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Kaitlyn M. Janicki
The Role of Self-Compassion in
Alcohol Use Disorders: An
Exploratory Study

ABSTRACT

The goal of this study was to replicate prior research that has examined differences between self-compassion, depression, anxiety and stress in adults with Alcohol Use Disorders (AUDs). This is the first study that has compared levels of self-compassion by whether or not participants are in sober recovery.

A clinical sample of 69 adults, who were currently in sober recovery or in treatment for an AUD, were administered a quantitative survey to assess various characteristics, which included: current depression, anxiety and stress levels; current alcohol use and related problems; and how they treat themselves during difficult times.

Major findings were that participants had significantly lower levels of self-compassion and higher levels of depression, anxiety and stress compared to norms for the general population. In addition, respondents in sober recovery (no longer drinking) were found to be significantly more self-compassionate and less depressed and anxious than those struggling with an active AUD. Such results indicate that interventions designed to enhance self-compassion may be beneficial to incorporate into substance abuse treatment.

**THE ROLE OF SELF-COMPASSION IN ALCOHOL USE DISORDERS:
AN EXPLORATORY STUDY**

A project based upon an investigation at
ServiceNet, Inc., Northampton, Massachusetts,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2015

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CHAPTER I

Introduction

Alcohol abuse and dependence have been associated with negative affect, depression and inappropriate coping strategies (Camatta & Nagoshi, 1995). It can be argued that the discomfort of certain thoughts, emotions, bodily states, and behavioral predispositions result in Alcohol Use Disorders (AUDs) to eliminate, attenuate or to reduce these painful experiences. Furthermore, preliminary evidence has shown that people with alcohol dependence have lower levels of self-compassion than the general population (Brooks, Kay-Lambkin, Bowman & Childs, 2012), suggesting that these individuals may lack important coping strategies to recover from their addiction (Rendon, 2007).

Over the past decade self-compassion has gained popularity as a related and complementary construct to mindfulness, and research on self-compassion continues to grow. Self-compassion is a measurable trait within individuals that involves treating oneself with the same kindness, concern, and support one would show to a good friend. When faced with difficult life struggles, or confronting personal mistakes, failures, and inadequacies, self-compassion responds with kindness, rather than harsh self-judgment, recognizing that imperfection is part of the shared human experience. In order to give oneself compassion, one must be able to turn toward, acknowledge, and accept that one is suffering, meaning that mindfulness is a core component of self-compassion (Neff, 2003a). Recent research has begun

to examine the use of self-focused compassion and mindfulness as a way of alleviating the distress associated with psychological disorders, such as anxiety and depression (Neff, 2011).

Preliminary research has already shown an inverse relationship between self-compassion and depression, anxiety and other forms of psychopathology (see Barnard & Curry, 2011 for a review; Neff, 2011). Yet, very little research has been conducted examining trait self-compassion on the chosen target group for this study: adults with alcohol use disorders treated in clinical settings. Although research has been successful in documenting the incidence and prevalence of alcohol use and abuse, there exists an ongoing need to examine the psychological factors associated with this problem (Camatta & Nagoshi, 1995; Pullen, 2001). For example, a pattern of impulsivity and sensation seeking is strongly related to increased drinking amongst college students. This pattern is supported by research into personality, drinking motives, alcohol expectancies and drinking contexts (Wilson & Byrd, 2005).

A second pattern of drinking associated with negative emotional states is also documented. Alcohol abuse has been associated with negative affect, depression and inappropriate coping strategies (Camatta & Nagoshi, 1995). It can be argued that the discomfort of certain thoughts, emotions, bodily states, and behavioral dispositions contributes to alcohol abuse and dependence in an attempt to eliminate or reduce these painful experiences (Wilson & Byrd, 2005). Empirical studies examining the association between self-esteem and drinking have found that global positive self-esteem, how one *typically* feels about oneself and one's self-worth, does not necessarily protect against alcohol abuse (Baumeister, Campbell, Krueger & Vohs, 2003) and, in fact, narcissistic self-esteem (i.e., inflated view of self-worth) and contingent self-esteem (i.e., how we feel about or evaluate ourselves based on external sources such as what others say, our success or failures, or one's competence) are both positively correlated with

alcohol abuse (Luhtanen & Crocker, 2005). However, research on self-esteem and alcohol use has failed to produce consistent results regarding the nature of the relationship between alcohol abuse and self-esteem (Crocker & Park, 2004). As a result, a different psychological construct has emerged: self-compassion, which seems particularly relevant to alcohol abuse and dependence (Neff, 2003a).

The existing research that has been conducted on self-compassion and alcohol use disorders (AUDs) is scarce and has numerous limitations. However, there is one study that provides important preliminary evidence for the relationship between self-compassion, depression, anxiety, stress and hazardous alcohol use in an Australian population (Brooks et al., 2012). The current study aims to replicate this previous research by investigating the role that self-compassion has on a clinical sample of adults with a diagnosis of AUDs within the United States. The current study used a quantitative method design to explore relationships between self-compassion, depression, anxiety and stress in adults with alcohol use disorders who are currently in treatment. Participants were asked to complete a quantitative survey, either online or on paper, which assessed a number of variables: current alcohol use and alcohol-related problems; current levels of depression, anxiety and stress; and how participants treat themselves during difficult times (self-compassion).

CHAPTER II

Literature Review

Alcohol abuse and dependence have been associated with negative affect, depression and inappropriate coping strategies (Camatta & Nagoshi, 1995). It can be argued that the discomfort of certain thoughts, emotions, bodily states, and behavioral predispositions result in Alcohol Use Disorders (AUDs) in an attempt to get rid of or reduce these painful experiences. Furthermore, preliminary evidence has shown that people with alcohol dependence have lower levels of self-compassion than the general population (Brooks et al., 2012), suggesting that these individuals may lack important coping strategies to recover from their addiction (Rendon, 2007). In order to better understand the relationship between trait self-compassion and alcohol use disorders this review will include a look at the literature offered by the psychological and addiction treatment communities.

The literature review for this study aims to examine the most current articles available that offer an in-depth look at both theoretical and empirical studies of the benefits of self-compassion with respect to psychological well-being and decreased psychopathology. This review will also thoroughly examine both the theoretical and empirical studies of alcohol use disorders and the common co-occurring disorders and symptomology of depression, anxiety and stress. The literature employed in this study spans no more than 25 years with the majority of articles being from more recent years.

Alcohol Use Disorders

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM 5; American Psychological Association, 2013), has combined alcohol abuse and alcohol dependence into a single disorder, called alcohol use disorder (AUD)—with mild, moderate and severe classifications. According to the DSM 5, the essential feature of an AUD, one subtype of Substance Use Disorders, is a cluster of cognitive, behavioral, and physical symptoms indicating that the individual continues use of the substance despite significant substance-related problems. In addition, the individual develops a pattern of repeated self-administration that can result in withdrawal, tolerance, cravings, and compulsive alcohol seeking behavior (APA, 2013, p. 492). The DSM-5 includes the following criteria for an AUD:

Preoccupation with the substance between periods of use, using more of the substance than had been anticipated, development of tolerance to or cravings for the substance, use of the substance to avoid withdrawal symptoms, repeated efforts to stop use of the substance, intoxication at inappropriate times, withdrawal that interferes with daily functioning, and reduction in social, occupational, or recreational activities in favor of further substance use (APA, 2013, p. 490-491).

Prevalence of Alcohol Use Disorders in the United States

The prevalence of alcohol use and abuse in the United States is alarming. According to the Substance Abuse and Mental Health Services Administration (SAMSHA), in 2013, 71% of people ages 18 or older reported that they drank alcohol in the past year; 24.6% were classified as binge drinkers and 6.8% were classified as heavy drinkers. Approximately, 16.6 million adults (7% of this age group) met criteria for an Alcohol Use Disorder (AUD) in 2013. This

includes 10.8 million men (9.4% of men in this age group) and 5.8 million women (4.7% of women in this age group) (SAMSHA, 2014).

According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA, 2015), excessive alcohol use, including underage drinking and binge drinking (drinking 5 or more drinks on a single occasion for men or 4 or more drinks on an occasion for women), can increase a person's risk of developing serious health problems, including brain and liver damage, heart disease, hypertension, and fetal damage in pregnant women. The Centers for Disease Control and Prevention (CDC) report that alcohol is implicated in nearly 32% of fatal automobile accidents, and approximately 40% of all violent crimes are committed under the influence of alcohol. Furthermore, each year in the United States, nearly 88,000 people die from alcohol-related causes, making it the third leading preventable cause of death in the country (CDC, 2013).

SAMHSA's 2013 National Survey on Drug Use and Health (NSDUH) reports that men are more likely to report heavy alcohol use (binge drinking for 5 or more of the past 30 days) than women, 9.5% to 3.3%. People reporting two or more races had the highest rate of heavy alcohol use at 8.9%, and 7.3% of non-Hispanic whites reported heavy alcohol use. African Americans reported heavy alcohol use at 4.5%, and Hispanics reported it at 4.8%. At 2%, Asian Americans had the lowest rate of heavy alcohol use.

However severe the problem may seem, most people with an alcohol use disorder can benefit from treatment. Unfortunately, only a fraction of people who could benefit from treatment receive help. In 2012, for example, 1.4 million adults received treatment for an AUD (8.4% of adults in need). This included 416,000 women (7.3% of women in need) and 1.0

million men (8.9% of men in need) (SAMSHA, 2013). Ultimately, receiving treatment can improve an individual's chances of success in overcoming an AUD.

Theoretical Assumptions of Alcohol Use Disorders

Current research cites many factors contributing to alcohol abuse and dependence including genetics, family environment and structure, and brain changes from addiction expressed in behavioral ways and within social contexts (Crum et al., 2013). In addition, several studies have found that drinking behaviors are associated with psychological variables (Grant et al., 2004). For instance, research has demonstrated that experiencing stressful life events significantly predicts the amount and frequency of alcohol consumed as well as the onset of alcohol dependence, suggesting that stress plays a key role in the development of AUDs (Lloyd & Turner, 2008). Other research has found that alcohol abuse and dependence has been associated with co-morbid depression, anxiety and cognitive problems, especially in clinical settings (Grant et al., 2004). There have been a number of causal explanations attempting to account for the high incidence of co-morbidity between depression, anxiety and alcohol use. One of these explanations is that individuals who experience depression and anxiety may choose to use alcohol to relieve symptoms (Khantzian, 2003; Pullen, 2001).

Alcohol consumption often becomes a preferred way of coping with unpleasant situations and feelings that are provoked by depression and anxiety (Pullen, 2001), which is also referred to as the Self-Medication Hypothesis (Khantzian, 2003). The Self-Medication Hypothesis suggests that people predisposed to substance abuse suffer painful affective states (Goeders, 2004), and that substance addiction functions to allow them to self-soothe or to regulate and cope with overwhelming emotions and psychological states, and to adapt to external situations that are otherwise unmanageable (Khantzian, 2003). However, if no effort is made to heal the

underlying causes of such unbearable psychological, mental, or emotional states, and if such painful states are continually present, an eventual dependence upon alcohol develops (Baumeister et al., 2003; Khantzian, 2003).

Conversely, research has also suggested that alcoholism promotes the development of anxiety and depressive disorders, and that the associated symptoms are actually a consequence of alcohol withdrawal (Kushner, Abrams & Borchardt, 2000).

Self-Esteem and Alcohol Use, Abuse & Dependence

There is a long-held belief that self-esteem plays an important role in the use of alcohol. Some researchers have argued that low self-esteem serves as a high risk factor for substance abuse in some populations, especially in college students (Baumeister et al., 2003). A number of studies have indicated that those who refrain from drinking alcohol have higher self-esteem than those who drink (Neighbors, Larimer, Gesiner & Knee, 2004). Low self-esteem, high anxiety, depression, lack of assertiveness or lack of success in attainment of life goals have been positively correlated with alcohol abuse (Huber, 1985; Baumeister et al., 2003).

One possible explanation for the association between alcohol abuse and low self-esteem is the correlation between depression and low self-esteem (Chadhury et al., 2010) and between depression and alcohol abuse (Crum et al., 2013). Depression-prone individuals can descend into patterns of thinking and behavior that are repetitive, ruminative, and self-perpetuating. If negative moods get established, then old patterns of automatic thoughts and behavior will dominate, leading to more negativity and distress, which increases the likelihood of alcohol abuse. Threats to self-esteem are one source of negative emotions, as low self-esteem is associated with negative emotions. Baumeister (1997) explored variables related to the

explanation of alcohol use and discovered that threats to one's self-esteem may lead to behaviors—such as excessive drinking—that offer an escape from self-awareness.

Low self-esteem has been found to pose a high risk for substance abuse and alcohol dependence, and is commonly related to negative emotions such as depression, anxiety and poor adjustment (Chadhury et al., 2010). However, there have been multiple studies that have found it difficult to define, measure, and develop a theory to explain self-esteem in relation to these psychological disorders, specifically alcohol abuse (Crocker & Park, 2004). For instance, empirical studies examining the association between self-esteem and drinking have found that global self-esteem—how one generally views oneself and one's worth—does not always protect against alcohol abuse (Baumeister et al., 2003). In fact, alcohol abuse has been positively correlated to unhealthy outcomes, such as narcissism, a disregard for weaknesses, and contingent self-esteem, which involves making self-evaluations based on comparisons with others (Luhtanen & Crocker, 2005). As a result, a different psychological construct has emerged: *self-compassion* (Neff, 2003a), which is also related to alcohol abuse (Rendon, 2007; Brooks et al., 2012).

Self-Compassion

Self-compassion is less dependent on external circumstances and focuses more on valuing the self while still acknowledging subjective imperfections (Neff, 2011). As an internally validating self-concept, self-compassion has been theorized to allow for healthier coping that benefits oneself and others during times of sadness and disappointment (Baker & McNulty, 2011; Neff & Vonk, 2009). Since self-compassion does not promote an unrealistic view of self, it may be more stable than self-esteem, which often fluctuates. Therefore, increases in this trait should be more reliable than increases in the trait of self-esteem (Neff, 2011). Furthermore,

preliminary evidence has shown that people with alcohol dependence have lower levels of self-compassion than the general population (Brooks et al., 2012), suggesting that these individuals may lack important coping strategies to recover from their addiction (Rendon, 2007).

Although Western psychologists have done a considerable amount of empirical research examining empathy and compassion for others, only recently have they begun to explore self-compassion (Neff, 2003a). In order to better understand what self-compassion is, it is useful to first consider what it means to feel compassion more generally. Buddhism asserts that compassion involves being touched by the suffering of others and oneself, opening one's awareness to others' and one's own pain and not avoiding or disconnecting from it, so that feelings of kindness toward others and oneself and the desire to alleviate this suffering emerge (Goetz, Keltner & Simon-Thomas, 2010; Neff, 2003a). This means that in order to experience compassion, you must first acknowledge the presence of pain. For instance, instead of ignoring a homeless person on the street, you must actually stop and consider how difficult that person's life must be. Therefore, compassion involves pausing, stepping out of your usual frame of reference, and seeing the world from the viewpoint of another. It also involves offering non-judgmental understanding to those who fail and do wrong, so that their actions and behaviors are seen in the context of shared human imperfection (Neff, 2003a; Neff, 2003b).

Self-compassion is simply compassion directed inward, relating to ourselves as the object of care and concern when faced with suffering (Neff, 2003a). It involves being touched by and open to one's own suffering, not avoiding or disconnecting from it, creating the desire to alleviate one's suffering and to heal oneself with kindness. Self-compassion also involves offering non-judgmental understanding to one's pain, inadequacies and failures, so that one's own experience is seen as part of the larger human experience.

Three components of self-compassion. Self-compassion is a measurable trait within individuals that involves treating oneself with the same kindness, concern, and support that one would show to a good friend. Self-compassion is relevant to all personal experiences of suffering including perceived inadequacies, failures, and painful life situations more generally. The concept of self-compassion, which has been adopted by the social work and psychology fields, has its roots in Eastern Philosophy, specifically Buddhism (Bennet-Goleman, 2001; Brach, 2003; Kabat-Zinn, 1990; Salzberg, 1997). Neff (2003b) focused on self-compassion as a healthy attitude and relationship with oneself and has defined self-compassion as consisting of three main, interacting components: self-kindness versus self-judgment, a sense of common humanity versus isolation, and mindfulness versus over-identification when confronting painful self-relevant thoughts and emotions.

Self-kindness. The first component of self-compassion involves generating the desire to alleviate one's suffering, to heal oneself with kindness, and involves being open to one's own suffering (Neff, 2003a). When external life events occur that are stressful, challenging, or difficult to bear, self-kindness enables an individual to soothe and nurture oneself (Neff, Kirkpatrick, & Rude, 2007a). Such self-kindness involves offering nonjudgmental understanding to one's own pain, inadequacies and failures. In other words, it involves extending forgiveness, empathy, sensitivity, warmth, and patience to all aspects of oneself including all of one's actions, feelings, thoughts and impulses (Gilbert & Irons, 2005; Neff, 2003a). People who are kind to themselves view their worth as unconditional (Ellis, 1973; Maslow, 1968; Rogers, 1961, as cited in Neff, 2003a).

The opposite of self-kindness is harsh self-judgment, which involves an individual being overly self-critical in instances of pain and failure. People who are harshly self-judgmental

reject their own feelings, thoughts, impulses, actions, and worth (Whelton & Greenberg, 2005). Harsh self-judgment is often relentless and the pain it causes can often equal or outweigh the pain of the precipitating situation (Germer, 2009). However, harshly judging oneself often feels natural to people, so they may not be aware that they are judging themselves or how these self-judgments may be causing their suffering (Whelton & Greenberg, 2005). Therefore, it is thought that part of developing self-kindness is becoming aware of self-judgment and its harmful impact (Gilbert & Irons, 2005).

Common humanity. The second component of self-compassion is common humanity, which involves perceiving one's experiences in a larger context in which all humans experience suffering, failure and inadequacies (Neff, 2003a). Often, however, individuals tend to feel isolated and cut off from others when considering their struggles and failures, irrationally feeling that it is only "me" who is having such a hard time. This sort of tunnel vision makes one feel alone and isolated, making one's suffering even worse (Neff, 2011). With self-compassion, however, one takes the stance of compassionate other towards oneself, taking on a broader perspective of oneself and one's life. For this reason, self-compassion is different from self-pity. Self-pity is a "woe is me" attitude in which individuals become absorbed in their own problems and forget that others have similar problems. The common humanity component of self-compassion recognizes that all people suffer, and therefore enables individuals to feel connected to others. By remembering that suffering is a shared human experience, one feels less isolated when experiencing pain, thus recognizing that all humans are imperfect.

Mindfulness. The third component of self-compassion involves mindful awareness of our negative thoughts and emotions in a balanced awareness—as opposed to over-identifying with them (Neff, 2003a). Bishop and colleagues (2004) argued that when we are mindful, we are

open to the reality of the present moment, without judgment, avoidance, or repression of our thoughts. Mindfulness is an important component of self-compassion because it encourages one to see his or her own failings clearly, rather than ignoring or disregarding them. Moreover, the mindfulness component of self-compassion encourages change where needed, such as repairing harmful or unproductive patterns of behavior, thereby supporting optimal functioning and health (Neff, 2003a; Neff 2003b).

Mindful attention is thought to help one more deeply experience and learn from the present without the distractions of self-evaluations or worries about the past or the future. Mindfulness involves observing and labeling thoughts and emotions rather than reacting to them (Kabat-Zinn, 2003). Thus, mindfulness can change how one relates to dysfunctional thoughts and negative affect rather than changing or eliminating the states themselves. In addition, mindfulness refers to the tendency to acknowledge and accept good and bad aspects of the self; as opposed to wanting to reduce self-awareness (Neff, 2004). This also suggests that mindfulness may play an important role in adaptive and maladaptive emotion regulation (Van Dam, Sheppard, Forsyth & Earleywine, 2011).

Over-identification and avoidance of thoughts and emotions can interfere with one's ability to be mindful. Over-identification involves ruminating on one's own limitations that prevents deep experiencing of the present moment (Gilbert & Procter, 2006; Neff & Vonk, 2009). People who tend to over-identify may magnify the importance of failures (Neff, Hsieh, & Dejitterat, 2005; Shapiro, Brown, & Biegel, 2007). The other extreme is avoidance of painful experiences, thoughts and emotions (Kabat-Zinn, 2003; Neff, 2003a). Germer (2009) argued that avoidance increases negative feelings in the long run and sacrifices understanding. Overall,

both over-identifying with and avoiding pain hinder mindfulness, which is thought to help people explore and learn from thoughts, emotions, and experiences (Neff, 2003a).

Interactions among the components of self-compassion. Surprisingly, little has been written on how the components of self-compassion relate to one another. Neff (2003b) proposed that the three components of self-compassion are conceptually distinct, but it is unclear whether Neff viewed the three components as inherently related or as positively correlated with one another. At the very least these components tend to overlap and enhance one another (Barnard & Curry, 2011). For instance, the accepting stance of mindfulness helps to lessen self-judgment and provide insight needed to recognize our community humanity. Similarly, self-kindness lessens the impact of negative emotional experiences, making it easier to be mindful of them. In addition, realizing that suffering and personal failure happens to everyone may lessen one's feelings of self-blame, while also helping to suppress over-identification, or getting caught up in one's emotions (Neff, in press). Thus, self-compassion is best understood as a single experience comprised of interacting parts. Moreover, it seems to be the combination of these elements that will help researchers distinguish self-compassion from other self-concepts.

Self-Compassion and Other Self-Concepts

In defining self-compassion it is important to compare it to other aspects of the self that have already been studied in Western Psychology, including humanistic self-concepts and self-criticism. It is also important to demonstrate how self-compassion differs from self-pity, self-esteem, self-centeredness, and self-complacency.

Self-compassion and humanistic psychology. The self-kindness component appears similar to three humanistic themes central to well-being. First, Rogers' (1961) "unconditional positive regard" involves adopting an unconditionally caring stance towards the self. This, like

self-kindness, does not require making unconditional positive evaluations about oneself, but instead involves taking on a less defensive, open stance towards oneself. Second, Maslow's (1968), "B-perception" involves learning to acknowledge and accept personal failings with a nonjudgmental, loving, forgiving stance to oneself. Third, Ellis' (1973) "unconditional self-acceptance" involves the belief that one's worth does not need to be evaluated but assumed, and weaknesses are to be acknowledged and forgiven.

Self-compassion appears similar to these humanistic constructs. However, Eastern thinkers' have criticized these self-concepts are too focused on the individual (Neff, 2003a; Brach, 2003; Salzberg, 1997). Consequently, Neff (2003a) argued that self-compassion is more encompassing as it includes feelings of self-acceptance which are derived from a sense of shared humanity without separating the self from others. In other words, self-compassion is similar to but broader than these other humanistic themes because it includes the concepts of common humanity and mindfulness.

Self-compassion and self-criticism. Prior to Neff's (2003a) conceptualization of self-compassion, researchers referred to self-judgment with a variety of terms such as self-attack, self-contempt, self-disparagement and self-criticism (Dunkley, Zuroff & Blankstein, 2003; Gilbert & Irons, 2005; Whelton & Greenberg, 2005). However, self-criticism has been empirically shown to be related to over-identification and isolation.

Dunkley and colleagues (2003) have argued that self-criticism may increase isolation. For example, Dunkley et al. (2003) examined self-reports from 163 undergraduates and found that self-critical students reported more perceived criticism from others, and less perceived social support. Zuroff, Moskowitz, & Cote (1999) studied 119 nonclinical, self-critical adults from the community and used event-contingent recording to examine their communal activities and their

resulting emotions. Self-critical adults reported less trait-based and behavior-based communion with others, and less pleasant affects after interacting with others. These results indicated that self-critics show less intimacy and affiliative strivings perhaps because they fear rejection and disapproval. When self-critics do interact, they gain little reassurance or positive affect. Their social withdrawal may keep them from recognizing that their insecurities are part of the shared human experience (Zuroff et al., 1999).

In the same study of undergraduates, self-critics tended to cope by avoiding situations that presented opportunities for failure (behavioral disengagement) or by avoiding thoughts and feelings associated with self-criticism (mental disengagement; Dunkley et al., 2003). In addition, self-critics were found to be avoidant rather than mindfully aware. Overall, self-criticism has been empirically validated as being identical to self-judgment. Therefore, it can be inferred that self-criticism may also enhance feelings of isolation and behavioral and mental disengagement (Dunkley et al., 2003).

Self-compassion v. self-esteem. Although self-compassion produces positive emotions, it doesn't do so by judging the self as "good" rather than "bad." In this way, self-compassion differs from self-esteem. Self-esteem refers to the degree to which we evaluate ourselves positively. It represents how much we like or value ourselves, and is often based on comparisons with others (Harter, 1999). In American culture, having high self-esteem means standing out in a crowd—being special and above average (Heine, Lehman, Markus & Kitayama, 1999). There is general consensus that self-esteem is essential for good mental health, while the lack of self-esteem undermines wellbeing by promoting depression, anxiety, and other pathologies (Leary, 1999). However, there are potential problems with obtaining high self-esteem (Crocker & Park, 2004). For instance, people often put others down and exaggerate their own self-worth as a way

to feel better about themselves (Tesser, 1999), which may result in narcissism, prejudice, and bullying (Aberson, Healy & Romero, 2000; Morf & Rhodewalt, 2001; Salmivalli, Kaukiainen, Kaistaniemi & Lagerspetz, 1999). Self-esteem also tends to be contingent on success in valued life domains (Crocker, Luhtanen, Cooper & Bouvrette, 2003), and therefore, fluctuates according to performance outcomes (Kernis, Paradise, Whitaker, Wheatman & Golman, 2000).

In contrast, self-compassion is not based on positive judgments or evaluations, but it is a way of positively relating to ourselves. People feel self-compassion because they are human beings, not because they are special or above average. Consequently, interconnection rather than separateness is emphasized (Neff, 2003b). This means that with self-compassion, you do not have to feel better than others to feel good about yourself. It also offers more emotional stability than self-esteem because it is a more reliable trait in that it remains with a person in good times and bad times (Neff, 2012).

In a survey involving a large community sample in the Netherlands, self-compassion was shown to be a stronger predictor of healthy functioning than self-esteem (Neff & Vonk, 2009). Self-compassion was associated with more consistent feelings of self-worth than self-esteem over an eight month period (assessed 12 different times). This may be related to the finding that self-compassion was also found to be less dependent upon factors such as physical attractiveness or successful performances than self-esteem. Results indicated that self-compassion was associated with lower levels of social comparison, public self-consciousness, self-rumination, anger, and defending their viewpoints, than self-esteem. Also self-esteem had a strong association with narcissism while self-compassion had no association with narcissism. These findings suggest that in contrast to those with high self-esteem, self-compassionate people are less focused on evaluating themselves, feeling superior to others, worrying about whether or not

others are evaluating them, defending their viewpoints, or angrily reacting against those who disagree with them (Neff & Vonk, 2009). In sum, self-compassion is a healthier way of feeling good about oneself than self-esteem, which is based on the need to feel better than others.

Self-compassion versus self-pity, self-centeredness or self-complacency. Gilbert and Irons (2005) have researched individuals with high levels of reported shame, and they have discovered that these individuals worry that becoming more self-compassionate may also cause them to become self-pitying, self-centered, or complacent. Although self-compassion has been theoretically distinguished from these concepts (Neff, 2003a; Neff 2003b), it needs to be distinguished empirically as well.

First, self-compassion is thought to be distinct from self-pity because those who pity themselves are thought to lose a sense of common humanity and to over-identify with their feelings, thoughts, and experiences (Neff, 2003a). Self-pity is associated with a type of tunnel vision that involves being absorbed in one's own suffering to the point of exaggerating it. Self-compassion is thought to break self-absorption by relating one's own suffering to others' and by holding pain in mindful awareness (Neff, 2003a, p. 224). Second, self-compassion is thought to avoid causing self-centeredness because of the common humanity component. Buddhist thought asserts that self-compassion should lead to increased feelings of social connectedness and compassion for others. Initial empirical work supports this theory (Neff, 2003a). Third, self-compassion is theoretically distinct from self-complacency. Self-compassion is thought to enable a clear view of one's failings without a need for defensiveness (Germer, 2009; Leary, Tate, Adams, Allen, & Hancock, 2007; Neff, 2003b). Self-compassion is about balanced awareness, not indifference or resignation; it's about understanding faults, and not colluding with

them. Also, having compassion for the self means desiring health and well-being for the self, so self-compassion should encourage personal growth (Neff, 2003a).

Overall, the common humanity and mindfulness components of self-compassion are thought to separate self-compassion from self-pity and self-centeredness, whereas the clear perspective of one's faults and motivation to grow are thought to separate self-compassion from self-complacency.

Self-Compassion and Emotional Wellbeing

One of the most consistent findings in the research literature is that greater self-compassion is related to greater psychological health and well-being (see Barnard & Curry, 2011 for a review). In fact, a recent meta-analysis (MacBeth & Gumley, 2012) found a large effect size when examining the link between self-compassion and psychopathology across twenty studies. A key feature of self-compassion is the lack of self-criticism, and self-criticism is known to be an important predictor of anxiety and depression (Blatt, 1995). However, self-compassion still offers protection against anxiety and depression when controlling for self-criticism (Neff, 2003a).

In a study done by Neff, Kirkpatrick and Rude (2007a), participants were given a mock job interview in which they were asked to "describe their greatest weakness." Even though self-compassionate people used as many negative self-descriptors as those low in self-compassion when describing their weaknesses, they were less likely to experience anxiety as a result of the task. Self-compassionate individuals also tended to use more connected and less isolating language when writing about their weaknesses, for instance, using fewer "I statements," using more "we statements," and making more social references to friends, family, and others. This

suggests that self-compassion may reduce self-evaluative anxiety because weaknesses feel less threatening when considered in context of the shared human experience.

Self-compassionate people have also been found to ruminate much less than those who lack self-compassion (Neff, 2003a), presumably because they can break the cycle of negativity by accepting their human imperfection with kindness. A study by Raes (2010) found that rumination mediated the association between self-compassion and depression and anxiety, suggesting that reduced rumination is another key benefit of self-compassion.

So far, the majority of studies focusing on self-compassion have been correlational, using the Self-Compassion Scale (SCS) (Neff, 2003a), which assesses the participant's various thoughts, emotions, and behaviors that correspond to the different dimensions of self-compassion—self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification. Increasingly, however, researchers are also using methods such as mood inductions (Breines & Chen, 2012; Leary et al., 2007); behavioral observations (Sbarra, Smith & Mehl, 2012) or short-term interventions (Shapira & Mongrain, 2011) as a means of examining the impact of self-compassion on well-being.

Self-compassion has been shown to mitigate the effect of negative life events on emotional functioning in general. For instance, a series of studies by Leary, Tate, Adams, Allen & Hancock (2007) investigated the way that self-compassionate people deal with negative self-relevant thoughts or life events. These studies found that individuals with higher levels of self-compassion had more perspective on their problems and were less likely to feel isolated by them. For example, they were more likely to feel that their struggles weren't any worse than what others go through. The researchers also found that priming their self-compassion helped

participants to take responsibility for their role in past negative life events without experiencing as much negative affect as controls who were not primed (Leary et al., 2007).

There may be physiological processes underlying the link between self-compassion, anxiety and depression. Gilbert & Irons (2005) suggested that self-compassion deactivates the threat system (associated with feelings of insecure attachment, defensiveness and autonomic arousal) and activates the self-soothing system (associated with feelings of secure attachment, safety, and the oxytocin-opiate system). In support of this argument, Rockcliff, Gilbert, McEwan, Lightman, and Glover (2008) found that giving individuals a brief self-compassion exercise lowered their levels of the stress hormone cortisol. It also increased heart rate variability, which is associated with a greater ability to self-soothe when stressed (Porges, 2007).

While self-compassion helps lessen the hold of negativity, it's important to note that self-compassion does not push negative emotions away in an aversive manner. In fact, self-compassionate individuals are less likely to suppress unwanted thoughts and emotions than those who lack self-compassion (Neff, 2003a), and are more likely to acknowledge that their emotions are valid and important (Leary et al., 2007; Neff et al., 2005; Neff et al., 2007b). Furthermore, positive emotions are created by embracing the negative ones, instead of replacing negative feelings with positive ones. For this reason, self-compassion is associated with positive psychological strengths (Neff, 2012), such as emotional intelligence, wisdom, life satisfaction, and feelings of social-connectedness—important elements of a meaningful life (Neff, 2003a; Neff, Pisitsungkagarn & Hsieh, 2008).

People high in trait self-compassion or who are induced to be in a self-compassionate frame of mind also tend to experience more happiness, optimism, curiosity, creativity, and positive emotions such as enthusiasm, inspiration, and excitement than those who are self-critical

(Hollis-Walker & Colosimo, 2011; Neff, et al., 2007). Shapira and Mongrain (2010) conducted a study in which individuals were asked to write a self-compassionate letter to themselves every day for seven days, and found that this brief intervention increased happiness levels compared to a control group who wrote about early memories for the same period. Moreover, this increased level of happiness was maintained at one month, three month, and six-month follow-ups.

Therefore, by being kind and compassionate to oneself during painful times, positive feelings are generated that help people balance the negative ones, allowing for more pleasant states of mind.

Overall, researchers have found that self-compassion is correlated with positive outcomes in a variety of domains such as affect, cognitive patterns, achievement, and social connections (see Barnard & Curry, 2011 for a review) and that interventions that raise self-compassion may also correlate with positive change in these domains (Neff, in press). However, many of these studies rely on self-report, and need to be improved upon with other methodologies.

Self-Compassion, Motivation and Health

Recent research has highlighted the potential role of self-compassion in enhancing health outcomes. Much of the limited research has focused on the role of self-compassion for promoting resilience in general (Neff, Kirkpartrick & Rude, 2007), in the context of illness (Brion, Leary & Drabkin, 2014), and for reducing stress (Allen & Leary, 2010; Sirois, 2014). There is, however, promising but limited evidence linking self-compassion to intentions to engage in health-promoting behaviors (Terry, Leary, Mehta & Henderson, 2013), and to reducing health risk behaviors (Adams & Leary, 2007; Brooks et al., 2012; Kelly, Zuroff, Foa & Gilbert, 2010). Terry and Leary (2011) hypothesized that self-compassion facilitates health-promoting behaviors via self-regulation processes, such as through setting goals, taking action, attention to and evaluation of ongoing behavior, and emotional regulation. The three

components of self-compassion: self-kindness (vs. self-judgment), common humanity (vs. isolation), and mindfulness (vs. over-identification) (Neff, 2003b), are each proposed to facilitate these self-regulatory processes. For example, breaking one's diet can often result in feelings of shame, self-criticism, and binge-eating (Polivy, Herman & Deo, 2010), and discontinuation of the diet. People with self-compassion, however, may view these missteps less negatively, perhaps realizing that everyone makes mistakes (common humanity) and, therefore, not becoming overly self-critical (self-kindness) or enmeshed in feelings of guilt, shame or frustration (mindfulness). Research demonstrating that self-compassion is associated with less negative reactions after imagining a diet-breaking scenario (Adams & Leary, 2007), and fewer binge eating symptoms (Webb & Forman, 2013), supports this proposition.

Self-compassion may also promote engagement in positive health behaviors because of its ameliorating effects on negative affective states (Leary et al., 2007), which might otherwise jeopardize health goals. Sirios & Kitner (2014) found that self-compassion may facilitate the experience of healthy emotions in the context of health behavior change by moderating the potential negative responses to minor setbacks and failures, and by encouraging the positive emotions necessary to maintain motivation in pursuing health goals. Further research, of a prospective nature, is needed to clarify these interrelationships, as both positive and negative affect appear to play contributing roles in self-regulation (Baumeister, Zell, & Tice, 2007).

It is important to note that previous research has suggested that enhancement of self-compassion is possible (Neff & Germer, 2013), and that interventions to enhance someone's level of self-compassion can have beneficial effects such as reducing health risk behaviors such as smoking (Kelly, Zuroff, Foa & Gilbert, 2010), and over-eating (Adams & Leary, 2007). Self-compassion has also been found to promote health-related behaviors such as seeking

medical treatment when needed (Terry & Leary, 2011) and exercising (Magnus, Kowalski & McHugh, 2010). The relative ease of administering self-compassion interventions makes them a potentially useful tool for promoting health behavior change. Therapeutic encouragement of self-compassion may be accomplished by using a variety of strategies, including evoking self-compassionate imagery, writing a compassionate-self letter, loving-kindness meditation, and affectionate breathing (Adams & Leary, 2007; Neff & Germer, 2013). Such interventions can be done through group workshops or training sessions and individual therapy, as well as home exercises.

Such interventions may be especially valuable in clinical settings and with at-risk populations for whom making health behavior change is critical. Sirios & Kitner (2014) argued that self-compassion may motivate individuals to engage in adaptive health-promoting behaviors, as opposed to just reducing health-risk behaviors. For example, in individuals with diabetes, cardiovascular heart disease, or hypertension, engendering self-compassion may lead to increased activity in exercising and healthy eating and may improve sleep—all of which contribute to better functioning and disease prognosis (Buxton & Marcelli, 2010; Lee et al., 2012; Schulze & Hu, 2002). By capitalizing on the tendency for self-compassionate individuals to focus on goals that are of personal benefit to their well-being, and their enhanced ability to break from unhealthy or unattainable goals and reengage with more adaptive health-related goals (Neely, Schallert, Mohammad, Roberts & Chen, 2009), clinicians and health-service professionals who promote self-compassion may be able to effect positive behavioral change in those under their care.

What is unknown, however, is the amount of change in self-compassion that may be necessary to impact health behaviors beneficially. Previous research focused on improvement of

harmful health behaviors, rather than on promotion of adaptive health behaviors, has suggested that only minimal change in self-compassion is necessary; for instance, only small improvements in the self-compassion components of isolation ($\Delta = .28$; effect size = .26) and self-kindness ($\Delta = .08$; effect size = .10) were needed to reduce alcohol misuse (Brooks et al., 2012), and in a separate study, small changes in self-compassion were related to reduced cigarette smoking (effect size = .19; Kelly et al., 2010). Although future prospective studies are needed, it is likely that interventions yielding similar effects would contribute to the promotion of adaptive health behaviors.

Self-Compassion as an Inherited Trait

Gilbert (2009) has argued that self-compassion is an evolved ability that emerges from behavioral systems involving attachment and affiliation. Seeking closeness and soothing from caregivers in order to provide a sense of security in the world is a mammalian behavior. For mammals, survival depends on the “tend and befriend” instinct (Taylor, 2002). In times of threat or stress, animals that are protective of their offspring and live within cooperative groups are more likely to successfully pass on their genes to the next generation (Taylor, 2002). Among humans, the sense of secure attachment and belonging that arises from the individual’s caregiving system creates feelings of safety, of being worthy of love and care, increased happiness, and reduced anxiety and depression (Mikulincer & Shaver, 2007).

For this reason, individuals who are raised in safe, secure environments and who experience supportive and validating relationships with caregivers should be more able to relate to themselves in a caring and compassionate manner. In contrast, individuals who are raised in insecure, stressful, or threatening environments are likely to have an insufficiently developed self-soothing system and few internalized models of compassion to draw upon (Gilbert &

Proctor, 2006). Research supports this theory that self-compassion is related to the caregiving system and early childhood interactions. People who lack self-compassion are more likely to have critical mothers, for instance, come from families in which there was a lot of conflict, and display insecure attachment patterns, while the converse is true for those with higher levels of self-compassion (Neff & McGeehee, 2010; Wei, Liao, Ku & Shaffer, 2011). However, while pre-existing trait levels of self-compassion have their origins, at least in part, in early childhood experiences, skills of self-compassion can also be taught or enhanced through various interventions.

Teaching Self-Compassion

A new area of research concerns the implications of self-compassion for clinical practice (Baer, 2010). Given that therapy clients often have problems related to their family background, they may be especially likely to benefit from developing greater self-compassion. Neff and colleagues conducted a study that tracked changes in self-compassion experienced in therapy clients over a one month period (Neff, Kirkpatrick & Rude, 2007a). Therapists used a Gestalt two-chair technique designed to help clients lessen self-criticism and have greater compassion for themselves (Safran, 1998, as cited in Neff et al., 2007a). Results indicated that increased self-compassion levels over the month-long period were associated with fewer experiences of self-criticism, depression, rumination, thought suppression and anxiety (Neff et al., 2007a).

Paul Gilbert developed a group-based therapy intervention for clinical populations called Compassionate Mind Training (CMT, 2006). CMT is designed to help people develop skills of self-compassion, especially when their usual ways self-to-self relating involves self-criticism. In a pilot study of CMT involving hospital day patients with intense shame and self-criticism, significant decreases in depression, self-attacking, shame, and feelings of inferiority were

reported after participation in the CMT program (Gilbert & Proctor, 2006). Moreover, almost all of the participants felt ready to be discharged from their hospital program at the end of the study.

Therapeutic approaches that rely on mindfulness, such as Jon Kabat-Zinn's Mindfulness-Based Stress Reduction (MBSR) program (Kabat-Zinn, 1982), may also be effective at helping people develop self-compassion. Mindfulness teaches people to notice the difficult thoughts and emotions that arise in present-moment awareness, so they can be experienced with kindness, acceptance, and without judgment. MBSR courses are commonly taught by therapists and other health professionals to help deal with stress, depression, and other forms of mental distress. Research has demonstrated that MBSR significantly increases self-compassion (Shapiro, Astin, Bishop & Cordova, 2005; Shapiro et al., 2007). Research has also shown that people who practice mindfulness meditation are more self-compassionate than those who are less experienced (Lykins & Baer, 2009; Neff, 2003a; Orezch, Shapiro, Brown & McKay, 2009).

As Germer noted in his book, *The mindful path to self-compassion* (2009), self-compassion adds another dimension to mindful acceptance. "Whereas acceptance usually refers to *what's happening to us*—accepting a thought or a feeling—self compassion is acceptance of *the person to whom it's happening*. It's acceptance of ourselves while we are in pain (Neff, 2003a, as cited in Germer, 2009, p. 33)." This is a key insight. When we are soothed and comforted by self-compassion, it becomes easier to relate to painful feelings in a mindful way. Thus, training that teaches self-compassion in addition to mindfulness skills may be especially useful in therapy.

To this end, Chris Germer and Kristin Neff have developed a training program designed to teach self-compassion skills to the general public called Mindful Self-Compassion (MSC; Neff & Germer, 2012). The structure of MSC is modeled on Mindfulness-Based Stress

Reductions (MBSR; Kabat-Zinn, 1982), with participants meeting for two and a half hours once a week over the course of eight weeks, and also meeting for a half day retreat. Formal meditation practices are taught such as loving-kindness meditation (LKM), an ancient Buddhist practice designed to increase good will for oneself and others by repeating a series of phrases such as “May I be safe, may I be peaceful, may I be healthy, and may I live with ease” (Grossman, Niemann, Schmidt & Walach, 2004). A variant of the practice is also taught that focuses on generating self-compassion—calling to mind an emotionally difficult situation in one’s life and repeating phrases such as “May I feel safe, may I feel peaceful, may I be kind to myself, may I accept myself as I am.” Informal practices are taught such as placing one’s hands on one’s heart in times of stress, or repeating a set of memorized self-compassion phrases for use in daily life. Throughout the program, interpersonal exercises are used to help generate feelings of common humanity. Home practices are assigned at the end of each session, such as writing a compassionate letter to oneself. Participants are asked to do 40 minutes of self-compassion practice each day, which can be a combination of formal and informal practices (Neff & Germer, 2012).

Neff & Germer (2013) recently conducted a randomized controlled study of the MSC program that compared outcomes for a treatment group to those who were randomly assigned to a waitlist control group. Results indicated that the more MSC participants practiced formal meditation, the more they increased their self-compassion levels. Similarly, the degree that participants practiced informal self-compassion techniques in daily life also predicted gains in self-compassion. This implies that self-compassion is a teachable skill and the more one practices it, the more one learns. This study was limited by the lack of an active control group, a shortcoming that will need to be addressed in future research. Also, given that most participants

had prior mindfulness meditation experience, it might be that practices taught in the program are effective only for those who already know how to meditate. On the other hand, the result that MSC participants' levels of wellbeing increased, even though most had prior meditation experience, suggests that MSC offers tangible benefits over and above mindfulness meditation alone.

Gender Differences in Self-Compassion

Though research has revealed potential positive mental health outcomes associated with self-compassion, data suggest that these benefits might not be experienced equally for men and women. Multiple studies on self-compassion have found that men have consistently higher levels of self-compassion than women (Neff et al., 2005; Neff & McGehee, 2010; Yarnell & Neff, 2012). From an evolutionary perspective this may be because women are more threat-focused—focused on dangers in order to keep their babies alive and pass on their genes—which may overrule their own need for self-compassion (Germer, 2009). In addition, women who tend to be more self-critical than men, and display a ruminative coping style (Leadbeater, Kuperminc, Blatt & Hertzog, 1999), often suffer more mental health challenges than men. Conversely, other studies have not found significant gender differences (Iskender, 2009; Neff et al., 2007b; Neff, Pisitsungkagarn, & Hsieh, 2008).

However, there has been no research aimed at determining whether gender plays a role in the self-compassion levels of adults seeking treatment for AUDs. It may be that self-compassion differences are more clear-cut for this population, given that self-criticism and rumination play a key role in AUDs (Crum et al., 2013). If women with AUDs are found to display less self-compassion than men, it would suggest that substance abuse counseling centers and treatment

programs may want to focus more explicitly on raising self-compassion levels of women seeking treatment.

Self-Compassion and Alcohol Use Disorders

Self-compassion is no stranger to substance abuse treatment. When an Alcoholics Anonymous (AA) member says at a meeting, “I’m an alcoholic,” he or she is speaking from a larger frame of self-acceptance—nothing to hide. Resisting the idea that one is an alcoholic, or becoming overwhelmed by shame when a relapse occurs, can be obstacles to staying clean and sober. The self-kindness component of self-compassion involves the capacity to understand and to be sensitive to what one is feeling (Neff, 2003a). Consequently, this component might protect against alcohol use for adults who drink as a means of coping with failure and self-criticism. One reason for this is that self-compassion is an antidote to self-criticism (Neff, 2003a), which is also related to alcohol abuse. Accepting failure with kindness, as opposed to a self-critical attitude, might imply that one does not need alcohol to cope with feelings of failure in the present moment. This is particularly relevant for individuals who use alcohol as a remedy for self-criticism, depressive symptoms, anxiety, and stress (Crum et al., 2013). The self-kindness and mindfulness components may also help adults with AUDs to connect their inner pain and discomfort with alcohol abuse and/or dependence with kindness and sensitivity. This is relevant when alcohol is used as an attempt to avoid painful emotional states (Khantzian, 2003). Moreover, the common humanity construct might contribute to breaking the cycle of self-absorption that contributes to alcohol misuse (Campbell & Page, 1993); as one realizes that others have similar fears of anxiety and humiliation. This awareness of common humanity may combat feelings of isolation often associated with drinking.

In one of the few studies of self-compassion conducted in the drug and alcohol field, Moeller & Crocker (2009) tested participants' self-image goals and goals as they related to high self-compassion on heavy episodic alcohol use and alcohol related problems in a sample of 258 undergraduate college students. The results from the study found that heavy alcohol use and alcohol-related problems were associated with goals to improve one's *self-image* (e.g., as a means to cope with negative affect, especially in social situations). In contrast, goals to improve one's *self-compassion* were not associated with heavy drinking or alcohol-related problems, suggesting that self-compassion may act as a protective coping skill against alcohol abuse or alcohol-related problems.

Similarly, Rendon (2007) completed a study examining the relationship between alcohol use, self-compassion, mindfulness and self-esteem using 300 psychology students. The results indicated that alcohol use was negatively correlated to self-esteem, self-compassion and psychological symptoms, partially mediating the association between these constructs. Additionally, self-compassion was found to be a stronger predictor of psychological health than mindfulness. In another study, Neff (2004) found that self-compassionate individuals experience greater psychological well-being and are less likely to use drugs and alcohol.

To date there has only been one published research study examining the relationship between alcohol dependence, hazardous alcohol use and self-compassion (Brooks et al., 2012). Brooks et al. (2012) used various semi-structured questionnaires to assess the relationship between the pre-existing trait of self-compassion on participant levels of depression, anxiety and stress; before treatment and at 15 weeks post-baseline. At baseline, participants were found to have significantly lower levels of overall self-compassion (and its components) than the norms for the general population. After completion of treatment, participants' alcohol consumption had

been reduced and their overall levels of self-compassion (and its components) had improved (although still below norms for the general population), which provided preliminary evidence for the relationship between self-compassion, depression, anxiety, stress and alcohol use amongst adults with AUDs.

One limitation of the Brooks et al (2012) study was that it was part of a larger naturalistic research study. The researchers were not able to select a study sample for a targeted intervention, nor were they able to accurately determine the length and quality of psychosocial interventions for participants. There were no treatment integrity checks and treatment sessions were not audio or video recorded. Therefore, replication of this study would be difficult. Other limitations consisted of limited generalizability due to the geographical location, uneven sample sizes between alcohol users and non-users, as well as no examination of time-based relationships between self-compassion and depression, anxiety, stress and alcohol consumption.

Self-Compassion and AUDs, Depression and Anxiety

Another consistent finding in the research literature is that greater self-compassion is related to less anxiety and depression and greater overall wellbeing (MacBeth & Gumley, 2012). Thus, based on the high incidence of co-morbidity between depression, anxiety and AUDs (Grant et al., 2004), one can theorize that self-compassion might also offer protection against AUDs. Although research on self-compassion and AUDs is scarce, a few studies have provided preliminary evidence that self-compassion is related to alcohol abuse (Rendon, 2007; Brooks et al., 2012). These preliminary findings state that adults with AUDs have lower levels of self-compassion and higher levels of depression, anxiety, stress and hazardous alcohol use than the general population (Rendon, 2007; Brooks et al., 2012), suggesting that individuals with dual-

diagnoses (e.g., AUD and depression) may lack important coping strategies to help in their recovery.

Summary

After conducting this literature review it became apparent how important it is to conduct further study to extend the scant research on self-compassion and alcohol-use disorders (AUDs). So far, the majority of the studies focusing on self-compassion have been correlational, using the Self-Compassion Scale (SCS; Neff 2003b) to determine the association between the trait self-compassion and psychological health (Neff, 2003a). These studies have also focused primarily on the general population, and mostly with college students. Research related to self-compassion and clinical populations has primarily been confined to depression, anxiety, and eating disorders (see Barnard & Curry, 2011 for a review; Macbeth & Gumley, 2012).

In addition, only two studies to date have been published which examine the relationship between hazardous alcohol use and self-compassion (Brooks et al., 2012; Rendon, 2007). The Brooks et al. (2012) and Rendon (2007) studies have provided preliminary evidence for an association between these two variables—indicating that self-compassion may buffer against alcohol abuse or dependence—but these studies have numerous methodological issues and the results need to be replicated. Therefore, more studies need to be conducted on this topic to advance the understanding of the relationship between the trait self-compassion as it pertains to adults with Alcohol Use Disorders (AUDs).

The current study used a quantitative method design to explore relationships between self-compassion, depression, anxiety and stress in adults with AUDs who are currently in treatment. The over-arching research questions that guided this study were: Do adults with AUDs have lower levels of self-compassion and higher levels of depression, anxiety and stress

than norms for the general population? Is there an inverse correlation between overall self-compassion (and its components) and levels of depression, anxiety and stress in a clinical sample of adults with AUDs? Do adults with a history of AUDs, but currently not drinking, have higher levels of self-compassion and lower levels of depression, anxiety and stress than adults who are actively abusing alcohol? This study will also examine differences in and will seek to establish relationships between self-compassion and alcohol use disorders based on age, gender and severity of drinking-related problems.

CHAPTER III

Methodology

Nature of the Study

This research study was a cross-sectional, correlational study that was exploratory in nature. I used two different methods of data collection, both of which utilized a quantitative survey that took approximately 15-30 minutes and could be completed at home. The rationale for selecting a quantitative method is for the versatility, efficiency, reliability and validity that this type of study yields (Engel & Schutt, 2013, p. 228). Given the Smith College School for Social Work Master's Thesis requirements, limited financial resources, and the researcher's access to this vulnerable population, the current research design and method was chosen to improve feasibility.

Recruitment

The first recruitment method was a confidential mail-in survey distributed to clients of ServiceNet, a Community Health Center with outpatient clinics and recovery homes throughout Western Massachusetts. ServiceNet's outpatient clinics provide behavioral health and substance abuse treatment to adults in the form of individual and group psychotherapy and medication management. The recovery homes serve as transitional residences for men and women 18 years of age and older who are in the early stages of substance abuse recovery. Participants who completed the mail-in surveys returned them to the research assistant at ServiceNet in Northampton, MA.

Due to the initial slow response rate of mail-in surveys, I chose to include an additional method of data collection, which was an anonymous, online version of this study's survey via Survey Monkey. The survey's website link was posted on various online addiction websites, targeting adult individuals within the United States who met the study's eligibility criteria. Eligible participants were 18 years of age or older, held a primary diagnosis of—or history of—an AUD, currently receiving mental health or substance abuse treatment, and were able to read and write in English.

For this study, I first obtained Smith College School of Social Work Institutional Review Board approval. Next, I obtained approval from ServiceNet's Clinical Research Director, Jennifer Geertsma, to conduct the study there, and to contact clinicians regarding recruitment for potential participants. Once approval was confirmed, Mrs. Geertsma assisted in identifying eligible participants from ServiceNet's client database. I then emailed a recruitment letter to ServiceNet clinicians at various outpatient clinics and recovery homes in Northampton, Pittsfield, Orange, and Greenfield, MA.

The recruitment letter outlined the purpose and procedure of the study and requested that clinicians, with clients who met the study's eligibility criteria, respond if they were willing to assist in distributing surveys. Clinicians who chose to assist then discussed with their clients the possibility of participation in the research study during a treatment session. These clinicians were instructed not to coerce their clients into participation, nor to later ask their clients about completion of the survey unless clients initiated the discussion in order to minimize an ethical concern in motivation for participants.

If a client expressed interest in participating in the study, the clinician gave them a packet in a sealed envelope. The packet included the survey, recruitment flyer, and the informed

consent form, which educated participants about the voluntary and confidential nature of this study. Both the recruitment flyer and the informed consent form stated that participation—or refusal to participate—did not affect their treatment in any way, and their therapist would not know if they had chosen to participate, nor would the therapist be given any information they provided in the survey. The study’s packet also included a stamped and pre-addressed envelope to return completed surveys to the Clinical Research Director at ServiceNet in Northampton, MA. In addition, my confidential email and phone number were provided to participants to enable them to ask questions about the study, if necessary.

Since response to paper survey recruitment was slower than anticipated, I obtained IRB approval from Smith College School of Social Work for an online version of my survey. Once approval was confirmed, I posted a link to my survey on Facebook, and various online addiction forums: The Addiction Recovery Guide.org, Sober Recovery.com, AddictionSurvivors.org, and Daily Strength.org; and included a brief description of my study that invited eligible individuals to participate. This description indicated the voluntary and anonymous nature of the survey and provided my email address to participants should they have any questions. The survey was hosted via Survey Monkey and also included the informed consent document and the 4-question eligibility screening test, which participants were required to complete before starting the main survey.

Compensation was given in the form of entry into a raffle to win one of two \$50 gift cards to Walmart. Participants who completed the survey online were given the option of entering the raffle by clicking on the link to a separate website, which asked them to provide their contact information. Two participants were randomly selected as winners (both were from

ServiceNet), and were mailed their gift cards by the Clinical Research Director at ServiceNet to further protect their anonymity.

Data Collection Methods

The current research study used previously designed instruments, whose psychometric properties have been found to have high reliability and validity (DASS-21; Lovibond & Lovibond, 1995; SCS; Neff, 2003a; AUDIT; WHO, 1982). Both the online and paper surveys assessed for individuals' levels of self-compassion, anxiety, depression and stress, and screened for an Alcohol Use Disorder (AUD) or history of an AUD (sober recovery). In addition, the online survey included a brief, four-question, screening questionnaire to ensure that potential participants met the study's eligibility criteria. For the purposes of this study, demographic information such as age, gender, and racial/ethnic identification were collected for stratification of sample into groups, and may lead to considerations for future research.

In order to protect the confidentiality of participants who completed the paper surveys, the Clinical Research Director at ServiceNet removed identifying information from all surveys before forwarding them to me for data analysis. Thus, all paper survey respondents remained anonymous to me. My research advisor and I, as well as, the Smith College Statistician were the only individuals who had access the data after all identifying information had been removed. All online surveys were completely anonymous. Participants' information was aggregated so that it would not be individually identifiable. Electronic data was encrypted and password protected.

Sample

The current study used a non-probability, availability (convenience) sample of adults (18+ years old), within the United States, who either had a primary presentation of an Alcohol Use Disorder or identified as being in sober recovery (history of an AUD), and were currently

receiving mental health and/or substance abuse treatment. Out of the 150 paper surveys that were distributed to clients of ServiceNet's outpatient behavioral health and/or substance abuse clinics and recovery homes, 49 (31%) completed and returned their surveys. In addition to the 49 participants who completed paper surveys, 20 completed online surveys. Online survey respondents identified themselves as an adult living within the United States who was currently receiving treatment for an AUD or who identified as being in sober recovery, and who subscribed to at least one of various online alcohol and addiction forums on which the survey had been posted (Table 1).

Little ethnic diversity was represented within this sample, in part due to the geographical location and population served by ServiceNet's outpatient clinics. Almost three quarters ($n = 49$, 71%) of the participants were from Western Massachusetts (e.g., Berkshire, Franklin, and Hampshire Counties). Online respondents' geographical location information within the United States was not collected. Overall, most respondents identified themselves as White/Caucasian ($n = 56$, 81.3%), followed by Hispanic/Latino ($n = 5$, 7.2%), two or more races/ethnicities ($n = 4$, 5.8%), African American ($n = 3$, 4.3%), and Asian ($n = 1$, 1.4%). Participants' other drug use/abuse and co-morbid DSM-V diagnoses were not collected.

Of the 69 participants, 28 (41%) identified as being in sober recovery (which was indicated by a score of 0 on the first AUDIT question), and 41 (59%) identified as having a primary presentation of an AUD (as diagnosed by the referring clinicians). More men ($n = 39$, 57%) than women ($n = 27$, 39%) completed the surveys. Three individuals, who identified their gender as 'other,' also completed the survey (4%). Sixty two indicated their age, which ranged from 22-71 years. Seven individuals declined to indicate their age on the survey. Although participants were asked to indicate their exact age, for analysis purposes I chose to divide age

into three categories: 18-34 years ($n = 17, 27\%$), 35-50 years ($n = 19, 31\%$), and 51-71 years ($n = 26, 58\%$).

Table 1
Demographic Characteristics of Population

	Frequency	Percent
Gender		
Male	39	57
Female	27	39
Other	3	4.3
Age (in years)		
18-34	17	27
35-50	19	31
51-71	26	42
Missing	7	0
Race/Ethnicity		
White/Caucasian	56	81.3
Hispanic/Latino(a)	5	7.2
Two or more ethnicities/races	4	5.8
Black or African American	3	4.3
Asian	1	1.4
American Indian or Alaskan Native	0	0
Other	0	0
I prefer not to answer	0	0
Sober Recovery		
Yes	28	40.6
No	41	59.4
AUDIT Category/Drinking Severity		
Low (0-7)	24	35
Moderate (8-19)	19	27
High (20+)	26	38

Note. $N = 69$.

Instruments

This study used previously designed instruments, whose psychometric properties have been found to have high reliability and validity. To assess for trait self-compassion the participants completed the 26-item Self-Compassion Scale (SCS), which is based on the Buddhist concept of self-compassion (Neff, 2003a; see Appendix E). Items include: “I try to be loving towards myself when I’m feeling emotional pain” (self-kindness); “When I fail at something important to me I become consumed by feelings of inadequacy” (self-judgment); “I try to see my failings as part of the human condition” (Common humanity); “When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world” (isolation); “When something upsets me, I try to keep my emotions in balance” (mindfulness); “When I’m feeling down I tend to obsess and fixate on everything that’s wrong” (over-identification).

SCS respondents indicated how frequently they had the experience described in each statement using a 5-point Likert scale from 1 (*almost never*) to 5 (*almost always*). When averaged, scores ranging from 1 to 2.5 indicated low levels of self-compassion; 2.5 to 3.5 indicated moderate levels; and 3.5 to 5 indicated high levels of self-compassion. Each of the three components were measured by two factors, one of which was reversed scored. Taking the mean of each subscale and adding the subscales together will calculate the total self-compassion score. Evidence for validity and reliability of the scale has been presented in a series of studies (Neff, 2003; Neff, Kirkpatrick & Rude, 2007a). Previous research has shown the internal consistency reliability for scores on the SCS $a = .94$ (Neff, 2003a, 2003b).

The World Health Organization’s (WHO) Alcohol Use Disorders Identification Test (AUDIT; Saunders et al., 1993) was used to screen for risky and high risk (or hazardous and

harmful) drinking. The AUDIT has three questions on alcohol consumption (1 to 3), three questions on drinking behavior and dependence (4 to 6), and four questions on the consequences or problems related to drinking (7 to 10). Questions 1-8 are scored on a five-point scale from 0, 1, 2, 3, and 4. Questions 9 and 10 are scored on a three-point scale from 0, 2, and 4. A score of 8- 15 indicates hazardous drinking, which is defined as “a pattern of alcohol consumption that increases the risk of harmful consequences for the user or others (Babor, Higgins-Biddle, Saunders & Monteiro, 2001, p. 5).” A score of 16 or higher indicates alcohol dependence, which is defined as “a cluster of behavioral, cognitive, and physiological symptoms that may develop after repeated alcohol use (Babor et al., 2001, p. 5).” Typically, these phenomena include a strong desire to consume alcohol, impaired control over its use, persistent drinking despite its harmful consequences, a higher priority given to drinking over other activities and obligations, increased alcohol tolerance, and a physical withdrawal reaction once alcohol use is stopped (APA, 2013; Babor et al., 2001). For the purposes of this study, a score of ≤ 7 indicated low risk, 8-19 indicated moderate risk, and a score of 20 and higher indicated high risk/severity of AUD and alcohol-related problems. The AUDIT has been found to have high internal and external validity and high reliability ($r = .86$) (Babor et al., 2001; Saunders et al., 1993).

Depression, anxiety and stress were measured using the Depression, Anxiety and Stress Scale-21 (DASS-21; Lovibond & Lovibond, 1995). According to the DASS-21, depression is defined as “low positive affectivity” (similar to anhedonia); anxiety will be defined as “physiological hyperarousal”; and stress will be defined as “nervous tension, difficulty relaxing and irritability (Lovibond & Lovibond, 1995).” Each seven-item scale on the DASS-21 has response options ranging from 0 (*did not apply to me at all*) to 3 (*applied to me much, or most of the time*). The DASS-21 total scale score has excellent internal consistency of .93 (Henry &

Crawford, 2005), and its score interpretations have sound construct validity (Henry & Crawford, 2005; Page, Hooke & Morrison, 2007). For the purposes of this study, mild depression was indicated by a score of 0-6, moderate depression was indicated by a score of 7-10, and severe depression was indicated by a score of 11 or higher. Anxiety scores were as follows: 0-5 for mild, 6-7 for moderate, and 8+ for severe. Stress scores were indicated as: 0-9 for mild, 10-12 for moderate, and 13+ for severe stress.

This study also collected demographic information such as age, gender, and racial/ethnic identification and status of current alcohol use. In addition, the online survey included a brief, four-question, screening questionnaire to ensure that potential participants met the study's eligibility criteria.

Analysis

The statistical package SPSS 19.0 for Windows was used for all analyses. Pearson correlation analyses were performed on the scores for the DASS-21 (Lovibond & Lovibond, 1995), the Self-Compassion Scale (SCS; Neff, 2003) and the AUDIT (Saunders et al., 1993). *T*-tests compared differences in the DASS-21 and overall Self-Compassion (and subscale) scores to norms of the general population. *T*-tests were also performed to examine the differences in scores on the DASS-21 and the SCS, by whether or not participants were in sober recovery and by type of survey completed (paper vs. online). One-way analyses of variance were used to examine the effect of age and gender on DASS-21 and SCS scores. One-way analyses of variance were also conducted to examine the differences in the SCS scores, the DASS-21 and the AUDIT categories (low, moderate, high).

CHAPTER IV

Findings

The purpose of this exploratory study was to examine relationships between self-compassion (and its components) and depression, anxiety and stress in a clinical sample of adults with alcohol use disorders (AUDs). Of special interest to this study was to explore potential differences in self-compassion (and its components), and depression, anxiety and stress by whether or not respondents were in sober recovery or still drinking, as well as by type of survey taken (paper and pencil version v. anonymous online version), and by gender. The goal was to replicate prior research, which has found that adults with AUDs have lower levels of self-compassion and higher levels of depression, anxiety and stress than norms for the general population. Such results suggest that interventions designed to enhance self-compassion may be beneficial if incorporated into substance abuse treatment.

This study consisted of a clinical sample of 69 adults. Participants who had a history of an AUD but were no longer drinking at the time of participation were referred to as “in sober recovery,” and those who had a primary presentation of an AUD at time of participation were referred to as “not in sober recovery.” Severity of alcohol use and alcohol-related problems were used as a continuous variable and were also separated into three categories (low, moderate, and high) and were referred to as “AUDIT score” or “AUDIT Category.”

This chapter contains a description of the sample and summaries of the quantitative data including comparisons of self-compassion scores (and its subscales) and depression, anxiety, and

stress overall to norms for the general population; by whether or not respondents were in sober recovery, by gender, and by type of survey taken (paper vs. online).

I began analysis by calculating the means and standard deviations for each variable: overall self-compassion (and its subscales), depression, anxiety and stress, and severity of drinking related problems (AUDIT scores). On average, respondents reported feeling moderately depressed ($M = 9.22$), moderately anxious ($M = 6.39$), and stressed ($M = 10.41$). Respondents also reported moderate levels of overall self-compassion ($M = 2.71$), self-kindness ($M = 2.63$), common humanity ($M = 2.94$), mindfulness ($M = 2.96$), self-judgment ($M = 3.52$), isolation ($M = 3.42$), and over-identification ($M = 3.27$). The overall mean AUDIT score of 16.1 confirmed that all participants who were not in sober recovery at time of participation met criteria for an alcohol use disorder (AUD).

I then ran t -tests to determine if the mean scores for depression, anxiety, and stress were different from the means in a previous study on adults with AUDs (Brooks et al., 2012). Results indicated that participants in the current study were significantly less depressed, less anxious, and less stressed than participants in the Australian study (Brooks et al., 2012). The mean depression score for the current study was 9.22, whereas the Brooks study had a mean depression score of 17.48 ($t(68) = 11.35$, two-tailed, $p = .000$). The mean anxiety score for the current study sample was 6.39 versus a mean of 10.57 ($t(68) = 6.050$, two-tailed, $p = .000$) in the previous study. Mean stress score for the current study was 10.41 compared to a mean score of 21.20 ($t(68) = 16.64$, two-tailed, $p = .000$) in the Brooks et al. study.

T -tests were also used to compare differences in means for overall self-compassion and its subscale means for the current study compared to the study by Brooks and colleagues. Significant differences were found between self-kindness ($t(68) = 4.623$, two-tailed, $p = .000$),

common humanity ($t(68) = 3.49$, two-tailed, $p = .001$), and mindfulness ($t(68) = 3.262$, two-tailed, $p = .002$), which indicated that participants in the current study had higher levels of these subscales. No significant differences were found in overall self-compassion, self-judgement, isolation, and over-identification when comparing the current study and the Brooks et al. study.

Gender Differences

T-test analysis disclosed differences by gender in depression, ($t(64) = 2.093$, two-tailed $p = .040$), and stress ($t(64) = 2.071$, two-tailed, $p = .042$), but not in anxiety. Respondents who identified their gender as other than male or female were not included in analysis due to the small sample size ($n = 3$). Overall, males were found to be significantly more depressed and anxious than females (Table 2). No other significant differences were found in self-compassion and its subscales.

Table 2
Mean and SD Scores for Depression, Anxiety and Stress by Gender

Variable	<i>n</i>	<i>M</i>	<i>SD</i>
Depression			
Male	39	10.74	5.30
Female	27	7.67	6.62
Anxiety			
Male	39	7.67	5.71
Female	27	5.11	5.58
Stress			
Male	39	11.82	4.91
Female	27	9.19	5.32

Respondents were asked to indicate their age, however, for analysis purposes, age was then separated into three age groups—18-34 years, 35-50 years, and 51-71—with the goal of examining differences between different generations (e.g., young adult to adult, adult to middle-age; older age). One-way analyses of variance found a significant effect of age on anxiety, $F(2, 59) = 3.450, p = .038$), but not in depression or stress. LSD post hoc testing showed that the significant difference occurred in the 35-50 age group and the 51-71 age group, and indicated that the 35-50 age group ($M = 4.47$) was significantly less anxious than the older age group ($M = 8.42$). No significant differences were found in self-compassion and its subscales.

I then evaluated 7 hypotheses. Of these six hypotheses, 6 were confirmed, and one was partially confirmed.

Hypothesis 1: It is predicted that participants in the current study will have lower levels of overall self-compassion (and its components) and higher levels of depression, anxiety and stress than norms for the general population.

One-sample t -tests were used to compare the components of self-compassion for participants in this study with the norms for the general population (Neff, 2003a). The results indicated that study participants had significantly lower overall self-compassion than the general population ($t(68) = 65.516$, two-tailed, $p = .000$). One-sample t -tests also compared scores for depression, anxiety, and stress for participants in this study to norms for the general population (Henry & Crawford, 2005), and means and standard deviations are displayed below in Table 3. The results suggest that study participants were significantly more depressed than the general population ($t(68) = 5.039$, two-tailed, $p = .000$). Respondents were also significantly more

anxious than the general population ($t(68)=4.099$, two-tailed, $p=.000$), and were significantly more stressed ($t(68) = 1.75$, two-tailed, $p = .084$).

Respondents in the present study scored significantly higher in the negative subscales of self-compassion compared to the general population (Table 3). This included: self-judgment ($t(68) = 3.499$, two-tailed, $p = .001$), isolation ($t(68) = 3.267$, two-tailed, $p = .002$), and over-identification ($t(68) = 2.043$, two-tailed, $p = .045$). In addition, respondents in this study, were significantly lower in the positive subscales of self-kindness ($t(69) = -3.660$, two-tailed, $p = 0.000$), and mindfulness ($t(68) = -3.933$, two-tailed, $p = .000$), but not in common humanity ($t(68) = -0.474$, two-tailed, $p = .637$).

Table 3
Mean and SD Scores for Study Participants v. General Population

Variable	<u>Study Participants</u>		<u>General Population</u>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Depression	9.217	6.046	5.55	17.481
Anxiety	6.391	5.737	3.56	10.571
Stress	10.406	5.389	9.27	21.203
Overall Self-Compassion	2.706	.771	18.25	2.752
Self-Kindness	2.633	.946	3.05	2.107
Common Humanity	2.935	.967	2.99	2.529
Mindfulness	2.957	.916	3.39	2.597
Self-Judgment	3.522	.906	3.14	3.391
Isolation	3.417	1.034	3.01	3.286
Over-Identification	3.273	.907	3.05	3.451

Hypothesis 2: It is predicted that participants who have less (or lower levels of) self-compassion will have higher levels of depression, anxiety and stress.

Pearson correlations were used to examine the associations between depression, anxiety and stress, and self-compassion (and subscales), and significant correlations were found for all scales (and subscales). Depression was significantly negatively correlated to overall self-compassion and its positive subscales (Table 4), indicating that participants who were more depressed also had lower overall self-compassion, self-kindness, common humanity, and mindfulness. Significant negative correlations were also found between anxiety and common humanity, mindfulness, and total self-compassion (Table 4). Stress was also found to be significantly negatively correlated to overall self-compassion and its positive subscales (Table 4), which indicated that higher-stressed participants also were lower in overall self-compassion, self-kindness, common humanity and mindfulness.

Significant positive correlations were found between depression, anxiety, stress and the negative subscales of self-compassion, indicating that individuals who were more depressed, more anxious, and more stressed also tended to be more judgmental of themselves and their perceived flaws, felt more isolated, and tended to become overwhelmed by their emotions (Table 4). No significant correlations were found between anxiety and self-kindness. Overall these correlations were within the weak to moderate range.

Table 4

Pearson Correlations depicting Relationships between Self-Compassion Scores and Depression, Anxiety and Stress Scores

Variable	Depression	Anxiety	Stress
Self-Compassion			
<i>r</i>	-.522***	-.394***	-.543***
<i>p</i>	.000	.000	.000
Self-Kindness			
<i>r</i>	-.332**	-.233	-.363**
<i>p</i>	.005	.054	.002
Common Humanity			
<i>r</i>	-.365**	-.309**	-.341**
<i>p</i>	.002	.010	.004
Mindfulness			
<i>r</i>	-.492***	-.374**	-.465***
<i>p</i>	.000	.002	.000
Self-Judgment			
<i>r</i>	.464***	.309**	.503***
<i>p</i>	.000	.010	.000
Isolation			
<i>r</i>	.504***	.396***	.536***
<i>p</i>	.000	.001	.000
Over-Identification			
<i>r</i>	.405***	.330**	.457***
<i>p</i>	.001	.006	.000

Note. $N = 69$.

** $p < .01$. *** $p < .001$, two-tailed.

Hypothesis 3: It is predicted that participants who are still drinking (not in sober recovery) will have lower levels of overall self-compassion, as well as lower subscales of self-kindness, common humanity and mindfulness and higher levels of self-judgment, isolation and over-identification, than participants who are in sober recovery.

T-tests were run to determine if there were differences in self-compassion (and its subscales) by whether or not participants were in sober recovery, and significant differences were found in all scales (Table 5). Participants who were actively drinking (not in sober recovery) had significantly lower self-compassion, self-kindness, common humanity, and mindfulness than those currently in sober recovery. In addition, respondents not in sober recovery had significantly higher self-judgment, isolation, and over-identification than those in sober recovery (Table 5).

Table 5

T-Tests of Self-Compassion Scores by Whether or Not in Sober Recovery

Variable	<i>n</i>	<i>M</i>	<i>t</i>	<i>df</i>	<i>p</i>
Self-Kindness					
Sober Recovery	28	3.00	2.791**	67	.007
Not Sober Recovery	41	2.38			
Common Humanity					
Sober Recovery	28	3.25	2.308*	67	.024
Not Sober Recovery	41	2.72			
Mindfulness					
Sober Recovery	28	3.36	3.202*	67	.002
Not Sober Recovery	41	2.68			
Self-Judgment					
Sober Recovery	28	3.10	-3.439***	67	.001
Not Sober Recovery	41	3.81			
Isolation					
Sober Recovery	28	3.10	-2.171*	67	.033
Not Sober Recovery	41	3.63			
Over-Identification					
Sober Recovery	28	2.88	-3.130**	67	.003
Not Sober Recovery	41	3.54			
Overall Self-Compassion					
Sober Recovery	28	3.08	3.572***	67	.001
Not Sober Recovery	41	2.45			

* $p < .05$, ** $p < .01$ level, *** $p < .001$, two-tailed.

Hypothesis 4: It is predicted that participants who are still drinking (not in sober recovery) will have higher levels of depression, anxiety and stress than those who are not in sober recovery.

T-tests were run to determine if there were differences in depression, anxiety, or stress by whether or not participants were in sober recovery and results are displayed below in Table 6. Respondents who were not in sober recovery were significantly more depressed, more anxious and more stressed than those currently in sober recovery (Table 6).

Table 6

T-Tests of Depression, Anxiety and Stress by Whether or Not in Sober Recovery

Variable	<i>n</i>	<i>M</i>	<i>t</i>	<i>df</i>	<i>p</i>
Depression					
Sober Recovery	28	7.25	-2.416	65.830	.018
Not Sober Recovery	41	10.56			
Anxiety					
Sober recovery	28	4.00	-3.252**	66.999	.002
Not Sober Recovery	41	8.02			
Stress					
Sober Recovery	28	8.39	-2.678**	67	.009
Not Sober Recovery	41	11.78			

** *p* < .01, two-tailed.

Hypothesis 5: No significant differences are predicted between levels of depression, anxiety, and stress and levels self-compassion and its subscales by sample sub-group (online or ServiceNet treatment program participant).

T-tests were conducted to explore differences in depression, anxiety and stress, and results are displayed below in Table 7. A significant difference was found in anxiety scores,

indicating that respondents who took the paper survey were significantly more anxious than those who took the online survey ($M = 3.85$). Paper survey respondents were also more depressed than online respondents, however, these did not reach a statistically significant level. In addition, no significant differences were found in stress by type of survey taken (Table 7).

T-tests also uncovered a significant difference in self-kindness. Findings indicated that paper survey respondents were significantly less kind to themselves ($M = 2.47$) than respondents who completed online surveys ($M = 3.03$). There were no significant differences in any of the other subscales or total self-compassion score (Table 7).

Table 7

T-Tests by Type of Survey Taken

Variable	Survey Type	<i>n</i>	<i>M</i>	<i>t</i>	<i>df</i>	<i>p</i>
Depression	Paper	49	10.04	2.093	67	.076
	Online	20	7.20			
Anxiety	Paper	49	7.43	1.804**	55.17	.005
	Online	20	3.85			
Stress	Paper	49	11.00	1.445	67	.153
	Online	20	8.95			
Self-Kindness	Paper	49	2.47	2.705**	54.10	.009
	Online	20	3.02			
Common Humanity	Paper	49	2.86	.975	67	.333
	Online	20	3.11			
Mindfulness	Paper	49	2.83	1.880	67	.064
	Online	20	3.28			
Self-Judgment	Paper	49	3.56	.476	67	.636
	Online	20	3.44			
Isolation	Paper	49	3.50	1.049	67	.298
	Online	20	3.21			
Over-Identification	Paper	49	3.34	.988	67	.327
	Online	20	3.10			
Overall Self-Compassion	Paper	49	2.61	1.561	67	.123
	Online	20	2.93			

***p* < .01, two-tailed.

Hypothesis 6: It is predicted that individuals with higher AUDIT scores (indicating that they are at higher risk for alcohol-related problems) will also have higher levels of depression, anxiety and stress.

Pearson correlation analyses were conducted to determine if there were relationships between AUDIT scores and depression, anxiety and stress. Significant positive correlations were

discovered between AUDIT scores and depression ($r = 0.400, p = .001$, two-tailed), anxiety ($r = 0.413, p = .000$, two-tailed), stress ($r = 0.344, p = .004$, two-tailed), indicating that the as participants' alcohol use increased in severity (AUDIT scores), their depression, anxiety and stress also increased. Overall these correlations were all within the moderate range.

Additionally, one-way analyses of variance were conducted to determine if there were differences in depression, anxiety, and stress by different AUDIT categories. Respondents were divided into three AUDIT categories (low, moderate, high): the low AUDIT group (which indicates low risk for problems caused by alcohol use) was identified by a score of ≤ 7 , the moderate AUDIT group (moderate risk) was specified by a score of 8 to 19, and the high AUDIT group (high/severe risk) had scores of 20 and higher. Significant differences were found between AUDIT categories for depression, anxiety and stress (Table 8).

For depression ($F(2, 66) = 10.712, p = .000$), the mean depression score for the low AUDIT group was 6.92, for the moderate group it was 6.89, and for the high AUDIT group, the mean was 13.04. Bonferroni post hoc testing showed the difference was between the low and high AUDIT groups and between the moderate and high AUDIT groups, indicating that both the low and moderate AUDIT groups were significantly less depressed than respondents in the high AUDIT group. There was not a significant difference between the low and moderate groups.

Regarding anxiety ($F(2, 66) = 10.037, p = .000$), Tamhane post hoc testing showed the difference was between the low and high AUDIT groups and between the moderate and high AUDIT groups, indicating that participants in the low and moderate AUDIT groups had significantly less anxiety than those in the high AUDIT group. Participants in the low AUDIT group had a mean anxiety score of 3.79; the moderate group had a mean of 4.89, and the high

AUDIT group had a mean anxiety score of 9.88. There wasn't a significant difference found between the low and moderate groups (Table 8).

For the variable stress ($F(2, 66) = 7.384, p = .001$), respondents in the low AUDIT group had a mean stress score of 8.08, the moderate group had a mean of 9.43, and the high AUDIT group had a mean stress score of 13.27. Bonferroni post hoc testing showed the differences were between the low and high AUDIT groups and between the moderate and high AUDIT groups, indicating that respondents in the low and moderate groups were significantly less stressed than their counterparts in the high AUDIT group. No significant differences were found between the low and moderate groups (Table 8).

Table 8

One Way Analyses of Variance for Depression, Anxiety and Stress by AUDIT Category

Variable	Source	SS	df	MS	F	p
Depression	Between Groups	609.155	2	304.577	10.712***	.000
	Within Groups	1876.584	66	28.433		
	Total	2485.739	68			
Anxiety	Between Groups	522.033	2	261.017	10.037***	.000
	Within Groups	1716.402	66	26.006		
	Total	2238.435	68			
Stress	Between Groups	361.057	2	180.529	7.384***	.001
	Within Groups	1613.580	66	24.448		
	Total	1974.638	68			

*** $p < .001$, two-tailed.

Hypothesis 7: It is predicted that as AUDIT scores increase (higher risk alcohol use), participants’ overall self-compassion, self-kindness, common humanity and mindfulness (positive subscales) will decrease, while their self-judgment, isolation, and over-identification of emotions (negative subscales) will increase.

Pearson correlations were run to determine if there were correlations between AUDIT scores and self-compassion (and subscales) scores and results are shown in Table 8 below. Significant positive correlations were found in the negative subscales for self-compassion, indicating that participants who had higher AUDIT scores (higher risk drinking) were significantly more judgmental of themselves, felt more isolated, and tended to over-identify with or become hijacked by their emotions. Significant negative correlations were found between AUDIT scores and overall self-compassion and its positive subscales, indicating that individuals who engaged in high risk (hazardous) drinking were also significantly less self-compassionate, less kind to themselves, felt less connected to others, and had less balanced emotions (Table 9).

Table 9

Pearson Correlations Depicting Relationships Between AUDIT Scores and Self-Compassion Scores

Variable	Overall Self-Compassion	Self-Kindness	Common Humanity	Mindfulness	Self-Judgment	Isolation	Over-Identification
AUDIT							
<i>r</i>	-.491***	-.403***	-.422***	-.462***	.386***	.337***	.399***
<i>p</i>	.000	.001	.000	.000	.001	.005	.001

Note. *N* = 69.

p* < .01. *p* < .001, two-tailed.

One-way analyses of variance were also run to determine if there were differences in self-compassion (and subscales) by the specific AUDIT category participants were in (low, moderate, or high), and significant differences were found in each scale (Table 10). Bonferroni post hoc testing found that the difference was between the low and high AUDIT groups and between the moderate and the high AUDIT groups for the following: common humanity, mindfulness, self-judgment, over-identification, and total self-compassion.

Bonferroni post hoc testing found the difference was between the low and high AUDIT groups for self-kindness, which indicated that respondents in the low AUDIT groups were significantly kinder to themselves ($M = 3.00$) than those in the high AUDIT groups ($M = 2.22$). Bonferroni post hoc testing also found that participants in the high AUDIT groups had higher mean isolation scores ($M = 3.91$) than those in the low AUDIT group ($M = 2.95$), indicating that those who had more severe alcohol use and related problems also felt more isolated than participants in the low AUDIT group.

Table 10

One-Way Analyses of Variance for Self-Compassion Scores by AUDIT Category

Variable	Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>
Self-Kindness	Between Groups	2	7.889	3.944	4.919**	.010
	Within Groups	66	52.925	.802		
	Total	68	60.813			
Common Humanity	Between Groups	2	9.363	4.681	5.699**	.005
	Within Groups	66	54.219	.821		
	Total	68	63.582			
Mindfulness	Between Groups	2	9.976	4.988	7.002**	.002
	Within Groups	66	47.019	.712		
	Total	68	56.995			
Self-Judgment	Between Groups	2	8.153	4.077	5.640**	.005
	Within Groups	66	47.704	.723		
	Total	68	55.857			
Isolation	Between Groups	2	11.268	5.634	6.052**	.004
	Within Groups	66	61.440	.931		
	Total	68	72.708			
Over-identification	Between Groups	2	9.341	4.671	6.623**	.002
	Within Groups	66	46.546	.705		
	Total	68	55.887			
Overall Self-Compassion	Between Groups	2	8.899	4.450	9.315***	.000
	Within Groups	66	31.528	.478		
	Total	68	40.427			

* $p < .05$. ** $p < .01$. *** $p < .001$, two-tailed.

CHAPTER V

Discussion

This research study is one of only a few to examine self-compassion among individuals with Alcohol Use Disorders (AUDs), and who, for the most part, were also experiencing depression and anxiety at higher levels than the general population (Brooks et al., 2012; Rendon, 2007). Furthermore, this is the only study that has compared levels of self-compassion by whether or not participants were currently in sober recovery. The goal of this study was to replicate prior research that has explored differences between self-compassion, depression, anxiety and stress in adults with alcohol use disorders (Brooks et al., 2012). Seven hypotheses were evaluated based on features identified in the literature and, of these seven hypotheses, six were confirmed and one was partially confirmed.

Comparison of Study Results to Similar Research

The current study found that individuals with AUDs have significantly lower levels of self-compassion and higher levels of depression and anxiety than norms for the general population (Neff, 2003a, b), but not higher levels of stress, thus partially replicating the results of previous research (Brooks et al., 2012; Rendon, 2007), which found significant differences in all variables. While comparing participants in the current study to those in a similar study of alcohol-dependent adults (Brooks et al., 2012), current study participants were found to be significantly less anxious, depressed and stressed. Participants in the current study had similar levels of common humanity ($M = 2.935$) and overall self-compassion ($M = 2.706$) to participants

in Brooks et al.'s (2012) study ($M = 2.682$; $M = 2.747$, respectively). The present study's respondents also reported higher levels of self-kindness, mindfulness, as well as lower levels of self-judgment, isolation, and over-identification than respondents in the Brooks study. However, it is important to note that the Brooks study was conducted in Australia and only included participants who were actively abusing or dependent on alcohol, whereas the current study also included respondents who were also in sober recovery. Consequently, it is possible that participants in the Australian study had more severe AUDs and related problems than those in the current sample.

Self-Compassion & Depression, Anxiety and Stress

A previous study by Neff (2003a) found that self-compassion was significantly inversely correlated to anxiety and depression. In addition, Van Dam and colleagues (2011) found that anxiety was significantly positively related to isolation and self-judgement. Supporting Neff's and Van Dam's findings, the results from the present study indicate that adults with AUDs, who are also more depressed and anxious tend to have lower overall self-compassion, and tend to be more judgmental of themselves, feel more isolated, and become overwhelmed by their negative emotions. These findings also replicate previous research which found that self-compassion in adults with AUDs was inversely correlated to anxiety only (Brooks et al., 2012).

Contrary to my prediction, no significant correlation was found between anxiety and self-kindness. The nature of this relationship is unclear and may be confounded by the relatively small sample size or by participants' relationship to alcohol, with use attributed to reasons such as: to avoid ruminating, to cope with stress and anxiety, and to self-medicate against everyday problematic thoughts and feelings. These results are worthy of future exploration to determine

the nature of the relationship between anxiety reported by alcohol-dependent treatment seekers and self-compassion.

In contrast to previous research (Brooks et al., 2012), the current study did find that lower levels of self-compassion are correlated to higher levels of depression in adults with AUDs. When examining the subscales of self-compassion and depression, participants who had more severe depression, also felt more isolated, judged themselves more harshly, and felt more responsible for negative consequences, such as after a relapse. This is consistent with the findings of Van Dam and colleagues (2011), who found that self-judgement and isolation were significantly positively correlated to depression. Moreover, the current findings suggest that individuals who had lower levels of depression and higher overall self-compassion also were kinder to themselves, had more balanced emotions, and had a higher sense of common humanity.

Supporting prior research (Brooks et al., 2012), the present study found that higher-stressed individuals were more likely to judge themselves harshly, feel more isolated from others, and become overwhelmed by their negative emotions. Stress was also found to be significantly negatively correlated to self-kindness, common humanity, and mindfulness. These results suggest that adults with AUDs may lack important coping skills to deal effectively with stress.

Paper surveys versus online surveys. A rather unexpected finding of this current study was the significant differences in self-kindness and in anxiety by the type of survey taken. Participants who completed the paper survey were significantly more anxious and significantly less kind to themselves than those who completed online surveys. Though the nature of these findings are unclear, one can speculate that differences in respondent characteristics may have been responsible. For example, some of the paper survey respondents were currently residing in

sober recovery homes rather than once-a-week outpatient therapy. Consequently, recovery home respondents may have been experiencing more acute symptoms of alcohol withdrawal, which would have likely contributed to higher anxiety and self-criticism. Although I tried to closely match the two samples by using similar criteria, these findings indicate that in fact the two samples are more different than expected.

AUDIT Scores & Depression, Anxiety and Stress

In examining the relationship between alcohol use risk severity (AUDIT scores) and depression, anxiety, and stress, this study's findings appear to support previous research that has indicated that excessive alcohol use is related to depression and anxiety, and such alcohol use can worsen depression, anxiety and stress to a significant degree (Grant et al., 2004; Rendon, 2007). However, more research is warranted to determine the extent of these relationships between alcohol use and depression and anxiety.

But you are right that since these two things seem to be related to one another, if only one of the conditions is treated, the other condition may hinder recovery.

AUDIT Scores & Self-Compassion

When AUDIT scores were used as a continuous variable, the current findings indicated that as participants' alcohol use risk severity increased, overall self-compassion decreased. In addition, as AUDIT scores increased, respondents were also less kind to themselves, felt more isolated, and experienced less balanced emotions. No significant differences were found between alcohol use severity (as a continuous variable) and the negative subscales of self-compassion.

However, when AUDIT scores were separated into categories (low, moderate, and high), significant differences were found in self-compassion and all of its subscales. These results

indicated that individuals who had severe problems related to alcohol use (High AUDIT category) were significantly more judgmental towards themselves, felt more isolated, and tended to get overwhelmed by negative emotions than those with low or moderate problems related to alcohol use (low or moderate AUDIT categories). Participants in the high risk AUDIT category also scored lower on the positive self-compassion subscales than those in the low or moderate risk AUDIT groups. Thus, these results provide support for previous research that suggests that people who abuse alcohol may lack important coping skills necessary to maintain recovery (Rendon, 2007).

Conversely, respondents who scored within the low and moderate AUDIT categories scored significantly higher in overall self-compassion, self-kindness, common humanity and mindfulness, and were lower on the negative subscales for self-compassion than those in the high AUDIT group. One possible explanation for these findings may be that the self-kindness component of self-compassion involves the capacity to understand and to be sensitive to what one is feeling (Neff, 2003a). Consequently, this component might protect against alcohol use with adults who drink as a means of coping with failure and self-criticism. One reason for this may be that self-compassion is an antidote to self-criticism (Neff, 2003a), which is also related to alcohol abuse (Baumeister et al., 2003). Accepting failure with kindness, as opposed to a self-critical attitude, might imply that one does not need alcohol to cope with feelings of failure in the present moment. This is particularly relevant for individuals who use alcohol as a remedy for self-criticism, depressive symptoms, anxiety, and stress (Crum et al., 2013).

The self-kindness and mindfulness components may also help adults with AUDs to connect their inner pain and discomfort with alcohol abuse or dependence with kindness and sensitivity. This is relevant because alcohol is sometimes used as an attempt to avoid painful

emotional states (Khantzian, 2003). Furthermore, having the awareness of common humanity might contribute to breaking the cycle of self-absorption that contributes to alcohol misuse (Campbell & Page, 1993); as one realizes that others have similar fears of anxiety and humiliation. This awareness of common humanity may combat feelings of isolation often associated with drinking.

Considering that current study participants' level of self-judgment was related to riskier alcohol use and related problems, efforts to incorporate self-compassion and other mindfulness-based interventions into alcohol addiction treatment could be a powerful combination in promoting positive self-judgments and more kindness to oneself, and perhaps instilling more enduring change.

Self-Compassion of Participants in Sober Recovery v. Not in Sober Recovery

The current study found that adults in sober recovery (history of an AUD but currently were no longer drinking) were more self-compassionate than respondents who were still struggling with their alcohol addiction. It is important to note that previous research posits that self-compassion may promote engagement in positive health behaviors because of its ameliorating effects on negative affective states (Leary et al., 2007a), which might otherwise jeopardize health goals. Furthermore, Sirios & Kitner (2014) found that self-compassion may facilitate the experience of healthy emotions in the context of health behavior change by moderating the potential negative responses to minor setbacks and failures, and by encouraging the positive emotions necessary to maintain motivation in pursuing health goals.

In synthesizing these results, I can only speculate that those in sober recovery may have felt more motivated to remain clean and sober because they genuinely care about themselves, want to be healthier, and have experienced more positive emotions related to their success in

maintaining their sobriety. Moreover, it is possible that the self-compassion of sober recovery respondents enabled them to handle minor setbacks, such as relapses or urges to drink, without becoming overwhelmed by shame and guilt (mindfulness) or by becoming overly self-critical and judgmental (self-kindness).

Depression, Anxiety and Stress of Participants in Sober Recovery v. Not in Sober Recovery

The current study found that respondents who were still drinking (not in sober recovery) were significantly more depressed, more anxious, and more stressed than their counterparts who had stopped drinking. These findings appear to support prior research linking hazardous alcohol use to increased depression and anxiety (Crum et al., 2013; Grant et al., 2004). These results also support other research that has demonstrated that experiencing stressful life events significantly predicts the amount and frequency of alcohol consumed as well as the onset of alcohol dependence, suggesting that stress plays a key role in the development of AUDs (Lloyd & Turner, 2008).

Gender Differences in Self-Compassion

There has been very little research examining possible gender differences in self-compassion, and findings have been relatively inconsistent. A few studies did find that men were more self-compassionate than women (Neff, 2003a, Neff & McGhee, 2010, Neff & Vonk, 2009), however, these studies examined college-aged students and the general population, not clinical populations. Although the results of the current study did not find any significant gender differences in self-compassion and its components, it is possible that with a larger sample size there may have been an effect caused by gender. If women who have AUDs were found to be less self-compassionate, then this would suggest that gearing self-compassionate interventions towards women in recovery would be beneficial.

Gender Differences in Depression, Anxiety and Stress

The findings that males were significantly more depressed and more stressed than females were rather unexpected, considering that previous research on gender differences in depression has found that women tend to be twice as likely to suffer from depression as men (APA, 2013, p. 165). However, these results are understandable, given that men are more likely to develop AUDs than women (SAMSHA, 2014), and that alcohol use, abuse or withdrawal tend to worsen depression and anxiety (SAMSHA, 2014). In addition, more men participated in this study than women, so it's possible that a larger sample may have yielded different results.

Limitations of the Study

The present study had a number of limitations that are important to consider. Due to the initial low response rate, I used two different methodologies—a confidential, mail-in survey to local respondents, and an anonymous online survey—thus, two different populations were studied. Due to the anonymous nature of the online survey, it is possible that participants did not have the same motivation to complete the survey. In addition, I was much more confident that participants met the study's inclusion criteria via the confidential survey distributed to ServiceNet clients because the Clinical Research Director at ServiceNet had identified all potential, eligible participants. However, for both methodologies, I had no control over the manner in which the respondents answered the questions—in what order they completed the survey, how long they took to return the surveys (if at all), or if they discussed the questions with significant others, family, friends, or therapists.

Measurement error may have also resulted based on the participant characteristics, such as their personal relationship to alcohol as mentioned previously. For instance, participants who use alcohol to avoid rumination, to cope with stress and anxiety, and/or to self-medicate against

every day problematic thoughts and feelings, may have inadvertently distorted the results of the surveys. This study was also susceptible to language barriers (since it was available in English only), memory recall, and social desirability (Engel & Schutt, 2011, p. 230). In addition, this study was also limited by participant self-report to accurately assess for self-compassion. Due to the cognitive distortions that are common in individuals with AUDs (Grant et al., 2004), many respondents may not have been aware enough of their own emotional experience to realize the extent to which they lack self-compassion. Those who repress or avoid their negative emotions will be especially difficult to accurately assess with self-report, since repression is an unconscious behavior.

Furthermore, participants who returned completed surveys may have shared similar characteristics. For instance, these participants may have been more interested in the study or in their recovery, which may have limited the representativeness of the sample. It is also possible that those who did not respond to the survey had more severe impairments related to their AUDs, which may have prevented them from accessing or finishing the survey. It is also pertinent to note that this study only examined differences in self-compassion and depression, anxiety and stress in adults who were currently in treatment for AUDs or with a history of an AUD (in mental health treatment, but no longer drinking). Therefore, this study did not include individuals who were currently in sober recovery or who may meet criteria for an AUD but are not in formal treatment, nor did it include individuals who attend AA exclusively—also limiting the representativeness of the sample.

Due to the relatively small sample size, external and internal validity of these findings may not be reliable and should not be considered as such. The sample size was small ($N = 69$), and there were a greater number of participants who completed the paper survey ($n = 49$) rather

than the online survey ($n = 20$). All of the paper survey respondents were located within Western Massachusetts, thus the sample was not fully representative of the general population in terms of geographical location, age, and racial and economic diversity.

Another sampling bias is apparent in the online survey, due to the disproportionate amount of individuals without internet access. According to the Pew Research Center, in 2013 approximately 27% of American households did not have broadband internet access. Households without internet access tend to be older and poorer than those that are connected (Rainie & Cohn, 2014). In addition, the online surveys may have only reflected the type of individuals who visit those particular websites (i.e. those more interested in sobriety). Furthermore, generalizability of these findings is limited due to the sample being a non-random, convenience sample.

A cross-sectional, correlational nature of this study was used to examine relationships between the independent and dependent variables; thus causality could not be established. In addition, the directionality of the correlations could not be determined. For example, it is unclear if it was alcohol use that caused low self-compassion or if participants drank to cope with low self-compassion, or if the relationship is more complex.

Furthermore, this study did not assess for changes in self-compassion, depression, and anxiety over time (e.g., via the use of pre- and post-tests), and did not control for potential moderating variables that may have better accounted for a significant correlation between self-compassion and alcohol use. Such potential moderating variables included: participants' other co-morbid DSM diagnoses and/or other drug use, how long participants have had an AUD diagnosis or how long they have been in sober recovery, reason for receiving treatment (e.g., mandated or voluntary), and type of treatment intervention. None of these variables were

examined for this study, which may have confounded the results. For instance, some individuals who identified as being in sober recovery may have only recently become clean and sober, and may have been still struggling with similar alcohol-related issues as their still drinking counterparts, while others may have been in recovery for some time. For those not in sober recovery, participants may have interpreted their use of alcohol as an act of self-kindness, or individuals who drink on a daily basis may have reported lower feelings of isolation, lower tendencies towards self-judgment and over-identification than non-daily users or those in sober recovery—possibly again due to the reasons for alcohol use commonly reported by alcohol-dependent treatment seekers. Therefore, future research should control for these variables in order to better understand the role that self-compassion plays in alcohol use disorders.

Strengths of the Study

While this study has limitations, it also had some strengths that are important to note. For instance, all instruments used were pre-existing surveys (SCS; Neff, 2003a; DASS-21; Lovibond & Lovibond, 1995; AUDIT; Saunders et al., 1993) that all have been empirically tested and found to have strong internal reliability and validity. The present study also extends the reliability and validity of the Self-Compassion Scale (SCS; Neff, 2003a) to the population of adults with alcohol use disorders.

Another strength of this study was that it measured alcohol use severity in three different ways, as an attempt to control for inaccurate reporting and to reduce the chance that a participant may view alcohol use as a socially desirable activity. Alcohol use severity was assessed in three ways: 1.) For pencil and paper version of the survey, the Clinical Research Director of ServiceNet identified all potential respondents that had an AUD diagnosis; 2.) all participants

completed the Alcohol Use Disorders Identification Test (AUDIT; WHO, 1982); 3.) and participants self-reported their alcohol use.

Implications for Future Research and Social Work

After examining the relationships between self-compassion and depression, anxiety, stress, and severity of AUDs, numerous implications for future research and the social work profession were identified. For instance, it would be beneficial to develop other ways to measure for self-compassion (e.g., clinical assessments) as a means of counteracting the limitations of the current Self-Compassion Scale (Neff, 2003a), which relies on self-reporting. It is also necessary for future research to control for any potential mediating variables between self-compassion (and its subscales) and alcohol abuse, depression, anxiety, and stress.

Future research should also focus on the antecedent of the relationships between these variables to determine the most effective treatment interventions and timing of such interventions to improve self-compassion, to improve coping strategies when faced with stressful situations, and to reduce the risk of developing an alcohol use disorder. More research is also needed to examine the effectiveness of a structured intervention in increasing self-compassion and in the treatment of depression, anxiety, stress and alcohol use disorders both in a clinical population and a non-clinical population, using both active treatment and control (treatment as usual, or no treatments). Additional studies are also needed to examine the relationship between depression, anxiety, stress and the components of self-compassion among adults with AUDs assessed at baseline and after completion of a targeted intervention to provide a better understanding of these relationships.

Data gained from this study adds to the body of literature and expands the understanding of the role self-compassion plays in alcohol use disorders, depression, anxiety and stress. This

study replicates prior research (Brooks et al., 2012) and provides additional evidence which suggests that higher self-compassion is associated with better resilience against developing an AUD. Thus, it is important for future research to examine the effectiveness of self-compassion interventions geared towards vulnerable populations that are susceptible to developing AUDs, such as vulnerable adolescents and college-aged students.

The current study's findings may help professionals who work within the substance abuse field, as well as individuals themselves, to gain more insight into their addiction and/or mental health. Lastly, the current findings suggest that incorporating self-compassion interventions into treatment of alcohol use disorders would be beneficial.

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Appendix A

Smith College HSR Committee Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

December 22, 2014

Kaitlyn Janicki

Dear Kate,

I have reviewed your amendment and it looks fine. This amendment to your study is therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten', written over a light blue horizontal line.

Elaine Kersten, Ed.D.

Co-Chair, Human Subjects Review Committee

CC: Michael Murphy, Research Advisor

Appendix B

Smith College HSR's Revision Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

October 24, 2014

Kaitlyn Janicki

Dear Kate,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Michael Murphy, Research Advisor

APPENDIX C

Agency Approval Letter



September 29, 2014

Smith College
School for Social Work
Lilly Hall
Northampton, MA 01063

To Whom It May Concern:

ServiceNet, Inc. gives permission for **Kate Janicki** to locate her research in this agency. We do not have a Human Subjects Review Board and, therefore, request that Smith College School for Social Work's (SSW) Human Subject Review Committee (HSR) perform a review of the research proposed by Kate Janicki. ServiceNet, Inc. will abide by the standards related to the protection of all participants in the research approved by SSW HSR Committee.

Sincerely,

Jennifer H. Geertsma
Director of Applied Research
ServiceNet, Inc.
Clinical Services Division

APPENDIX D

Consent Form for Paper Survey



Smith College School for Social Work • Northampton, MA

Consent to Participate in a Research Study

.....

Title of Study: The Role of Self-Compassion in Alcohol Use Disorders

Investigator(s): Kaitlyn Janicki

Smith College School for Social Work

.....

Introduction

- You are being asked to be in a research study that explores the relationship between drinking behaviors and how one typically acts towards oneself during difficult times.
- You were selected as a possible participant because you are an adult (18+) who is a client of Service Net who either has a current alcohol problem or who has had one in the past.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to learn about how individuals who have alcohol problems typically act towards themselves during difficult times and how this is related to their feelings of anxiety, depression and stress.
- This study is being conducted as a research requirement for my Master's in Social Work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: you choose to complete a survey that will take approximately 15-30 minutes of your time at your home and return this survey once completed by mail or in person to the researcher's personal mailbox at Service Net in Northampton, MA in a stamped, pre-addressed envelope which I will provide for you.

Risks/Discomforts of Being in this Study

- Participating in this study will not expose you to any serious risks. All information that you provide will be kept confidential, as described below. Some questions may bring up unpleasant emotions or past events that may cause you to feel uncomfortable. Please feel free to skip any question, or to stop the survey early if it becomes upsetting. I encourage you to talk with your therapist and/or case manager if participation in this study upsets you.

Benefits of Being in the Study

- Participating in the study may help you learn more about why you drink and how you treat yourself when you are feeling down, which you may find helpful to talk about with your therapist.
- The benefits to social work/society are: to provide information for future research and to identify strengths and potential areas of growth for the treatment of alcohol abuse.

Confidentiality

- In compliance with federal health privacy regulations, ServiceNet requires that I not have access to your name and contact information. I will keep confidential any information you provide in the survey itself.
- To further protect your privacy, I will provide you with a stamped, pre-addressed envelope in which you can seal the survey in once you have completed it. Once you have completed the survey you can return it to ServiceNet-Northampton in my personal mailbox by mail or in person. ServiceNet's Director of Applied Research will receive all consent forms and survey responses for this study. This director will separate all informed consent forms from survey responses before sending the responses to me. Your therapist or case manager will not know if you have taken part in the study unless you decide to tell him or her. In addition, the records of this study will be kept strictly confidential.
- I will store all research materials including paper surveys, transcriptions, and analyses in a secure location for three years according to federal regulations. ServiceNet will store signed Informed Consent forms in a secure file for three years as well. In the event that I need materials beyond this period, I will keep them secured until I no longer need them, then I will destroy them. All information stored on my computer will be password protected. All paper documents will also be stored in a separate locked filing cabinet for three years. I will not include any information in any report I may write that would make it possible to identify you.

Payments/gift

- You will receive the following payment/gift: Upon *returning* the survey to Service Net-Northampton, MA to my confidential mailbox, in a stamped and pre-addressed envelope, you will be entered into a raffle to win one of two \$50 gift cards to Walmart. To maintain your confidentiality, the gift cards will be mailed to each winner by a ServiceNet administrator who is not involved with direct client care.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to *February 28, 2015*. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by *February 28, 2015*. After that date, your information will be part of the final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, *Kaitlyn Janicki* at *kjanicki@servicenet.org*. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....

updated 9/25/13

APPENDIX E

Paper Survey

Demographic Survey

Please indicate your age: _____

Please indicate your gender: _____ Male _____ Female _____ Other _____ I prefer not to answer.

Please indicate your race/ethnicity:

- _____ American Indian or Alaskan Native
- _____ Asian
- _____ Black or African American
- _____ Hispanic/Latino (a)
- _____ White/Caucasian
- _____ Two or more ethnicities
- _____ Other
- _____ I prefer not to answer.

Please describe your current alcohol use:

_____ I am currently in recovery (I no longer drink but have had a problem with alcohol in the past)

- _____ I drink most days of the week
- _____ I drink once or twice a week
- _____ I drink a few times a month
- _____ Other. Please

describe: _____

1. How often do you have a drink containing alcohol?

- (0) Never (Skip to Questions 9-10)
- (1) Monthly or less
- (2) 2 to 4 times a month
- (3) 2 to 3 times a week
- (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

- (0) 1 or 2
- (1) 3 or 4
- (2) 5 or 6
- (3) 7, 8, or 9
- (4) 10 or more

3. How often do you have six or more drinks on one occasion?

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking?

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

- (0) No
- (2) Yes, but not in the last year
- (4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?

- (0) No
- (2) Yes, but not in the last year
- (4) Yes, during the last year

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

- | Almost
never | | | | | Almost
always |
|-------------------------|----------|----------|----------|----------|---|
| 1 | 2 | 3 | 4 | 5 | |
| _____ | | | | | 1. I'm disapproving and judgmental about my own flaws and inadequacies. |
| _____ | | | | | 2. When I'm feeling down I tend to obsess and fixate on everything that's wrong. |
| _____ | | | | | 3. When things are going badly for me, I see the difficulties as part of life that everyone goes through. |
| _____ | | | | | 4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world. |
| _____ | | | | | 5. I try to be loving towards myself when I'm feeling emotional pain. |
| _____ | | | | | 6. When I fail at something important to me I become consumed by feelings of inadequacy. |
| _____ | | | | | 7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am. |
| _____ | | | | | 8. When times are really difficult, I tend to be tough on myself. |
| _____ | | | | | 9. When something upsets me I try to keep my emotions in balance. |
| _____ | | | | | 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people. |
| _____ | | | | | 11. I'm intolerant and impatient towards those aspects of my personality I don't like. |
| _____ | | | | | 12. When I'm going through a very hard time, I give myself the caring and tenderness I need. |
| _____ | | | | | 13. When I'm feeling down, I tend to feel like most other people are probably happier than I am. |
| _____ | | | | | 14. When something painful happens I try to take a balanced view of the situation. |
| _____ | | | | | 15. I try to see my failings as part of the human condition. |
| _____ | | | | | 16. When I see aspects of myself that I don't like, I get down on myself. |
| _____ | | | | | 17. When I fail at something important to me I try to keep things in perspective. |

- _____ 18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.
- _____ 19. I'm kind to myself when I'm experiencing suffering.
- _____ 20. When something upsets me I get carried away with my feelings.
- _____ 21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.
- _____ 22. When I'm feeling down I try to approach my feelings with curiosity and openness.
- _____ 23. I'm tolerant of my own flaws and inadequacies.
- _____ 24. When something painful happens I tend to blow the incident out of proportion.
- _____ 25. When I fail at something that's important to me, I tend to feel alone in my failure.
- _____ 26. I try to be understanding and patient towards those aspects of my personality I don't like.

DASS₂₁

Name: _____

Date: _____

Please read each statement and circle a number 0, 1, 2 or 3 that indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of time
- 3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Appendix F

Consent Form for Online Survey



SMITH COLLEGE

**Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA**

.....

Title of Study: The Role of Self-Compassion in Alcohol Use Disorders

Investigator(s): Kaitlyn Janicki

Smith College School for Social Work

.....

Introduction

- You are being asked to be in a research study that explores the relationship between drinking behaviors and how one typically acts towards oneself during difficult times.
- You were selected as a possible participant because you are an adult (18+) who is currently in treatment for mental health or substance abuse issues who either has a current alcohol problem or who has had one in the past.
- I ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

The purpose of the study is to learn about how individuals who have alcohol problems typically act towards themselves during difficult times and how this is related to their feelings of anxiety, depression and stress.

This study is being conducted as a research requirement for my Master's in Social Work degree.

Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- The study will be conducted through a quantitative questionnaire that will be administered via this website (SurveyMonkey.com). If you agree to be in this study, you will be asked to do the following things: you choose to complete a survey that will take approximately 15-30 minutes of your time. You will be asked 4 demographic questions (such as age and gender). You will then be asked about your typical drinking habits and how you treat yourself during difficult and stressful times.

Risks/Discomforts of Being in this Study

- Participating in this study will not expose you to any serious risks. All information that you provide is anonymous and any identifying information you provide will be kept confidential, as described below. Some questions may bring up unpleasant emotions or past events that may cause you to feel uncomfortable. Please feel free to skip any question, or to stop the survey early if it becomes upsetting. I encourage you to talk with your therapist and/or counselor if participation in this study upsets you.

Benefits of Being in the Study

- Participating in the study may help you learn more about why you drink and how you treat yourself when you are feeling down, which you may find helpful to talk about with your therapist.
- The benefits to social work/society are: to provide information for future research and to identify strengths and potential areas of growth for the treatment of alcohol abuse.

Confidentiality

- This survey is completely anonymous. In addition, I will keep confidential any information you provide in the survey itself.
- I will store all research materials including surveys, consent forms, transcriptions, and analyses in a secure location for three years according to federal regulations. In the event that I need materials beyond this period, I will keep them secured until I no longer need them, then I will destroy them. All information stored on my computer will be password protected.
- Initial data will only be viewed by myself, my research advisor, and a statistician employed by Smith College. When material for this study is used for future presentation and possible publication, any identifying information will be removed.

Payments/gift

- You will receive the following payment/gift: Upon *completion* of the survey, you will be directed to a separate link in which you may record in your contact information in order to be entered into the raffle to win one of two \$50 gift cards to Walmart. The raffle is a separate survey that will not be linked any of your previously entered data.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to *March 1, 2015*. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by *March 1, 2015*. After that date, your information will be part of the final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, *Kaitlyn Janicki* at *kjanick@smith.edu*.

If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- BY CHECKING THE BOX BELOW THAT SAYS, 'I AGREE' YOU ARE INDICATING THAT YOU HAVE READ AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION AND YOUR RIGHTS, AND THAT YOU AGREE TO PARTICIPATE IN THIS STUDY. Please print a copy of this page for your records.

_____ I disagree

_____ I agree

Appendix G

Online Survey

[Bold horizontal lines indicate a new page in the questionnaire. Questions without a line in between them will appear on the same page.]

I.) SCREENING QUESTIONS: *[Participants must answer 'Yes' to meet inclusion criteria; otherwise will be redirected to Disqualification page (See Appendix H)].*

*1.) Are you 18 years of age or older?

Yes

No

*2.) Are you currently receiving mental health or substance abuse treatment services?

Yes

No

*3.) Do you have a current diagnosis of—or history of—Alcohol Abuse or Dependence?

Yes

No

*4.) Are you able to read and write in English?

Yes

No

II.) INFORMED CONSENT [Please see Appendix I of this HSR Application for Informed Consent.]

III) DEMOGRAPHIC QUESTIONS

Please respond to the following demographic questions.

5.) What is your age? _____

6.) Please select the gender that you identify most with.

Male

Female

Other

I prefer not to answer.

7.) How do you identify racially/ethnically?

American Indian or Alaskan Native

Asian

Black or African American

Hispanic/Latino (a)

White/Caucasian

Two or more ethnicities

Other

I prefer not to answer.

8.) Please describe your current alcohol use:

I am currently in recovery (I no longer drink but have had a problem with alcohol in the past)

I drink most days of the week

I drink once or twice a week

I drink a few times a month

Other. Please describe: _____

IV) SURVEY QUESTIONS

You are being asked to be in a research study that explores the relationship between drinking behaviors and how one typically acts towards oneself during difficult times. The purpose of the study is to learn about how individuals who have alcohol problems typically act towards themselves during difficult times and how this is related to their feelings of anxiety, depression and stress.

Instructions: The 10 items below refer to how you have behaved **during the past year**. For each item, indicate the statement that is most true for you, by circling the most appropriate response listed.

Drink Definitions

Some items below ask questions about how many drinks you have had. For the purpose of this screening test, a drink is defined as follows: 1) a single small (8 ounces; 1/2 pint!) glass of beer, 2) a single shot/measure of liquor/spirits, 3) a single glass of wine.

9.) How often do you have a drink containing alcohol?

Never (Skip to Questions 9-10)

Monthly or less

2 to 4 times a month

2 to 3 times a week

4 or more times a week

10.) How many drinks containing alcohol do you have on a day when you are typically drinking?

1 to 2

3 to 4

5 to 6

7, 8 or 9

10 or more

11.) How often do you have six or more drinks on one occasion?

Never

Less than monthly

Monthly

Weekly

Daily or almost daily

12.) How often during the past year have you failed to do what was normally expected of you because of drinking?

Never

Less than monthly

Monthly

Weekly

Daily or almost daily

13.) How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never

Less than monthly

Monthly

Weekly

Daily or almost daily

14.) How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?

Never

Less than monthly

Monthly

Weekly

Daily or almost daily

15.) How often during the last year have you had a feeling of guilt or remorse after drinking?

Never

Less than monthly

Monthly

Weekly

Daily or almost daily

16.) Have you or someone else been injured as a result of your drinking?

No

Yes, but not in the last year

Yes, during the last year

17.) Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?

No

Yes, but not in the last year

Yes, during the last year

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale: (1-5; 1 indicating *almost never* and 5 indicating *almost always*).

18.) I'm disapproving and judgmental about my own flaws and inadequacies.

1 Almost Never

2

3

4

5 Almost Always

19.) When I'm feeling down I tend to obsess and fixate on everything that's wrong.

1 Almost Never

2

3

4

5 Almost Always

20.) When things are going badly for me, I see the difficulties as part of life that everyone goes through.

1 Almost Never

2

3

4

5 Almost Always

21.) When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

22.) I try to be loving towards myself when I'm feeling emotional pain.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

23.) When I fail at something important to me I become consumed by feelings of inadequacy.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

24.) When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

25.) When times are really difficult, I tend to be tough on myself.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

26.) When something upsets me I try to keep my emotions in balance.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

27.) When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

28.) I'm intolerant and impatient towards those aspects of my personality I don't like.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

29.) When I'm going through a very hard time, I give myself the caring and tenderness I need.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

30.) When I'm feeling down, I tend to feel like most other people are probably happier than I am.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

31.) When something painful happens I try to take a balanced view of the situation.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

32.) I try to see my failings as part of the human condition.

- 1 Almost Never
- 23
- 4
- 5 Almost Always

33.) When I see aspects of myself that I don't like, I get down on myself.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

34.) When I fail at something important to me I try to keep things in perspective.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

35.) When I'm really struggling, I tend to feel like the other people must be having an easier time of it.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

36.) I'm kind to myself when I'm experiencing suffering.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

37.) When something upsets me I get carried away with my feelings.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

38.) I can be a bit cold-hearted towards myself when I'm experiencing suffering.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

39.) When I'm feeling down I try to approach my feelings with curiosity and openness.

- 1 Almost Never
- 2

- 3
- 4
- 5 Almost Always

40.) I'm tolerant of my own flaws and inadequacies.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

41.) When something painful happens I tend to blow the incident out of proportion.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

42.) When I fail at something that's important to me, I tend to feel alone in my failure.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

43.) I try to be understanding and patient towards those aspects of my personality I don't like.

- 1 Almost Never
- 2
- 3
- 4
- 5 Almost Always

Please read each statement and circle a number 0, 1, 2, or 3 that indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of the time
- 3 Applied to me very much, or most of the time

44.) I found it hard to wind down.

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time

- 2 Applied to me to a considerable degree, or a good part of the time
 - 3 Applied to me very much, or most of the time
- 45.) I was aware of dryness of my mouth**
- 0 Did not apply to me at all
 - 1 Applied to me to some degree, or some of the time
 - 2 Applied to me to a considerable degree, or a good part of the time
 - 3 Applied to me very much, or most of the time
- 46.) I couldn't seem to experience any positive feeling at all.**
- 0 Did not apply to me at all
 - 1 Applied to me to some degree, or some of the time
 - 2 Applied to me to a considerable degree, or a good part of the time
 - 3 Applied to me very much, or most of the time
- 47.) I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion).**
- 0 Did not apply to me at all
 - 1 Applied to me to some degree, or some of the time
 - 2 Applied to me to a considerable degree, or a good part of the time
 - 3 Applied to me very much, or most of the time
- 48.) I found it difficult to work up the initiative to do things.**
- 0 Did not apply to me at all
 - 1 Applied to me to some degree, or some of the time
 - 2 Applied to me to a considerable degree, or a good part of the time
 - 3 Applied to me very much, or most of the time
- 49.) I tended to over-react to situations.**
- 0 Did not apply to me at all
 - 1 Applied to me to some degree, or some of the time
 - 2 Applied to me to a considerable degree, or a good part of the time
 - 3 Applied to me very much, or most of the time
- 50.) I experienced trembling (e.g., in the hands).**
- 0 Did not apply to me at all
 - 1 Applied to me to some degree, or some of the time
 - 2 Applied to me to a considerable degree, or a good part of the time
 - 3 Applied to me very much, or most of the time
- 51.) I felt that I was using a lot of nervous energy.**
- 0 Did not apply to me at all
 - 1 Applied to me to some degree, or some of the time
 - 2 Applied to me to a considerable degree, or a good part of the time
 - 3 Applied to me very much, or most of the time
- 52.) I was worried about situations in which I might panic and make a fool of myself.**
- 0 Did not apply to me at all
 - 1 Applied to me to some degree, or some of the time
 - 2 Applied to me to a considerable degree, or a good part of the time
 - 3 Applied to me very much, or most of the time
- 53.) I felt that I had nothing to look forward to.**
- 0 Did not apply to me at all
 - 1 Applied to me to some degree, or some of the time

- 2 Applied to me to a considerable degree, or a good part of the time
 - 3 Applied to me very much, or most of the time
- 54.) I found myself getting agitated.**
- 0 Did not apply to me at all
 - 1 Applied to me to some degree, or some of the time
 - 2 Applied to me to a considerable degree, or a good part of the time
 - 3 Applied to me very much, or most of the time
- 55.) I found it difficult to relax.**
- 0 Did not apply to me at all
 - 1 Applied to me to some degree, or some of the time
 - 2 Applied to me to a considerable degree, or a good part of the time
 - 3 Applied to me very much, or most of the time
- 56.) I felt down-hearted and blue.**
- 0 Did not apply to me at all
 - 1 Applied to me to some degree, or some of the time
 - 2 Applied to me to a considerable degree, or a good part of the time
 - 3 Applied to me very much, or most of the time
- 57.) I was intolerant of anything that kept me from getting on with what I was doing.**
- 0 Did not apply to me at all
 - 1 Applied to me to some degree, or some of the time
 - 2 Applied to me to a considerable degree, or a good part of the time
 - 3 Applied to me very much, or most of the time
- 58.) I felt I was close to panic.**
- 0 Did not apply to me at all
 - 1 Applied to me to some degree, or some of the time
 - 2 Applied to me to a considerable degree, or a good part of the time
 - 3 Applied to me very much, or most of the time
- 59.) I was unable to become enthusiastic about anything.**
- 0 Did not apply to me at all
 - 1 Applied to me to some degree, or some of the time
 - 2 Applied to me to a considerable degree, or a good part of the time
 - 3 Applied to me very much, or most of the time
- 60.) I felt I wasn't worth much as a person.**
- 0 Did not apply to me at all
 - 1 Applied to me to some degree, or some of the time
 - 2 Applied to me to a considerable degree, or a good part of the time
 - 3 Applied to me very much, or most of the time
- 61.) I felt that I was rather touchy.**
- 0 Did not apply to me at all
 - 1 Applied to me to some degree, or some of the time
 - 2 Applied to me to a considerable degree, or a good part of the time
 - 3 Applied to me very much, or most of the time
- 62.) I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat).**
- 0 Did not apply to me at all
 - 1 Applied to me to some degree, or some of the time

- 2 Applied to me to a considerable degree, or a good part of the time
- 3 Applied to me very much, or most of the time

63.) I felt scared without any good reason.

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of the time
- 3 Applied to me very much, or most of the time

64.) I felt that life was meaningless.

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of the time
- 3 Applied to me very much, or most of the time