcome.

How has CSA helped Jennifer?

- Reduced the large fluctuations/lability in her mood and resulted in more stable approaches to managing to deal with challenging/anxiety-provoking situations.
- She is learning to self-soothe and deal with situations by herself.
- She has stopped externalising help seeking and no longer calls helplines.
- She recognises overcompensating and self-defeating behaviours when she experiences negative emotions such as shame. Shame and guilt are the results of self-judgements that usually are negative.
- She understands that being kind to herself is not taking it easy on herself or being positive, but it is adopting a realistic and more helpful way to manage difficult situations.
- Building a positive set of emotions about herself consistent with self-acceptance and self-forgiveness may result in increased resilience (Cohn et al., 2009) and this may reduce the need for Jennifer to stay in touch with psychiatric care.

By being more self-accepting and hence more compassionate towards herself she can accept even those aspects of herself that she needs to work on. She develops self-acceptance of herself unconditionally, warts and all.

Resilience is developed as Jennifer has developed an awareness of the personal stress/internal assets that she can utilise in the 'here and now' to help her better manage her current difficulties and problems. This in turn facilitates the development of personal wisdom in managing ambiguous and challenging situations. For a person socialised into a lifetime of therapy we hold out the possibility of growth and complete treatment discharge over a prolonged period.

Summary

This chapter has sought to introduce for CBT therapists a target of increasing CSA in work with older clients some of whom display long-standing problems. While this is most commonly accepted as part of Ellis' rational emotive behaviour therapy (e.g. Ellis, 1962), it is approached from a more Beckian (Beck, Rush, Shaw, & Emery, 1979) stance. In this approach, reduction of negative affect is a goal as is increasing positive affect within an individual. Change is possible at any age and promoting change when working with individuals whose problems have a chronicity and longevity is a challenging endeavour. Despite the emphasis on CSA, it is important to reiterate that standard techniques in CBT have been employed in the case example illustrated here. This remains important as the evidence suggests that CBT is an efficacious therapy. This chapter encourages therapists considering individually tailoring therapy sessions in CBT for older people by applying theory to practice. This is neither new nor revolutionary as Beck et al. emphasised that CBT is individualised to fit the client and approaches such as these outlined here help CBT to be a better fit for the needs of older people. As we work with increasingly different and new cohorts of older people, we need to emphasise change in managing anxiety and depression is not just about reducing negative affect but it is also about increasing positive affect.

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