

Comparison of the Effectiveness of Compassion-focused Therapy and Quality of Life Therapy on Self-Criticism and Psychopathological Symptoms in Patients with Major Depressive Disorder

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Abstract

Background and Objectives: The main feature of major depressive disorder (MDD) is mood swings (from minor disappointment to extreme despair) for several days, weeks, months, or even years. This study aimed to compare the effectiveness of compassion-focused therapy and quality of life (QOL) therapy on self-criticism and psychopathological symptoms in patients with MDD.

Materials and Methods: This quasi-experimental study was conducted based on a pre-test, post-test, and follow-up design with a control group. The subjects included 45 MDD patients admitted to the psychological advisory centers in Neyshabur, Iran who were selected using the convenience sampling method. The patients were randomly divided into three groups: the compassion-focused therapy (CFT) group, the QOL therapy group, and the control group. The members of the CFT group and QOL therapy received 8 and 10 therapy sessions, respectively, while the control group members were put on a waiting list. The research tools were a Self-Criticism Scale, Depression-Anxiety-Stress Scale, and Beck-Depression Inventory-II. The participants were tested before the therapeutic interventions, immediately after the sessions, and two-month after the last session. The data were analyzed using the variance analysis test by repetitive measurements in the SPSS Software (version 24).

Results: Based on the results, both therapies are effective in the reduction of self-criticism ($P < 0.001$) and psychopathological symptoms ($P < 0.001$); however, this effect was significantly higher in the CFT group, compared to the QOL therapy group ($P < 0.001$).

Conclusion: Given the biological and psychological infrastructure of MDD, using the QOL therapy and self-compassion approaches (in addition to medication) can be effective in reducing MDD symptoms.

Keywords: Depressive disorder, Psychopathology, Quality of life, Self-Assessment, Signs and symptoms

1. Introduction

One of the disorders of adulthood that has a significant effect on one's physiological-social life is major depressive disorder (MDD). According to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), depression disorder affects a wide spectrum of one's life. This disorder usually appears for the first time during late adolescence and early youth (16-20 years of age), peaks between 18 and 30 years of age, and affects all the aspects of one's personal and social life. Based on the findings of epidemiological studies, depression is the most common mental disorder. In total, up to 4% of the male and 8% of the female population of the world suffer from clinically significant depressive disorder, while depressive symptoms are much more common (1). Prevalence rate of depression in Iran is 6-10% of the population (2).

According to the formal definitions, depression is a disorder with relatively chronic mood swings as its main feature that can cause the patient to oscillate between minor disappointments and extreme despair. These mood swings

lead to certain changes in behaviors, attitudes, thoughts, efficiency, and physical acts (3). Depression is an emotional condition of constant grief varying from despondency and minor sadness to disappointment and extreme despair. These moods are usually accompanied by a lack of motivation, insomnia, anorexia, and problems in concentration and decision-making abilities (4).

Given the dangerous structures of MDD, different approaches to depression have tried to provide various theoretical explanations for this disorder. Cognitive patterns of depression indicate that there are deficits and insufficiencies in the data processing abilities of the patients. Moreover, the level of creativity in such patients is low, and there are distortions in their cognitive procedures of data processing (5). Accordingly, it is believed that inefficient and negative thoughts are considered symptoms of depression (6) which are the result of primary incorrect perceptions (7). In this regard, Lazarus in 1996 described catastrophic consequences (8). Salcosix et al. in 2009 focused on identification and revision of negative

assessments of intrusive thoughts, prevention of the neutralization resulted from amenability-based assessment, increase of confrontation, and reduction of avoidance. In the latest cognitive list presented for depression, it is assumed that cognitive processes that damage assessment, including danger perception and personal responsibility assessment, can lead to neutralizing and depressing behaviors after negative thoughts (9).

Besides cognitive approaches, some approaches have paid attention to biological aspects (10), emotional and cognitive turmoil (11), and the social aspects of these behaviors (12). However, it seems that none of these theories can provide an appropriate and comprehensive explanation that would reduce the pathological symptoms of depression. Therefore, study and research on related and affective variables involved in the formation and evolution of this phenomenon are of high interest among the experts (3).

According to the previous research and investigations, the psychological status of patients with depression is affected by their attitude towards themselves, their assessment of themselves, and, more specifically, the amount and quality of their self-criticism (13). Acceptance of oneself and expression of compassion towards oneself are usually defined as self-kindness and self-forgiveness that can lead to self-esteem and self-evaluation (14). Previous studies have shown that self-criticism usually is conducted in a way that results in humiliation and depression (15). Therefore, psychological therapies used for patients with depression must pay attention to the self-criticism construct.

According to the self-compassion theory proposed by Gilbert (16), strict self-assessment or self-criticism is one of the most important psychological processes that affect the persistence and recurrence of psychopathological symptoms, including depression (4, 14, 17, 18). The theoretical model presented by Gilbert (16) collects and merges these findings and explains how psychological interventions can lead to the recovery of a patient from psychological symptoms by increasing self-compassion. According to this integrated viewpoint, Gilbert (16) believes that psychological problems occur and persist through deficiencies in the way people treat themselves.

These processes can vary based on the given intrapersonal or interpersonal nature of the outcomes of the psychological problems, as well as the negative or positive attitudes of people towards themselves. Therefore, psychological problems can be persistent due to the negative viewpoint of the patients towards themselves (14). Gilbert (16) presents a CFT approach given the pathological model provided by compassion theory. This approach tries to regulate the viewpoints of patients towards themselves and reduce the fear of compassion through the increase of self-compassion (13, 16).

Meta-analysis studies support the effectiveness of CFT. Kılıç et al. conducted a meta-analysis (19) and investigated different variables that play a functional role in the treatment of health-related problems in several studies. They reported that CFT possesses the highest justifiability regarding the prediction of the reduction of symptoms and recovery from these behaviors in a functional way.

Another therapy pattern that has led to a significant

revolution in the treatment of psychological problems of patients with depression is the quality of life (QOL) therapy. It must be mentioned that QOL therapy is derived from positive psychology (20). The QOL therapy is a relatively new approach that includes an interconnected cohesion of cognitive therapy and positive psychology (20, 21) and is consistent with the latest form of the cognitive therapy of Beck (22) and the cognitive theory of depression and psychopathology (21). The QOL therapy consists of an approach that aims to increase life satisfaction. In this approach, life satisfaction is described as one's assessment of different aspects of their lives (23).

The QOL therapy has gained the most robust empirical support among the existing theories about environmental and attitudinal factors of depression (23). Significant role of the QOL and unpleasant emotions related to life satisfaction have been demonstrated to prolong the pathological symptoms of depression (24). As such, the effectiveness of the QOL therapy has been approved by the findings of self-report studies, ecological momentary assessments, and laboratory studies (20, 25). In previous studies, the satisfaction of life variable (a contribution of Frisch to the field) was able to significantly predict the psychopathological symptoms (24).

According to this information, it can be said that compassion therapy is based on the attitudes of people towards themselves and emphasizes self-image in therapeutic interventions (17). The QOL therapy affects the viewpoints of people towards their social lives and improves their living environments (20). Even though several studies have mentioned the importance of paying attention to self-criticism constructs and psychopathological symptoms in patients with depression, up to now, no effective research in Iran has compared the effects of compassion therapy and QOL therapy on these patients.

Given the above-mentioned factors, acknowledging the different impacts of these two approaches has significant implications in employing therapeutic interventions for the treatment of patients with depression. Therefore, the main objective of the present research was to compare the effectiveness of compassion-focused therapy (CFT) and QOL therapy on self-criticism and psychopathological symptoms in patients with depression.

2. Materials and Methods

The present quasi-experimental study (pre-test, post-test, and follow-up test with a control group). The statistical population included all MDD patients admitted to psychological clinics in Neyshabur, Iran from March to May 2019, 45 of whom were selected by convenience sampling method. They were randomly divided into three groups, including the CFT group (n=15), the QOL therapy group (n=15), and the control group (n=15).

The inclusion criteria were: 1) passage of at least one month from the MDD diagnosis, 2) diagnosis of depression based on the Beck Depression Inventory, 3) at least a middle school diploma, 4) achievement of high scores in Beck Depression Inventory, 5) residence in Neyshabur, 6) willingness to participate in the research, 7) lack of diagnosis with other psychological disorders, 8) age range of 19-50 years, and 9) lack of physical illness. It should be

mentioned that the patients did not consume psychotropic medications during the research.

The exclusion criteria were 1) absence for more than two therapy session, 2) diagnosis of acute psychological or physical illness during the interventions, 3) affliction

with clinical disorders according to the client file and the treatment team, 4) drug abuse, 5) reception of psychological or medical treatment during the research, and 6) affliction with disabling physical illness in a way that made the patient unable to participate in the sessions.

Table 1. Summary of the training sessions based on Gilbert self-compassion (16)

Session	Content
First	The pre-test was conducted. The therapist and group members were introduced to each other and spoke about the objective of the sessions as well as the general form of the sessions. The expectations of the first therapy session were discussed, and the members learned about the foundations of compassion-focused therapy and the difference between self-compassion and self-sorrow.
Second	Mindfulness was taught, and bodily check and breathing were practiced. The members learned about compassion-based brain systems, compassionate people, and compassion toward others. They learned how to be compassionate toward themselves, how to understand the fact that everybody has flaws or deficits, and how to avoid self-destructive emotions.
Third	The group was taught how to increase warmth and energy. They also learned about mindfulness, acceptance, wisdom, and power. The participants were encouraged to avoid judgment, know themselves better, and investigate their character as “compassionate” or “non-compassionate” according to the lessons.
Fourth	“Compassionate mind”, “the value of compassion”, “empathy”, and “sympathy toward oneself and others” were practiced. The styles and methods of compassion, verbal compassion, practical compassion, temporary compassion, and permanent compassion were taught.
Fifth	The group learned how to practice the methods taught in the fourth session in their daily life and toward others. Compassion skills in areas like compassionate attention, compassionate argument, compassionate behavior, compassionate imagination, compassionate emotion, and compassionate understanding were taught. The participants learned how to play their role in three aspects of self (self-critic, self-criticized, and self-compassionate) using the Gestalt empty chair technique. They were also trained on how to find the tone and tune of self-critic vs. self-compassionate voice during their internal conversations and their similarity to the speaking pattern of their significant ones. The weekly table of critical thoughts and behaviors as well as compassionate thoughts and behaviors were also completed.
Sixth	The participants learned how to practice compassionate imagination, rhythmic and demulcent breathing, mindfulness, and writing a compassionate letter.
Seventh	This session was dedicated to summing up and concluding the intervention. The participants were also allowed to ask questions, and a general assessment was carried out of the intervention. Finally, the members were appreciated for their participation.
Eighth	This session was held after the test.

Table 2. Summary of the intervention based on the quality of life improvement, Frisch (23)

Session	Content
First	The therapist and group members were introduced to each other, and the pretest was conducted.
Second	The participants learned about the concepts of quality of life (QOL) therapy (the tree diagram of 16 areas of QOL was shown and the life satisfaction of the participants in these areas was determined).
Third	Aspects of the QOL therapy were introduced along with five factors that increase life satisfaction. The therapists worked on concrete conditions and tried to change the attitudes of participants in order to increase their life satisfaction based on the five factors discussed earlier in the session.
Fourth	A summary of the last session was presented. Some of the members of the group voluntarily wrote down their thoughts on the board and tried to substitute their irrational thoughts with rational ones. Afterward, the underlying principles and assumptions of thoughts were investigated, the pivotal beliefs in irrational thoughts were identified, and the irrational thoughts were challenged.
Fifth	The techniques and discussions of the third session were reviewed, and a summary was presented. The participants were introduced to “setting realistic goals” as the third factor of the five factors mentioned above. The therapist encouraged the group to re-prioritize their life issues and increase their satisfaction in other areas of life, where they felt a lower level of satisfaction.
Sixth	The participants learned about the 16 principles of QOL therapy with an emphasis on the fact that QOL therapy has some principles and rules that affect satisfaction in different aspects of life.
Seventh	The therapist continued teaching the 16 principles of QOL therapy.
Eighth	The therapist continued teaching the 16 principles of QOL therapy.
Ninth	The 16 principles of QOL therapy were practiced and employed in all aspects of daily life. Afterward, all the sessions were summed up, and a post-test was conducted.
Tenth	This session was the closing session and the post-test stage.

It should be mentioned that written informed consent was obtained from all participants. Furthermore, before starting the study, the participants were informed about the objective of the research, the confidentiality of their information, and the freedom principle. Therefore, conscious consent, voluntary nature of participation in the research, the right to exit the research, the harmlessness of the interventions, accountability of the researchers, and provision of the results for the participants were among the ethical criteria that were respected in this research. Moreover, after the end of the research, skill training based on the QOL therapy was provided for the participants in eight regular sessions, along with weekly homework. The study protocol was confirmed by the ethics board of the Cognitive Science and Technology Council, Iran.

2.1. Self-Criticism Scale

This scale was developed by Gilbert et al. in 2004 and contains 22 items. It has three sub-scales, namely incompetence, self-hatred, and self-assurance. The items are scored according to a five-point Likert Scale ranging from 0 (strongly disagree) to 4 (strongly agree). Cronbach's alpha of this scale for the three sub-scales of incompetence, self-hatred, and self-assurance are 0.90, 0.86, and 0.86, respectively (16). In this study, the reliability coefficients of the total scale and sub-scales obtained through Cronbach's alpha were between 0.79 and 0.85.

2.2. Depression Anxiety Stress Scale

Depression Anxiety Stress Scale (DASS) contains 21 items about the symptoms of negative emotions (i.e., depression, anxiety, and stress). Each sub-scale of DASS-21 consists of seven items, the final score of each is obtained by summing the scores of all of its items. Each item is scored based on a scale ranging from 0 (strongly disagree) to 3 (strongly agree).

Anthony et al. (26) performed a factor analysis on this scale and concluded that it includes the three above-mentioned factors (i.e., depression, anxiety, and stress). Based on the results of this research, 68% of the total variance was measured by these three factors. The eigenvalues of stress, depression, and anxiety in the mentioned research were 9.07, 2.89, and 1.23, respectively. Moreover, the alpha coefficients for these factors were 0.97, 0.92, and 0.95, respectively.

In addition, in a research carried out by Fathi-Ashtiani et al., Cronbach's alpha coefficients for depression, anxiety, and stress were calculated at 0.73, 0.69, and 0.76, respectively. Besides, the retest coefficients for the mentioned aspects were 0.75, 0.68, and 0.71, respectively, which are acceptable (2).

2.3. Beck Depression Inventory-II

This questionnaire is the revised version of the Beck Depression inventory that was developed to measure depression. This version is more consistent with DSM-IV, compared to the previous one and similarly consists of 21 items, covering all elements of depression according to the cognitive theory. In this questionnaire, the severity of depression is determined based on a scale from 0 to 3. The total score of the questionnaire varies between 0 and

63, and the scores 0-13, 14-19, 20-28, and 29-63 indicate minor, weak, mild, and major depression.

Based on the results of the studies conducted by Beck and Rush (22) on the second edition of this questionnaire, its internal stability was 0.73-0.92. Furthermore, they found that the Cronbach's alpha values for the patient and the non-patient groups were 0.86 and 0.81, respectively. Moreover, Dabson and Mohammadkhani (27) reported that Cronbach's alpha for the outpatients was 0.92, and the reliability coefficient for the retest after a week was 0.93.

First, an introduction letter was obtained from the university and all the paperwork was completed. Afterward, the Beck Depression Inventory-II was filled out by patients with depression symptoms admitted to psychological advisory centers in Neyshabur. In total, 45 patients who scored more than 18 on this inventory were selected as the sample population and were randomly divided into two intervention and one control groups (n=15 in each group).

Subsequently, the members of the CFT group received eight therapy sessions, which lasted 1.5 to 2 h, while the members of QOL therapy received 10 therapy sessions, which lasted 2 h. The control group members were put on the waiting list. Finally, all three groups underwent a post-test immediately after the end of the therapy sessions as well as a follow-up test for two months after the last session.

The data were analyzed in the SPSS software (version 21) using repeated-measures ANOVA. The descriptive statistics methods, such as frequency distribution tables as well as mean and standard deviation calculation were also used in this study.

3. Results

The mean age of the subjects in the compassion therapy, QOL therapy, and control groups were 34.65 ± 3.21 , 32.76 ± 3.09 , 32.19 ± 2.77 years, respectively. Among the subjects in the compassion therapy group, 40% (n=6), 40% (n=6), and 20% (n=3) of cases had a diploma, a bachelor's degree, and a master's degree, respectively. Among the subjects in the QOL treatment group, 26.7% (n=4), 40% (n=6), and 33.3% (n=5) of the participants had a diploma, a bachelor's degree, and a master's degree, respectively. Moreover, 26.7% (n=4), 46.6% (n=7), 26.7% (n=4) of the subjects in the control group had a diploma, a bachelor's degree, and a master's degree, respectively. In each group, 60% (n=9) of the subjects were female, and 40% (n=6) were male.

Table 3 summarizes the descriptive indices (i.e., mean and standard deviation) of self-criticism and psychopathological symptoms in the CFT, QOL therapy, and control groups at pre-test, post-test, and follow-up stages.

According to Table 3, in post-test and follow-up stages, the mean values of self-criticism and psychopathological symptoms in both intervention groups of compassion therapy and QOL therapy decreased, compared to the pre-test stage. Based on the results presented in Table 3, it can be said that compassion and QOL therapies have improved self-criticism and psychopathological symptoms of patients with MDD.

Shapiro-Wilk test was used in order to investigate the assumption of the normal distribution of the scores of the dependent variables. In this test, a p-value of more

Table 3. Mean and standard deviation of the scores of self-criticism and psychopathological symptoms during pretest, posttest, and follow-up stages

Variable	Group	Pre-test		Post-test		Follow-up	
		Mean	SD	Mean	SD	Mean	SD
Self-criticism	Control	55.80	7.49	53.73	4.44	53.46	4.61
	Compassion-focused therapy	55.73	4.87	40.93	4.57	40.33	5.06
	Quality of life therapy	55.80	5.68	47.2	5.58	47.13	5.47
Psychopathological Symptoms	Control	47.06	4.008	45.73	3.61	45.60	3.48
	Compassion-focused therapy	47.93	3.57	35.86	3.22	35	3.02
	Quality of life therapy	47.86	6.22	39.33	5.97	38.86	5.60

Table 4. Results of the repeated measure analysis of variance comparing the scores of self-criticism and psychopathological symptoms at pretest, posttest, and follow-up stages in intervention and control groups

Scale	Effect Source	Squared sum	Degree of freedom	Squared mean	F	Significance
Self-criticism	Time	2243.97	2	1121.98	266.568	0.001
	Time*Group	833.14	4	208.28	49.586	0.001
	Error	353.556	84	4.209		
	Group	1690.059	2	08450.3	10.673	0.001
	Error	3325.244	42	79.172		
Psychopathological Symptoms	Time	1717.970	2	858.985	283.38	0.001
	Time*Group	640.074	4	160.019	52.790	0.001
	Error	254.622	84	3.031		
	Group	981.793	2	490.896	9.138	0.001
	Error	2256.311	42	53.722		

*: P<0.01, **:P<0.05

than 0.05 was considered statistically significant, the null hypothesis was confirmed, and the data in all three groups was normal; therefore, the parametric tests could be used.

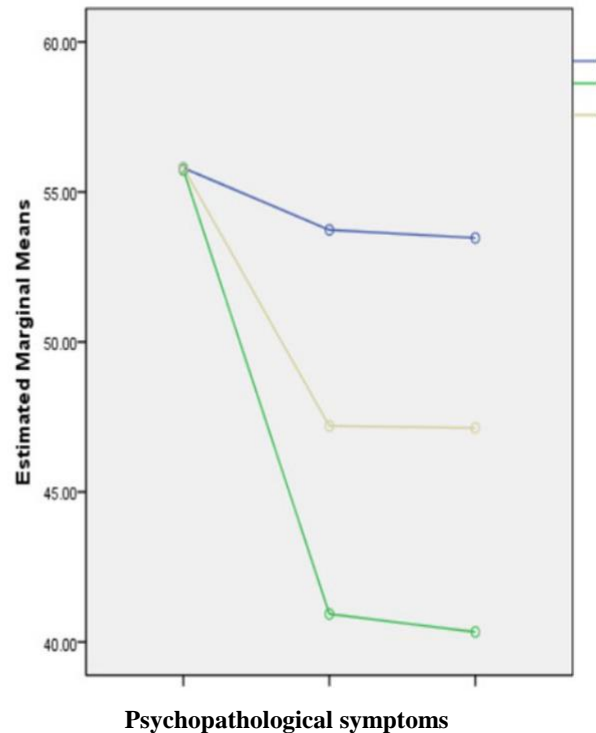
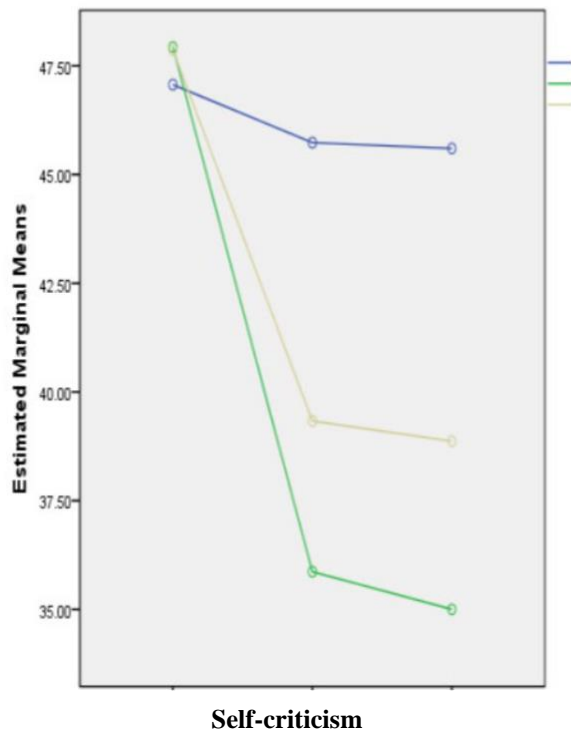
The first assumptions of homogeneity of variances and sphericity were examined in order to investigate the significant differences between self-criticism and psychopathological symptoms in the groups. Moreover, the results of the Box's M test confirmed the homogeneity of variances. Mauchly's test was used to investigate the sphericity, and the results indicated the rejection of the null hypothesis. Furthermore, the statistics corresponding to the correction were calculated and reported in SPSS software (version?). Table 4 tabulates the results of the multivariate analysis of variance.

According to Table 4, regarding the intra-group factor, the calculated F-value for the effect of time (pre-test, post-test, and follow-up stages) at the level of 0.05 was significant for self-criticism and psychopathological symptoms (P<0.05). Therefore, there was a significant difference between the mean scores of self-criticism and psychopathological symptoms in the three stages of pre-test, post-test, and follow-up.

Based on Table 4, regarding the interaction of time

and group factors, the calculated F-value for the effect of time (pre-test, post-test, and follow-up) between the two groups based on experimental and control groups at the level of 0.05 is significant for the self-criticism and psychopathological symptoms (P<0.05). Therefore, there was a significant difference between the mean scores of self-criticism and psychopathological symptoms at pre-test, post-test, and follow-up stages in the three groups. These results indicate the effectiveness of CFT and QOL therapy on the improvement of self-criticism and psychopathological symptoms.

Bonferroni post-hoc test was used to investigate the difference between the mean values in the treatment stages. Based on the results of the two experimental groups, there was a significant difference between the scores of self-criticism and psychopathological symptoms at the pre-test and post-test stages (P<0.05). Furthermore, there was a significant difference between the scores of self-criticism and psychopathological symptoms at the pre-test and follow-up stages (P<0.05). However, there was no significant difference between the scores of self-criticism and psychopathological symptoms at the post-test and follow-up stages.



Tukey post-hoc test was used to investigate the difference between the mean values of the three groups. Results indicated that there was a significant difference between the CFT and control groups regarding the scores of self-criticism and psychopathological symptoms at the post-test and follow-up stages ($P < 0.05$). In addition, there was a significant difference between the QOL therapy and control groups in terms of the scores of self-criticism and psychopathological symptoms ($P < 0.05$).

Moreover, based on the findings, there was a significant difference between the scores of self-criticism and psychopathological symptoms in the CFT and QOL therapy groups at the post-test and follow-up stages ($P < 0.05$). These results indicate that the CFT was more effective for the improvement of self-criticism and psychopathological symptoms than the QOL therapy.

An interactive graph of adjusted mean scores of self-criticism and psychopathological symptoms in the three groups at the pre-test, post-test, and follow-up stages is presented below. The green, yellow, and blue lines are indicative of CFT, QOL therapy, and the control groups, respectively.

According to the graphs, there was a difference between the CFT and QOL therapy in terms of the mean scores of self-criticism and psychopathological symptoms. The modified mean values show that the decrease in self-criticism and psychopathological symptoms were more dramatic in the CFT group, compared to the quality of the life therapy group.

4. Discussion

The present study aimed to compare the effectiveness of CFT and QOL therapy on self-criticism and psychopathological symptoms in patients with MDD. The first result of the present study was that CFT was effective

in the reduction of self-criticism and psychopathological symptoms. This was consistent with the findings of the study conducted by Barsma et al. (28) who tried to investigate the effectiveness of CFT on self-criticism. In their study, the experimental group, experienced a significant reduction in all aspects of self-criticism, compared to the control group (16).

The findings of this research also support those of another study conducted by O’Gorman and MacIntosh (29) which point out a reduction in self-criticism and its components in patients who participate in CFT (17). In this regard, Gonzalez-Hernandez et al. (30) also demonstrated that compassion-based intervention could improve self-criticism and the compatibility of the patient with psychological problems. Results of this study were also consistent with those of the research performed by Navarro-Gil et al. (17), Gilbert (16), Gonzalez-Hernandez et al. (30), Harris (31), O’Gorman et al. (29), and Boersma et al. (28), which emphasized the effectiveness of CFT on depressive thoughts, signs, and symptoms.

To explain the findings of this study, it can be said that in CFT, mindfulness and conscious attention to inner experiences are emphasized to help the patients develop mind-awareness processes, self-judgment skills, and the ability to accept life problems as part of human commonalities. It aims to facilitate the attainment of warmth and kindness in the relationship with oneself and others, instead of harsh judgment. Therefore, those who use CFT can become more flexible. Besides, by changing their cognitive attitude towards the challenges they face, they feel a sense of control and become more adaptable.

In the framework of CFT, the performance of love exercises in the form of relaxation and cultivation of a calm and compassionate mind gradually facilitated the process of soothing and calming in these patients. This

process can increase the level of psychological flexibility. In CFT, instead of focusing on changing self-esteem, the relationships of individuals with self-esteem change and they try to adopt a compassionate and non-judgmental attitude towards themselves and their shortcomings.

Moreover, Kilik et al. (19) stated that the elements of CFT, especially self-compassion and acceptance without judgment, are considered potentially effective antidotes for common forms of psychological disturbance, such as self-criticism and rumination. Many of these common forms of disturbance can lead to environmental incompatibility and health-related problems that result in an incompatible tendency toward avoidance, suppression, or over-involvement with disturbing thoughts and emotions. Avoidance, suppression, or over-involvement with disturbing thoughts and emotions are similar to mental health problems. In this regard, previous studies have confirmed the relationship of suppression and avoidance with increased self-criticism (28).

It can also be added that in compassion-focused interventions, the therapist tries to teach skills, like observing and describing one's emotions, passing through thoughts without judging them as good or bad, and adopting compassionate viewpoints on behaviors and emotions. Consequently, the improvement in emotional regulation and reduction of psychological symptoms affect self-criticism positively (32).

Negative emotions are related to depression and the possible outcome of therapy is to form a therapy alliance among the participants and consequently, create a positive sense of self and reduce self-criticism. When patients with depression reduce their engagement with suppression mechanisms, they experience unpleasant emotions, such as chronic anxiety, bewilderment, uncertainty, guilt about the future outlook, and helplessness regarding their disorder (i.e., depression).

In CFT interventions, the patients are encouraged to express these unpleasant emotions; moreover, they are provided with emotional support. The patients with MDD express unpleasant emotions, which make them believe that they are alone in tolerating them, in a sympathetic and supportive atmosphere. In addition, they realize that the people around them have the same emotions as themselves.

This process has two outcomes: first, their sense of loneliness caused by depression decreases; second, tolerating the unpleasant emotions is rendered easier for them as they come to know that the emotions are shared by others. These experiences help people with MDD to overcome their social isolation and make them extend their social relationships and accept themselves. Therefore, it can be expected that self-criticism decreases significantly after the therapy sessions.

The next finding of the present study was that QOL therapy was effective in reducing self-criticism and psychopathological symptoms. This finding is in line with those of the studies performed by Carroll et al. (20), Ramezani et al. (21), Frisch (23), and Karimi (24), which emphasized the effectiveness of QOL therapy on psychopathological symptoms and negative thoughts of patients about themselves.

In this regard, Carroll et al. concluded that QOL

therapy due to various strategies, such as identification and management of negative emotions, is a suitable treatment program for the reduction of depression, anxiety, and rumination (20). In addition, Frisch points out that QOL therapy aims to increase satisfaction and happiness in life; therefore, this approach emphasizes the evaluation and conceptualization of the problems and abilities of individuals and helps them to reduce their psychological symptoms (23).

To explain this finding, it can be said that QOL therapy helps people identify aspects of their lives that currently cause them dissatisfaction. As a result, achieving goals and satisfying one's needs in valuable areas leads to a successful experience of change (21). Considering more and fewer restrictions in the future, the main therapeutic strategy for changing attitudes towards an area of life is cognitive reconstruction, which aims to help the patients obtain correct comprehensions and positive interpretations of their situations. This helps them maintain self-esteem and hope for happiness in the intended area, or other areas of life (20).

Based on the results of the present study, this treatment is also effective in reducing self-criticism. This finding can be interpreted as that this method can effectively reduce self-criticism through the increase of the dominance and ability of people with self-criticism. This method also deals with how a person perceives the ability to change their behaviors, level of arousal, thought patterns, and emotional reactions. It should be noted that in this method, the emphasis is placed on acceptance, maintenance, and alteration of oneself instead of self-criticism (23).

Another explanation is that since the QOL therapy method examines different aspects of a person's ability, it helps self-critical people to increase their awareness. Therefore, this factor causes people to have higher self-esteem due to more cognition. The therapy aims to increase skills and awareness and also change and strengthen the self-esteem of the clients; therefore, they can understand self-position (20). In this approach, the principles and skills are focused on helping clients identify, pursue, and meet their needs, goals, and aspirations in valuable areas. To have a good feeling about oneself is a booster, and one of the great advantages of this treatment is to create a good feeling in people by lowering expectations, and this good feeling makes people have a higher level of tolerance and empower them to face problems more effectively (23).

Findings of this study support the issue that using QOL therapy and self-compassion approaches can be effective in reducing MDD symptoms. However, further research should be carried out on MDD patients to make definitive conceptualizations about the effectiveness of QOL therapy and self-compassion approaches on the reduction of MDD symptoms.

In this study, the time interval since the diagnosis of MDD was not specified. Absence of detailed records of time periods associated with MDD may influence the directionality of findings. Another limitation of the present study was that only self-report measures were used; therefore, it may not be possible to generalize the results to other populations. Furthermore, potential confounding variables, such as comorbidity or age were not considered. On the other hand, the lack of strong literature about CFT

and QOL therapy is another limitation of the present research.

Given the importance of paying attention to self-criticism and psychopathological symptoms in patients with MDD, it is highly recommended to carry out other studies in this regard for more generalization. Due to the heavy pressure they bear, patients with MDD need to receive adequate support interventions at the time they experience self-criticism and psychopathological symptoms. According to the findings of the present study, interventions that can increase self-esteem include communication skills training, self-expression training, and interventions based on emotion-focused group therapies, which can be helpful in reducing depression.

Since the findings of the present study indicate the major role of self-criticism in the mental status of people with MDD, it is suggested that considering self-criticism in the interventions planned to reduce depression can be useful. In these interventions, some skill training, such as cognitive structure reconstruction can correct distorted cognitions that lead to self-criticism.

6. Conclusion

According to the findings, participating in CFT sessions can reduce self-criticism and psychopathological symptoms in patients with MDD. Results of the present and previous studies support the idea that CFT interventions are effective in the improvement of the psychopathological status of people with MDD. Moreover, given the biological and psychological infrastructure of MDD, it seems that using QOL therapy in addition to medication can be effective in the reduction of MDD symptoms.

Conflict of Interest

The authors declare that there was no conflict of interest in this study.

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