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An examination of the psychometric properties of the Self-Compassion Scale – Short Form among a help-seeking clinical sample

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An examination of the psychometric properties of the Self-Compassion Scale – Short Form among a help-seeking clinical sample

Abstract
In recent years, interest in the use of mindfulness interventions in clinical psychology has grown exponentially. Self-compassion is an integral aspect of mindfulness practice and has become a burgeoning area of research. The Self-Compassion Scale (SCS; Neff, 2003a) was developed to make this research possible. Using the SCS, self-compassion has been shown to be related to psychological well-being and interventions are now being created to increase self-compassion. However, the SCS has primarily been used with undergraduate samples and the use of the SCS with clinical populations has been largely unaddressed in the research. Given the apparent benefits of high self-compassion, it is important that the SCS be validated with clinical populations, particularly if this population is going to be a target for intervention. The current study sought to address this issue by collecting normative data for the SCS among a help-seeking clinical sample. Due to small sample size, analyses were completed using only items found on Self-Compassion Scale – Short-Form (Raes, Pommier, Neff, & Van Gucht, 2011). It was found that self-compassion scores were significantly lower in the present sample compared to a previous non-clinical sample. Significant correlations were found between self-compassion and measures of self-esteem, anxiety, and stress, replicating previous findings. Self-compassion was not significantly correlated with satisfaction with life or depressive symptoms. Unfortunately, confirmatory factor analysis was not interpretable due to small sample size. Overall, the results provide some initial support that the SCS is an appropriate measure for help-seeking clinical populations. Additional research with this population is warranted.

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AN EXAMINATION OF THE PSYCHOMETRIC PROPERTIES OF THE SELF-COMPASSION SCALE – SHORT FORM AMONG A HELP-SEEKING CLINICAL SAMPLE

A DISSERTATION

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MEASURING SELF-COMPASSION IN A CLINICAL SAMPLE

ABSTRACT

In recent years, interest in the use of mindfulness interventions in clinical psychology has grown exponentially. Self-compassion is an integral aspect of mindfulness practice and has become a burgeoning area of research. The Self-Compassion Scale (SCS; Neff, 2003a) was developed to make this research possible. Using the SCS, self-compassion has been shown to be related to psychological well-being and interventions are now being created to increase self-compassion. However, the SCS has primarily been used with undergraduate samples and the use of the SCS with clinical populations has been largely unaddressed in the research. Given the apparent benefits of high self-compassion, it is important that the SCS be validated with clinical populations, particularly if this population is going to be a target for intervention. The current study sought to address this issue by collecting normative data for the SCS among a help-seeking clinical sample. Due to small sample size, analyses were completed using only items found on Self-Compassion Scale – Short-Form (Raes, Pommier, Neff, & Van Gucht, 2011). It was found that self-compassion scores were significantly lower in the present sample compared to a previous non-clinical sample. Significant correlations were found between self-compassion and measures of self-esteem, anxiety, and stress, replicating previous findings. Self-compassion was not significantly correlated with satisfaction with life or depressive symptoms. Unfortunately, confirmatory factor analysis was not interpretable due to small sample size. Overall, the results provide some initial support that the SCS is an appropriate measure for help-seeking clinical populations. Additional research with this population is warranted.

Keywords: self-compassion, measurement, clinical sample, confirmatory factor analysis
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In recent years, interest in the use of mindfulness interventions in clinical psychology has grown exponentially. Having deep roots in Buddhist philosophy, mindfulness meditation has been adapted for western use with the development of manualized treatments like acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999), dialectical behavioral therapy (DBT; Linehan, 1993), mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1982), and mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2002). Mindfulness has been defined as “paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally” (Kabat-Zinn, 1994, p. 4).

An assortment of assessments have been developed to measure mindfulness (e.g., the Mindfulness Attention Awareness Scale [MAAS; Brown & Ryan, 2003], the Kentucky Inventory of Mindfulness Skills [KIMS; Baer, Smith, & Allen, 2004], the Cognitive and Affective Mindfulness Scale [CAMS; Feldman, Hayes, Kumar, Greeson, & Laurenceau, 2007]); however, these assessments often focus exclusively on awareness and attention while overlooking other important Buddhist concepts (Kraus & Sears, 2009). Explicit interest in the how of mindfulness is slowly catching up in the research. Additional measures that examine practices like compassion and equanimity (e.g., the Self-Compassion Scale [SCS; Neff, 2003a], the Self-Other Four Immeasurables Scale [SOFIS; Kraus & Sears, 2009]) have been developed, which have allowed for a mounting body of evidence for their benefits. Self-compassion in particular is a burgeoning area of research and has been shown to be linked to various aspects of mental health (e.g., Neff, 2003a). In fact, recent research suggests that self-compassion may account for many of the positive outcomes previously attributed to mindfulness (e.g., Keng, Smoski, Robins, Ekblad, & Brantley, 2012; Van Dam, Sheppard, Forsyth, & Earleywine, 2011).
Self-Compassion

Eastern Tradition

In Eastern traditions, compassion is seen as a path to liberate and heal our minds from destructive emotions like envy and fear (Gilbert, 2005). Buddhism, for example, identifies compassion as basic to human nature and is highlighted in the Four Noble Truths. In these, the Buddha observed that all beings experience suffering (dukkha) and wish to be free of suffering. Further, he described the causes of suffering (e.g., craving, ignorance) and how to break free from it (i.e., the Eightfold Path). Compassion (karuna) is one of the solutions to suffering and involves not only empathizing with your own or another’s suffering but also taking action to end it (Eisenberg, 2002). Buddhists cultivate compassion for the self and others through meditation. Such meditations often center on loving-kindness (metta, which stems from the words “gentle” and “friend”; Salzberg, 1995, p. 24) and compassionate imagery (Rinpoche & Mullen, 2005). Loving-kindness meditations often begin with a focus on the self and then move to others, as compassion for oneself is considered the foundation for compassion toward others (Germer, 2009).

Western Conceptualizations

Despite its deep origins in the East, self-compassion has only recently gained notice in Western culture with the escalating interest in mindfulness meditation. Several Western psychologists have been key in translating and transplanting eastern philosophy into western psychological practices. Paul Gilbert’s (2005) conceptualization of compassion integrates Buddhist philosophy and biopsychosocial theory. He has described compassion as a complex interplay of elements, including influences from evolution, genes, environment, attitudes, and emotions. In particular, he has noted the evolutionary advantages of prosocial behavior like
compassion and caring. Part of his evolutionary explanation for compassion includes social mentality theory, in which a social mentality is essentially a social role that is elicited by certain environmental signals, internal experience, and information-processing patterns. Of importance, the activation of a certain social mentality also serves to create a complementary social mentality in others. He sees compassion as being part of a “care giving” mentality that has evolved due to its enhancement of survival (and thus, reproduction) rates (Gilbert, 2005, p. 16).

Further, Gilbert (1997) has identified shame as a lack of self-compassion and a key contributor to psychopathology and self-criticism (Gilbert & Irons, 2004). Gilbert and Irons (2004) conceptualize self-criticism as being a safety behavior that originates when the environment is rejecting and disparaging of the individual. Warm or reassuring experiences are met with responses from the oxytocin-opiate system, which regulates stress hormones. On the other hand, a lack of such experiences early in life can lead to this system being underdeveloped, leaving the individual’s threat system unrestrained. Further, shame and criticism by others has been shown to be a very powerful elicitor of the cortisol stress response, leaving children in such environments with over-stimulated threat systems. Additionally, individuals who have critical environments may try to prevent conflict with caregivers by internalizing criticism and therefore never learn how to be self-soothing or -reassuring. Of importance, external signals and internal fantasies trigger the same physiological systems, meaning that “self-criticism and self-reassurance may become the internal stimulators and maintainers of key threat or reassurance linked neurophysiological circuits” (Longe et al., 2010, p. 1850). Ironically, for the person who was shamed and criticized in childhood, later attempts at being self-reassuring are unfamiliar and can trigger the threat system (Longe et al., 2010). Indeed, for those who are highly self-critical,
CBT prompts to generate alternative thoughts can feel empty or even frightening (Gilbert & Procter, 2006).

Christopher Germer is a clinical psychologist who authored a self-instructional book that utilizes mindfulness and loving-kindness meditations to cultivate self-compassion. In The Mindful Path to Self-Compassion (2009), he describes self-compassion as arising out of a natural desire of all beings to be happy and free from suffering. However, despite this innate drive, he suggests we often seem to have great difficulty cultivating self-compassion. He points to the stress response as one explanation for our tendency to be self-critical (fight), self-isolative (flight), and self-absorbed (freeze) during times of suffering, which often leads to more suffering. He sees self-compassion as an answer to our knee-jerk response to run away from (and ironically, prolong) pain. He stated, “The experience of compassion is complete abandonment of the inclination to resist emotional discomfort. It’s full acceptance: of the person, of the pain, and of our own reactions to the pain” (Germer, 2009, p. 33). He conceptualizes self-compassion as a skill that can be bolstered through mindfulness and loving-kindness meditations.

Kristin Neff is another pioneering researcher who has brought academic attention to the self-compassion construct. Neff (2003b) conceptualizes self-compassion as being comprised of three facets; self-kindness, mindfulness, and common humanity. Self-kindness involves treating oneself kindly and gently in the face of failures or shortcomings rather than being self-critical and judgmental. Mindfulness requires holding one’s experience in balanced awareness and not getting entangled in one’s thoughts and emotions; a process Neff calls over-identification. Over-identification not only magnifies the experience of suffering but also creates feelings of isolation. The last component of self-compassion is common humanity, which involves remembering that
all human beings suffer rather than feeling alone in having painful experiences. Taken together, she offered this definition:

Self-compassion, therefore, involves being touched by and open to one’s own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one’s suffering and to heal oneself with kindness. Self-compassion also involves offering nonjudgmental understanding to one’s pain, inadequacies, and failures, so that one’s experience is seen as part of the larger human experience. (Neff, 2003b, p. 87)

Neff (2003a) made these components measurable with the development of the Self-Compassion Scale (SCS), which has led to empirical validation of the construct of self-compassion and has provided evidence for its benefits (see below).

**Distinctions**

Neff has also examined the distinctions of self-compassion and has addressed common misunderstandings about self-compassion. Neff (2003b) explains that self-compassion is not self-centeredness, self-absorption, or self-pity, which all lead to feelings of isolation and disconnection. On the contrary, cultivating genuine self-compassion should lead to more feelings of interconnectedness and equality with others because it acknowledges that one’s experiences are a part of the human condition. Indeed, research has shown that having a lack of compassion for the self is related to a decreased capacity for compassion toward others (Allen & Knight, 2005). Further, the mindful component of self-compassion prevents people from becoming overly engrossed in their own experience, which frees up energy that can be directed to other people or pursuits.

Another concern is that being self-compassionate will lead to passivity and a tendency to “go easy” on oneself by overlooking areas for growth. However, when shortcomings are met
with self-condemnation, “the protective functions of the ego will often act to screen inadequacies from self-awareness so that one’s self-esteem is not threatened” (Neff, 2003b, p. 87). Because self-compassionate people have no need to harshly criticize themselves, they are better able to squarely face their failings and clearly aim for more optimal functioning. In fact, research has shown that self-criticism is not as distressful when one also has high self-compassion and when failure is seen as part of the human condition (Kwan, Kuang, & Hui, 2009). Self-compassion provides the “emotional safety needed to see the self clearly without fear of self-condemnation, allowing the individual to more accurately perceive and rectify maladaptive patterns of thought, feeling, and behavior” (Neff, 2003b, p. 87). As stated above, the original Buddhist definition of compassion goes further than mere empathy; it requires that one take action to end suffering whenever possible, including one’s own.

Various authors have also compared self-compassion and self-esteem. Self-esteem has been widely studied in recent decades and appears to be a strong predictor of mental well-being (Neff & Vonk, 2009). The research has identified three primary sources of self-esteem: having a compassionate view of self and others, merit, and narcissistic self-bias (Kwan, Kuang, & Hui, 2009). This indicates that for some people, self-compassion may actually be the source of their self-esteem. Indeed, self-esteem and self-compassion have been found to be moderately correlated (Neff, 2003a). Other people may find their self-esteem predominately in achievement while others in an unrealistically high self-appraisal. Often, self-esteem will be related to all three sources in varying degrees.

Research has shown that high self-esteem sometimes comes at a cost, and the consequences of high self-esteem likely depend on the primary source of one’s self-esteem. When self-esteem is highly dependent on achievement, failure could cause a significant blow to
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one’s self-worth. Research shows that self-esteem is actually the outcome of doing well rather than the cause of it (Neff, 2011). The tenuous nature of self-esteem is further supported by the finding that self-compassion predicts more stability in self-esteem than does self-esteem, when self-compassion is controlled for (Neff & Vonk, 2009). Moreover, in modern society, success is often gauged on how one “measures up” compared to others and practically speaking, not everyone can be above average at every moment. Self-compassion, on the other hand, arises from the simple idea that all human beings deserve compassion and caring in the face of suffering, regardless of context and comparison. Self-compassion is helpful precisely in times of failure, shame, and shortcoming.

Self-esteem that arises out of a self-bias or “defensive self-esteem” (Kwan, Kuang, & Hui, 2009, p. 177) seems to be a likely source of many of the other negative correlates of self-esteem the research has found, including narcissism, self-centeredness and -absorption, distortions in self-knowledge, and prejudice toward out-groups (Neff, 2011). Many of the unfortunate consequences of maintaining high self-esteem are relational in nature, such as engaging in downward social comparisons, dismissing feedback from others, and not taking responsibility for harmful actions (Neff & Vonk, 2009). Self-compassion not only spares the individual from self-directed harsh judgment but also “allows for less judgment of others, as comparisons between oneself and others are not needed to enhance or defend self-esteem” (Neff, 2003b, p. 87).

The complicated nature of self-esteem may be part of the reason why programs that seek to increase self-esteem often fail (Swann, 1996). Kwan, Kuang, & Hui (2009) wrote,

The motivation behind the development of a Task Force to promote self-esteem in the 1980s was a noble one but it is important for interventions to be designed with the
complexity of self-esteem in mind. If we are going to promote self-esteem as a means of bettering our children, we should be sure that we are promoting its beneficial aspects. (p. 190)

Self-compassion may very well be one of the crucial components of positive self-worth. Overall, although enhanced self-compassion appears to demonstrate similar benefits of enhanced self-esteem, it does not appear to have the same potential negative outcomes.

**Benefits of Self-Compassion**

The growing body of evidence for the psychological benefits of self-compassion is encouraging. For example, self-compassion has demonstrated significant positive correlations with a variety of measures of psychological health, including happiness, positive affect, optimism, wisdom, curiosity and exploration, and personal initiative (Neff, Rude, & Kirkpatrick, 2007). Positive correlations have also been found between self-compassion and life satisfaction, social connectedness, and emotional intelligence (Neff, 2003a). Further, Neff (2003a) found that self-compassion is negatively correlated with depression, anxiety, and neurotic perfectionism. Self-compassion demonstrated significant relationships in the expected direction with depression, anxiety, life satisfaction, and neurotic perfection even after controlling for self-criticism, suggesting that self-compassion independently predicts many aspects of mental health (Neff, 2003a).

The relationship between self-compassion and personality characteristics has also been explored. Neff et al. (2007) investigated the relationship between self-compassion and the five-factor model of personality and found that self-compassion was significantly negatively correlated with neuroticism and significantly positively correlated with agreeableness, extroversion, and conscientiousness. There was not a significant relationship with openness to
experience and the authors hypothesized that certain aspects of this factor, like aesthetic
sensitivity and preference for variety, are simply unrelated to self-compassion. Instead, they
proposed that curiosity and exploration, which were found to be related to self-compassion, tap
into the open-minded aspect of openness to experience and suggested that future studies measure
separate facets of each personality trait.

Research has also examined the links between self-compassion and self-esteem. Self-
compassion and self-esteem have been found to be moderately correlated (e.g., Neff, 2003a; Neff
& Vonk, 2009); however, further analyses have highlighted important differences between the
two constructs. As noted above, while self-esteem is associated with narcissism, self-compassion
is not (Neff, 2003a; Neff & Vonk). Additionally, regression analyses have demonstrated that
self-compassion accounts for a significant amount of variance over and above self-esteem in to
the prediction of ego reactivity and positive emotional states. In a two-part study, Neff and Vonk
found that self-compassion was a stronger negative predictor than self-esteem on measures of
self-esteem instability, self-worth contingency (i.e., when worth is based on external factors like
academic performance or attractiveness), social comparison, self-rumination, public self-
consciousness, anger, and need for cognitive closure. Additionally, self-compassion was an
equally strong positive predictor as self-esteem for happiness, optimism, and positive affect.
They concluded,

Overall, the results of these two studies suggests that self-compassion is linked to many
of the benefits typically attributed to high self-esteem in terms of positive emotions,
while also providing stronger protection against the ego-defensive drawbacks sometimes
associated with the pursuit and maintenance of high self-esteem. (p. 44)

Further,
If self-compassion levels were not taken into account, it would have appeared that global levels of self-esteem were strongly protective against ego-focused reactivity. For the majority of outcomes, however, self-esteem offered no benefits whatsoever over and above those attributable to self-compassion. (p. 39)

Self-compassion appears to provide a more stable and realistic sense of worth than self-esteem. Additional evidence for the differences between self-compassion and self-esteem are described below.

In a series of studies, Leary, Tate, Allen, Adams, and Hancock (2007) found that participants with high levels of self-compassion demonstrated fewer negative emotions than those low in self-compassion when confronted with imagined, remembered, and real situations involving failure, embarrassment, and rejection. These participants experienced less rumination and self-judgment than those low in self-compassion. Additionally, they perceived themselves more accurately and demonstrated equitable reactions regardless of context as compared to those with low self-compassion, who endorsed overly harsh judgments of themselves and whose reactions depended on others’ feedback. When comparing self-compassion and self-esteem, the authors found that those high in self-esteem discounted their personal contribution to unflattering evaluations and events while those high in self-compassion did the opposite. Moreover, “self-compassion, but not self-esteem, was related to more favorable ratings of other people and lower negative affect after receiving unflattering feedback” (Leary et al., p. 902). Further, just as Neff and Vonk (2009) found, self-compassion “accounted for more of the unique variance in outcomes that are typically regarded as correlates of self-esteem...[which] raises the possibility that what are widely regarded as self-esteem effects may, in fact, be better explained in terms of self-compassion” (Leary et al., p. 902).
Self-compassion appears to have very practical implications for students in particular. In the first of two studies with undergraduate populations, Neff, Hsieh, and Dejitterat (2005) found that self-compassion was positively correlated with adopting mastery-based academic achievement goals in which learning is intrinsically motivated by curiosity and a desire for understanding. Students with a mastery orientation create their own personal standards for achievement and view mistakes as opportunities for learning. Significant positive correlations were also found between self-compassion and intrinsic motivation and perceived competence. On the other hand, self-compassion showed a significant negative association with anxiety, fear of failure, and performance-based achievement goals, in which students are motivated by social comparison and a fear of failure. “By not harshly judging the self or blowing one’s failures out of proportion, self-compassion is associated with greater self-confidence in one’s ability to learn and less trepidation concerning possible failure, which in turn is linked to greater mastery goal adoption” (Neff et al., 2005, p. 275).

In Neff et al.’s (2005) second study, the authors examined self-compassion levels in the face of an actual academic failure and replicated the results from the first study. Further, self-compassion was significantly positively related to coping by reinterpreting the failure as an opportunity to grow and by accepting the failure. Conversely, self-compassion demonstrated significant negative correlations with coping by venting emotions, by denying the reality of the event, and by giving up on one’s goals. Neff et al. (2005) interpreted these findings as being evidence for adaptive coping by self-compassionate individuals in the face of failure. Overall, self-compassion “appears to help students focus on mastering the tasks at hand rather than worrying about performance evaluations, to retain confidence in their competence as learners, and to foster intrinsic motivation” (Neff et al., 2005, p. 284).
Williams, Stark, and Foster (2008) found further empirical support for the benefits of self-compassion among students. Their study examined the relationship between self-compassion, motivation, and procrastination. They found that participants who were high in self-compassion were less likely to report a tendency to procrastinate. Given the potential for negative consequences when students procrastinate, the authors proposed that self-compassion and procrastination behavior should be explored further. Additionally, high levels of self-compassion were related to lower levels of academic worry and emotionality. The authors drew similar conclusions to Neff et al. (2005), saying that students who are high in self-compassion are more likely to be focused on learning than performance. However, they did not find a significant correlation between self-compassion and either mastery-based or performance-based achievement orientations. They hypothesized the achievement orientation measure was not comprehensive enough, though it demonstrated strong high internal consistency.

Self-compassion appears to also be important for divorcees. Sbarra, Smith, and Mehl (2012) had recently divorced adults speak for 4 minutes in a stream-of-consciousness manner about their separation experience. Trained judges rated the recordings for levels of self-compassion based on a modified version of the Self-Compassion Scale-Short Form. The judges were blind to the hypotheses of the study and there was high interrater agreement. The participants were assessed at a 3-month follow up, and again at either 6-months or 9-months. Seventy-six of the original participants completed both follow up assessments, with those who did not exhibiting similar levels of divorce related distress but significantly less self-compassion at the initial assessment. The researchers found that high levels of self-compassion at the initial assessment were significantly associated with less divorce-related distress up to 9 months later,
even after they controlled for a range of other factors. Given that almost 2 million adults experience a divorce each year in the United States, these are very promising findings.

Brain imaging studies are also exploring self-compassion. Recently, Longe et al. (2010) used MRI to examine differences in brain activity in people who employed varying levels of self-criticism (i.e., low self-compassion) and self-reassurance (i.e., high self-compassion). They found that self-criticism was associated with activation of the lateral prefrontal cortex (PFC) and dorsal anterior cingulate (AC), indicating that self-criticism is linked to error processing and resolution and subsequent inhibitory processes. Alternatively, self-reassurance was associated with activation in the left temporal pole and insula, which are the same regions that are activated when generating compassion for others. This supports philosophical assumptions that compassion for the self and for others go hand in hand.

**Group Differences**

Research on self-compassion has begun to identify potential group differences in self-compassion levels. Currently, differences in self-compassion have been found according to age, gender, and ethnicity, though some of the research is mixed. Several studies (i.e, Neff & Vonk, 2009; Shapira & Mongrain, 2010; Shapiro, Brown, & Biegel, 2007) have demonstrated a positive correlation between age and self-compassion. However, Neff and McGeehee (2010) found no difference in self-compassion between adolescents ($M_{age} = 15.2$ years) and young adults ($M_{age} = 21.1$ years). It is possible, though, that such differences do not emerge until later in life (Neff, 2011). For example, Neff and Vonk found that self-compassion was positively associated with age but was not significantly associated with income, while self-esteem was negatively associated with age and positively associated with income. They explained,
In the youth- and wealth-conscious culture of the West, positive self-evaluations (i.e., self-esteem) may tend to decline with advancing age and decreasing income levels. In contrast, the ability to treat oneself compassionately does not appear to depend on wealth and actually increases slightly with age, consistent with prior findings that self-compassion is associated with reflective wisdom. (p. 38)

In terms of gender, there is evidence that women are less self-compassionate than men (Neff, 2003a; Neff & Vonk, 2009; Neff, Hsieh, & Dejitterat, 2005; Neff, Pisitsungkagarn, & Hsieh, 2008). Neff (2003a) suggests this may be explained by the higher prevalence of rumination and self-criticism in women. Other studies (e.g., Neff, Rude, & Kirkpatrick, 2007), however, have not found gender differences.

Culture appears to play an important role in self-compassion levels, as well. Neff et al. (2008) compared self-compassion levels of American, Taiwanese, and Thai participants. They found that Taiwanese participants had the lowest levels of self-compassion, with American participants falling in the middle and Thai participants exhibiting the highest levels. Neff et al. (2008) pointed out that although Taiwan and Thailand are both Eastern, interdependent societies, they differ greatly in other cultural features. While Thailand’s culture is heavily influenced by Buddhist teachings (of which compassion is an important aspect), Taiwanese culture employs Confucian teachings that utilize “shame as a means of self-development” (Neff et al., 2008, p. 270). Such cultural differences were supported by the finding that the Taiwanese sample scored significantly lower than the Thai sample on levels of self-kindness and significantly higher than the Thai participants on self-judgment, over-identification, and isolation. Because the Taiwanese and Thai samples did not differ in mindfulness scores, the “results suggest that the lack of self-compassion displayed by the Taiwanese is primarily due to
high levels of negative self-relevant emotions” (Neff et al., 2008, p. 278). It is also interesting that the authors found an interaction between gender and culture, with no sex differences found amongst the Thai and Taiwanese samples and U.S. female participants exhibiting significantly lower self-compassion than U.S. male participants. However, in all three samples, self-compassion was significantly related to well-being.

Kwan, Kuang, & Hui (2009) investigated cultural differences in the sources of self-esteem. As discussed above, Kwan et al. (2009) found that self-compassion was one of three major sources of self-esteem, with two other sources being self-efficacy and self-bias (i.e., narcissism). In their study, they compared American and Chinese undergraduates on levels of self-esteem, self-efficacy, self-compassion, and narcissism. They found that the Chinese participants had significantly higher self-compassion. The authors wrote,

This finding may help to explain why a self-critical attitude is less distressful for East Asians than for North Americans. People may distress themselves by being critical. However, a self-critical attitude itself does not necessarily cause distress. As long as people are aware that failure is part of the human condition, a self-critical attitude may motivate self-improvement without causing harm to one’s psyche. (p. 187)

The researchers also found that the Chinese participants had significantly higher levels of narcissism than the American participants, and narcissism was significantly correlated to levels of self-compassion amongst the Chinese participants but not the American participants. It appears that the correlates (or lack thereof) of self-compassion vary across cultures.

Not surprisingly, Neff (2003a) found that self-compassion levels were higher among an American sample of practicing Buddhists compared to an undergraduate sample. Self-compassion levels were correlated with the number of years participants had been practicing
Buddhism. Further, the gender differences in self-compassion that were found with the undergraduate sample were not found with the Buddhist sample. More research on cultural differences in self-compassion is certainly warranted.

Cultivating Self-Compassion

Mindfulness-Based Interventions

Various programs have demonstrated successful enhancement of self-compassion levels. While some interventions focus explicitly on self-compassion, other programs incorporate self-compassion into interventions primarily aimed at cultivating mindfulness. One of the most widely known and studied is Jon Kabat-Zinn’s Mindfulness-Based Stress Reduction (MBSR), an 8-week group intervention that uses mindfulness, meditation, and yoga to achieve stress management (Kabat-Zinn, 1982, 1990). Self-compassion is cultivated in MBSR through loving-kindness meditations, which typically start with the self and then are directed to others. Though self-compassion is not a major component of the MBSR interventions, the assumed stance for a meditative practice is one of non-judgment and self-compassion.

MBSR has been shown to increase self-compassion levels. Shapiro and colleagues have administered MBSR protocols to therapists in training (Shapiro, Brown, & Biegel, 2007) and health care professionals (Shapiro, Astin, Bishop, & Cordova, 2005). Shapiro et al. (2007) implemented MBSR with therapists in training and found that self-compassion increased significantly at the end of treatment compared to the control group. Shapiro et al. (2005) also found that health care professionals in the MBSR group showed significant increases in self-compassion compared to the control group. Moreover, self-compassion mediated changes in perceived stress. Self-compassion, however, did not predict changes in satisfaction with life.
Keng, Smoski, Robins, Ekblad, and Brantley (2012) also examined whether self-compassion mediated MBSR’s effects and found that self-compassion was a significant mediator of changes in worry and fear of emotion, after controlling for mindfulness. Though these three studies had fairly small sample sizes, their results are encouraging for the contribution self-compassion makes to the beneficial effects of MBSR.

Mindfulness-based cognitive therapy (MBCT; Segal et al., 2002) is another mindfulness-based intervention that has demonstrated effects on self-compassion levels. MBCT was developed to address the distressing thoughts and feelings that are common in depression and can contribute to relapse. The aim of MBCT is to interrupt habitual negative processing styles (cognitive reactivity) by approaching these experiences with acceptance and self-compassion (Kuyken et al., 2010). “As the person learns mindfulness skills, s/he learns to give less authority to self-judgment and blame – the fuel for depressive thinking – and to respond to these states with compassion” (Kuyken et al., p. 1106). To test this, Kuyken et al. randomly assigned 123 patients with recurrent depression to either MBCT plus discontinuation of anti-depressant medications or maintenance anti-depressant medication (mADM). They measured mindfulness, cognitive reactivity, and self-compassion to investigate the mechanisms of change for MBCT. Participants engaged in follow up testing 15 months post-treatment. They found that participants who engaged in MBCT showed significantly higher levels of self-compassion at the end of treatment compared to the control group that took anti-depressant medication. It was also found that increases in mindfulness and self-compassion during treatment accounted for participants having less severe depressive symptoms at the 15 month follow up, independent of changes in depression severity. Further, self-compassion, but not mindfulness, moderated the relationship between cognitive reactivity and outcome. For MBCT participants who showed the greatest
improvements in self-compassion during treatment, post-treatment cognitive reactivity scores related less strongly to outcome. On the other hand, cognitive reactivity predicted poorer outcomes for participants in the mADM group.

Further support for the predictive value of self-compassion came from Van Dam, Sheppard, Forsyth, and Earleywine’s (2011) study. They investigated whether mindfulness or self-compassion better predicted anxiety, depression, worry, and quality of life in a large community sample seeking self-help for anxious distress. They found that self-compassion uniquely accounted for 10-27% of the variance of the outcome variables while mindfulness uniquely accounted for only 1-3%. Mounting evidence suggests that self-compassion is an important component of mindfulness-based interventions, and the research should continue to investigate its role.

Interventions Primarily Targeting Self-Compassion

A program that has been specifically developed to enhance compassion for the self is Gilbert and colleagues’ (2004, 2006) Compassionate Mind Training (CMT). CMT was created to address the life-long consequences of internalized criticism, which the authors believe is the antithesis of self-compassion. They described CMT as

involv[ing] the elements of a specific psycho-educational focus on the qualities of self-compassion, locating self-criticisms as forms of safety strategies/behaviour, recognizing the fears behind it, developing empathy for one’s own distress and safety efforts and refocusing on compassionate images, thoughts, emotions and behaviours – with warmth.

(Gilbert & Procter, 2006, p. 365)

CMT has been used with people suffering from trauma (Beaumont, Galpin, & Jenkins, 2012), psychosis involving malevolent voices (Mayhew & Gilbert, 2008), and personality disorders and
chronic mood disorders (Gilbert & Procter, 2006). Initial studies with small samples indicate positive outcomes with CMT. Gilbert & Procter (2006) found that participants endorsed significantly less depressive symptoms, anxiety symptoms, shame, self-attacking, feelings of inferiority, and submissive behavior. Unfortunately, in this study self-compassion levels were not measured directly but conceptualized via measures of self-attacking, self-reassurance and – soothing, and self-monitoring diaries. Beaumont et al. (2012) did measure self-compassion in their study of CBT plus CMT with people who had experienced a traumatic incident. They found significant reductions in avoidance, intrusive thoughts, hyper-arousal, anxiety, and depression, though this was not significantly different from the CBT-only control group. However, the group that received CMT developed significantly more self-compassion than the CBT-only group, indicating that CMT may be an effective treatment to target self-compassion. More research is needed to further support the efficacy of CMT.

Neff and Germer (2012), two of the leading self-compassion experts, have also developed an intervention that targets self-compassion, saying, “Although mindfulness-based interventions can increase self-compassion, these programs devote relatively little time explicitly teaching skills of self-compassion and focus primarily on teaching techniques to enhance mindfulness” (p. 3). Mindful Self-Compassion (MSC) was created to give formal and informal self-compassion practices primary focus, with mindfulness as a secondary emphasis. Participants are given a variety of tools to increase their self-compassion and the program is considered to be a resource building course. However, “because self-compassion is primarily aimed at emotional suffering,” one of the two group leaders is a trained therapist who can handle situations that require a clinician’s attention (p. 4). Neff and Germer indicated their program is intended for both the public and some clinical populations. Participants meet weekly for 2-2½ hours for 8 weeks and
attend a half-day meditation retreat, similar to the structure of MBSR. In their first study of the effectiveness of MSC, the authors found that participants reported significantly higher levels of self-compassion, mindfulness, life satisfaction, and happiness at the end of treatment. They also showed significantly lower levels of depression, anxiety, and stress. There was no change in levels of social connectedness.

Neff and Germer’s (2012) second study on MSC implemented a waitlist control group. Compared to the control group, the MSC participants showed significantly higher levels of self-compassion, mindfulness, compassion for others, and life satisfaction at posttest. The MSC group also demonstrated significantly lower depression, anxiety, stress, and avoidance than the control group. The effect size for the change in self-compassion was large ($d = 1.67$) and there were medium to large effect sizes for all other significant findings except stress. They did not find a difference between the MSC group and the control group for happiness or social connectedness, though this significantly increased for both groups. The control group also showed significant increases in self-compassion and mindfulness. To understand this, the researchers contacted the control group to see if participants had engaged in activities related to self-compassion and mindfulness while they were waiting to start MSC, and 26 of the 27 participants responded. They learned that 50% had read books or online materials about self-compassion and 77% said they intentionally tried to practice self-compassion in their daily lives. The authors wrote, “This actually strengthens confidence in current study findings because the waitlist control group was relatively active in their attempts to increase self-compassion, making comparative gains by the intervention group more marked” (p. 12).

Participants who engaged in the MSC program were followed up with at 6 months and 1 year post treatment. The gains demonstrated by the MSC group were maintained at 6-month and
1-year follow up, and life satisfaction actually showed a significant increase from posttest to 1-year follow up. Interestingly, self-compassion scores increased significantly between pretest and week 3, and again between week 3 and week 6, but remained stable after that up to 1 year follow up. Perhaps the benefits of MSC can be achieved in fewer weeks than the authors originally thought. Finally, hierarchical regression analyses showed that increases in self-compassion were significantly associated with gains in well-being for all the outcome measures except avoidance, for which mindfulness was the only significant predictor. Though mindfulness contributed significant additional variance to compassion for other, happiness, and perceived stress, it did not contribute to variance for self-compassion. Though the results of these studies are encouraging, they should be replicated with more diverse samples. For both samples, over 70% of participants were white, female, highly educated, and had prior meditation experience.

Brief interventions to raise self-compassion have also demonstrated encouraging results. Shapira and Mongrain (2010) asked participants who were vulnerable to depression to engage in a week-long self-compassion exercise, in which they adopted a self-compassionate attitude while writing a letter to themselves reflecting on recent distressing situations. Participants who completed the exercises showed significantly less depression and significantly more happiness at the 3 month follow-up compared to the control condition, in which participants focused on early childhood memories throughout the week. While the gains in happiness persisted at the 6 month follow up, the difference in depressive symptoms between the control and the self-compassion condition reduced to non-significant levels at this time. Unfortunately, the authors offered no explanation for this finding. In further analyses, the authors found that those who were high in connectedness (“mature dependence”) benefitted more from the self-compassion exercises than those high in neediness (“immature dependence”), who “may not have the inner resources
necessary to abandon their reassurance-seeking strategies” (p. 379). Brief interventions for self-compassion appear to provide some benefit for particular populations.

Lastly, research indicates that self-compassion can be experimentally induced in a laboratory setting in an extremely brief time interval. Leary et al. (2007) asked college students assigned to a self-compassion, self-esteem, or control condition to write about a memory involving failure, rejection, or humiliation. Writing exercises were used to induce Neff’s (2003a) three facets of self-compassion: common humanity, self-kindness and understanding, and mindfulness. Self-esteem was induced using three writing exercises that intended to make participants feel better about themselves. They found that those in the self-compassion condition were significantly more likely to admit personal responsibility in the remembered event and to report lower negative affect. Conversely, the self-esteem and control conditions were less likely to acknowledge personal responsibility, which was positively correlated with negative emotion for these groups. This implies that when self-compassion was induced, participants were not only more willing to admit personal responsibility but also were not distressed by this awareness as participants in the other groups were, “possibly because their self-judgments are less tainted by either catastrophizing self-criticism, on one hand, or defensive self-enhancement, on the other” (Leary et al., 2005, p. 901).

Measuring Self-Compassion

**Self-Compassion Scale.** To date, self-compassion has largely been measured in Western psychology using the Self-Compassion Scale (SCS; Neff, 2003a). The SCS is 26-item self-report measure that assesses Neff’s three facets of self-compassion (Self-Kindness, Mindfulness, Common Humanity) and their respective opposites (Self-Judgment, Over-identification, Isolation). Sample items include, “When I’m going through a very hard time, I give myself the
caring and tenderness I need” (Self-Kindness), “When things are going badly for me, I see the difficulties as part of life that everyone goes through” (Common Humanity), and “When something upsets me I try to keep my emotions in balance” (Mindfulness). The six subscales have been supported by factor analyses, which have also found an overarching self-compassion factor. Further, the SCS has demonstrated good internal consistency ($\alpha = 0.92$), with subscale internal consistency values ranging from 0.75 (Mindfulness) to 0.81 (Overidentification; Neff, 2003a). The SCS shows good overall test-retest reliability over three weeks (.93), with each of the subscales also demonstrating adequate levels as well (Kindness = .88, Self-Judgment = .88, Common Humanity = .80, Isolation = .85, Mindfulness = .85, Over-Identification = .88; Neff, 2003a).

A short form of the SCS was also recently developed (Raes, Pommier, Neff, & Van Gucht, 2011). The 12-item Self-Compassion Scale – Short Form (SCS-SF) was constructed and validated with two Dutch samples and then validated again with an English sample. The SCS-SF demonstrated a very high correlation with the SCS in each of the samples ($r \geq .97$). Further, it displayed good internal consistency ($\alpha \geq .86$ in all samples). Analyses revealed the same six subscale factors and higher-order self-compassion factor as the SCS. Preliminary evidence suggests the SCS-SF is an economical alternative to the long-form SCS.

To date, almost all of the research using the SCS and SCS-SF has been with non-clinical samples, many of them college students (K. Neff, personal communication, June 20, 2010). Currently, only a handful of studies have used the SCS with clinical populations. Beaumont et al. (2012) used the Self-Compassion Scale with a small sample (N = 32) of people who were referred for CBT following a traumatic incident. Another study (Van Dam, Sheppard, Forsyth, & Earleywine, 2011) recruited their sample online from a variety of self-help and mental health...
websites and listservs and 50% percent of their sample indicated they were currently in
treatment. Finally, Kuyken et al. (2010) measured changes in self-compassion amongst
participants with depression who were engaging in MBCT. Due to the nature of these studies, the
factor structure of the SCS was never examined, and self-compassion scores were not compared
to previous undergraduate samples. Also, given that there is some variability in the way the SCS
is scored (i.e., averaging the subscales versus using the total score), post hoc statistical
comparisons based on published findings are difficult. Unfortunately, the SCS has not yet been
validated with a clinical population.

Self-Other Four Immeasurables. The Self-Other Four Immeasurables (SOFI) scale was
developed in response to the lack of measures that tap into how mindfulness is practiced,
including positive qualities like loving kindness and compassion (Kraus & Sears, 2009). The
authors see current mindfulness measures as giving exclusive focus to the mere presence of
isolated components of mindfulness, like awareness and attention, while missing the quality of
these states. Further, they criticize the SCS as having “lengthy” items that may be “burdensome”
in a battery of tests and for only measuring compassion toward the self and not others (Kraus &
Sears, p. 171). The authors settled on four factors, including Positive Self, Negative Self,
Positive Other, and Negative Other. In an initial study, the SOFI scale demonstrated good
internal consistency on each subscale (Positive Self = 0.86; Negative Self = 0.85; Positive Other
= 0.80; Negative Other = 0.82). Further, it appeared to offer good concurrent and discriminate
validity, with the SCS correlating strongly with the Self items and less strongly with the Other
items. Despite initial findings of good psychometric properties and an attention to a current gap
in assessment options, the SOFI Scale does not appear to be widely researched.
MEASURING SELF-COMPASSION IN A CLINICAL SAMPLE

Statement of the Problem/Current Study

The goal of this dissertation is to add to the growing body of evidence that supports the validity and usefulness of the self-compassion construct by examining the psychometric properties of the SCS-SF among a clinical sample. The SCS and the SCS-SF are currently the most widely used and researched measures of self-compassion; however, clinical norms for the SCS and SCS-SF are still lacking, and this dissertation aims to address this significant gap. Examining the SCS-SF, in particular, is useful given the benefits of having economical alternatives to lengthier measures.

Establishing these norms will also promote more meaningful measurement and application of the self-compassion construct amongst this population. Jacobson and Revenstorf (1988) suggest that it is important to not only calculate statistical significance but also clinical significance, to ensure that results are clinically meaningful. Clinical significance calculations require clinical normative data. Without these norms, researchers will be unable to assess whether the measure is even relevant to this population. Further, norms will allow for researchers to examine whether changes in self-compassion are actually predictive of positive therapy outcomes for clinical populations and will allow clinicians to track changes in self-compassion during therapy.

Hypotheses

It was predicted that:

1) The average SCS-SF score for the current help-seeking clinical sample would be significantly lower than the average SCS-SF score found in the undergraduate validation study sample (Raes et al., 2011)
MEASURING SELF-COMPASSION IN A CLINICAL SAMPLE

2) There would be a significant, moderate correlation between the SCS-SF and the Rosenberg Self-Esteem Scale

3) There would be a significant correlation between the SCS-SF and the Satisfaction With Life Scale

4) There would be a significant correlation between the SCS-SF and the subscales of the Depression Anxiety Stress Scales - 21

5) A confirmatory factor analysis would support the six factor loadings found in the Raes et al. (2011) validation study sample.
MEASURING SELF-COMPASSION IN A CLINICAL SAMPLE

Method

Participants

The sample was comprised of 42 adults who had voluntarily presented for outpatient mental health treatment. They were recruited from a convenience sample of clinical sites, including Pacific University’s School of Professional Psychology training clinics, Allies in Change (Portland, OR), and Southern Illinois University’s Counseling Center. Participants needed to be at least 18 years old and to have received five or fewer sessions in the current treatment episode. Participants were recruited at the beginning of treatment to reduce the potential confound that therapy may have influenced self-compassion levels. The mean age of participants was 35 ($SD = 12.4, 18-66$). Seventeen of the participants were male (40.5%) and 25 were female (59.5%). Thirty-seven identified as Caucasian (88.1%) and five identified as multiracial (11.9%), which included endorsements of Caucasian, Asian, Hispanic, and Native American.

Materials

Self-Compassion. The Self-Compassion Scale (SCS; see appendix C; Neff 2003a) was administered in order to collect normative data for a clinical population and to calculate correlations and conduct a confirmatory factor analysis. The SCS consists of 26 self-report items that are answered with a five-point Likert-type scale ($1 = \text{Almost Never}$ to $5 = \text{Almost Always}$). It attempts to tap into Neff’s (2003a) three facets of self-compassion and their opposites, including Self-Kindness/Self-Judgment, Common Humanity/Isolation, and Mindfulness/Over-Identification. Factorial analyses have revealed six factors that correlate with each of the subscales (Neff, 2003a). Due to small sample size, however, analyses were conducted using only the 12 items of the SCS that are included in the SCS-SF (Raes et al., 2011). The SCS-SF has
demonstrated the same six-factor structure as the SCS.

**Self-Esteem.** The Rosenberg Self-Esteem Scale (RSES; see appendix D; Rosenberg, 1965) is a general measure of self-esteem. This scale has demonstrated a positive significant correlation \( r = .59 \) with the SCS (Neff, 2003a). The RSES consists of 10 items that are measured using a four-point Likert-type scale (1 = *Strong Agree* to 4 = *Strong Disagree*). Sample items include, “On the whole, I am satisfied with myself” and “I am able to do things as well as most other people.” The RSES has demonstrated good internal consistency \( (\alpha = .91) \) and convergent and discriminate validity (Sinclair, Blais, Gansler, Sandberg, Bistis, & LoCicero, 2010).

**Satisfaction with Life.** The Satisfaction with Life Scale (SWLS; see appendix E; Diener, Emmons, Larsen, & Griffin, 1985) measures respondents’ general satisfaction with their lives. This scale has demonstrated a positive significant correlation \( r = .45 \) with the SCS (Neff, 2003a). The SWLS is a widely-used 5-item scale that uses a seven-point Likert-type scale (1 = *Strong Disagree* to 7 = *Strongly Agree*). Sample items include “The conditions of my life are excellent” and “If I could live my life over, I would change almost nothing.” The SWLS has shown good internal consistency \( (\alpha = .87) \), test-retest reliability (.82 over 2 months), and has been normed with diverse populations (Pavot & Diener, 1993).

**Psychopathology.** The Depression Anxiety Stress Scales – 21 (DASS-21; see appendix F; Ng, Trauer, Dodd, Callaly, Campbell, & Berk, 2007) assess the presence of broad psychopathology in the domains of depression, anxiety, and stress. The 21 item version of the scale has been selected over the original 42-item version (DASS) in an effort towards parsimony and minimizing the time required by participants. The DASS-21 has been found to have comparable psychometric properties as the DASS. It has demonstrated good internal consistency
MEASURING SELF-COMPASSION IN A CLINICAL SAMPLE

(Depression = .94, Anxiety = .87, Stress = .91; Antony, Bieling, Cox, Enns, & Swinson, 1998). Clearly, this scale is not exhaustive of all clinical conditions; however, depression and anxiety are the two most common psychological impairments and are highly comorbid (Antony et al., 1998).

Demographics. A short demographic questionnaire (see Appendix H) was included with the measures in order to examine possible group differences. This questionnaire also asked about participants’ meditative practices, to examine and control for the possibility that a meditative practice was related to self-compassion scores, as previous studies suggest (e.g., Shapiro, Astin, Bishop, & Cordova, 2005; Shapiro, Brown, & Biegel, 2007).

Procedure

Data was collected after IRB approval had been given by Pacific University. Participants were invited to participate by their clinician, the front desk staff, or via a recruitment poster placed on the front desk (see appendix B). When invited by their clinician or the front desk staff, participants were asked to participate in a study about self-compassion, were told that their participation was voluntary, and were instructed to read and sign the informed consent if they were interested in partaking in the study. The study packet included the informed consent (see appendix A), two envelopes labeled “informed consent” and “measures,” and the study materials. The informed consent instructed participants to seal the signed page of their informed consent in its respective envelope while the measures went in their respective envelope, to de-identify their responses and protect confidentiality. The envelopes had matching numbers written on the inside to allow the researcher to double check that responses were given with informed consent. Participants were instructed to seal their materials in the envelopes and to give these back to their clinician or the front desk staff.
Design

The internal consistency of each of the measures was examined using Cronbach’s alpha. Descriptive statistics were calculated and a one-sample \( t \)-test was run to see if there were differences in average SCS-SF score between the current sample and the average non-clinical self-compassion score (i.e., the average self-compassion score found in the Raes et al., 2011 validation sample), and Cohen’s \( d \) was calculated to measure the effect size of the difference. Independent samples \( t \)-tests were also used to explore whether there were differences in self-compassion scores based on gender, race, previous therapy, and having a current meditative practice. Convergent and discriminant validity of the SCS-SF was tested by evaluating Pearson \( r \) correlation coefficients with the RSES, the SWLS, and the DASS.

A confirmatory factor analysis (CFA) was conducted to test the hypothesis that the factor structure previously found for the SCS-SF with a non-clinical sample would be found with the current clinical sample. CFA “is used to verify the number of underlying dimensions of the instrument (factors) and the pattern of item-factor relationships (factor loadings)” (Brown, 2006, p. 2). When a theory has proposed a relationship pattern amongst variables, CFA tests this pattern statistically. In this study, the CFA model was tested using robust maximum likelihood using the statistical software LISREL 8.8 (Jöreskog & Sörbom, 2004). Four fit indices were examined to assess the fit of the previously established six-factor model of the SCS-SF. These included: the comparative fit index (CFI; Bentler, 1990), the Satorra Bentler chi square (\( \chi^2 \); Satorra & Bentler, 2001), the standardized root mean squared residual (SRMR; Hu & Bentler, 1999), and the root mean square error of approximation (RMSEA; March, Balla, & Hau, 1996). Brown (2006) describes these various fit indices as follows. The CFI is an incremental fit index that compares the existing model fit with a model that assumes there is no relationship among the
indicators (i.e., null model). CFI results can range from 0.0-1.0, with values of .95 indicating
good fit. On the other hand, the SBχ² is an absolute fit index that uses an adjusted chi square
statistic to correct for bias that occurs when the data has a non-normal distribution. The SRMR is
another absolute fit index that examines the average discrepancy between the correlations
predicted by the model and the correlations observed in the data. For SRMR, a value of 0
indicates perfect fit, while values that are close to .08 or below are considered a good fit. Finally,
rather than measuring the exact fit of a model (like the absolute fit indices) the RMSEA assess
the extent to which a given model fits a population reasonably well. As with SRMR, the closer
the value is to 0, the better the fit of the model, with values less than or equal to .06 indicating a
good fit.

Results

Preliminary Analyses

SPSS 20.0 (IBM Corp., 2011) was used to assess whether variables complied with
univariate assumptions. No outliers were found using a z-score cut off of 3.29. The data was also
examined for missing responses. Two participants had one missing response on the RSES, while
one participant had one missing response for the stress scale of the DASS. The mean for the
respective item was used in place of the missing value. One participant answered only 3 of the 21
items on the DASS and this person was excluded from analyses using the DASS. Skewness and
kurtosis statistics were also calculated to assess normality. All measures were normally
distributed, except the SCS-SF was slightly positively skewed (.88), though not enough to affect
the analyses. The positive skew was caused by one participant with a SCS-SF score that was
three standard deviations (z = 3.01) above the mean. All of the measures demonstrated good
internal consistency, with an alpha value of .88 for the SCS-SF (see Table 2). The internal
consistencies for the SCS-SF subscales ranged more widely, from .38 (Isolation) to .80 (Mindfulness) (see Table 1).

Descriptive Statistics

Age was not correlated with self-compassion scores ($r = .19, p = .22$). SCS-SF scores were also unrelated to gender, race, whether a person had previously attended therapy, and whether a person had a current meditative practice. Men ($M = 32.00, SD = 9.19$) and women ($M = 31.80, SD = 8.52$) had similar SCS-SF scores, $t(40) = 0.07, p = .79$. SCS-SF scores were also not significantly different between Caucasian participants ($M = 32.00, SD = 8.91$) and multiracial participants, $t(40) = 0.24, p = .58$. Additionally, self-compassion levels were similar between participants who had previously attended therapy ($M = 31.77, SD = 8.95$) and those who had not ($M = 32.18, SD = 8.30$), $t(40) = -0.13, p = .90$. Further, self-compassion scores were not significantly different between people who had a current meditative practice ($M = 37.43, SD = 13.41$) and those who did not ($M = 30.77, SD = 7.18$), $t(6.70) = 1.28, p = .24$. Finally, according to the severity ratings for the DASS (Lovibond & Lovibond, 1995), the average scores on the DASS for the current sample fell into the moderate range for depression, the moderate range for anxiety, and the mild range for stress.

Hypothesis 1

Because the analyses were completed using the SCS-SF, the current sample was compared to Raes et al.’s (2011) English-speaking validation sample instead of Neff’s (2003a) SCS validation sample. Again, these participants were undergraduate students. As hypothesized, self-compassion scores were significantly lower for the current clinical sample ($M = 31.88, SD = 8.68$) than the previous non-clinical sample ($M = 36, SD = 7.33$), $t(41) = -3.07, p = .004$. The 95% confidence interval for the SCS-SF mean ranged from -6.83 to -1.41. On average, self-
compassion scores for the current clinical sample were 4.12 points lower than scores for the non-clinical sample. The effect size $d$ of .47 indicates a medium effect. This supports the hypothesis that people presenting to therapy have lower self-compassion levels than average. See Table 1 for a comparison of the subscale and total scores of the current sample and the Raes et al. (2011) validation study sample.

Robust tests were conducted to compare the subscale means between the current sample and the Raes et al. (2011) validation study sample. The two samples differed significantly on four out of the six subscales (see Table 1). The current sample had a significantly lower average score than the validation study sample on the self-kindness subscale, $F(1, 455) = 15.89, p < .001$. Average scores were significantly higher on self-judgment, $F(1, 455) = 8.84, p = .003$; Isolation $F(1, 455) = 11.32, p = .001$; and Over-identification $F(1, 455) = 11.39, p = .001$. There was not a significant different for the Common Humanity or Mindfulness subscales, $F(1, 455) = .15, p = .70$ $F(1, 455) = .04, p = .85$, respectively.
### Table 1

**Comparison of Current Sample and the Raes et al. (2011) Validation Study Sample**

<table>
<thead>
<tr>
<th></th>
<th>α</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Kindness</td>
<td>.72 (.54)</td>
<td>4.90 (5.86)*</td>
<td>1.73 (1.46)</td>
</tr>
<tr>
<td>Self-Judgment</td>
<td>.70 (.63)</td>
<td>6.81 (5.98)*</td>
<td>1.86 (1.71)</td>
</tr>
<tr>
<td>Common Humanity</td>
<td>.51 (.62)</td>
<td>5.69 (5.79)</td>
<td>1.81 (1.60)</td>
</tr>
<tr>
<td>Isolation</td>
<td>.38 (.68)</td>
<td>7.14 (6.14)*</td>
<td>1.89 (.83)</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>.80 (.69)</td>
<td>6.64 (6.69)</td>
<td>1.90 (1.55)</td>
</tr>
<tr>
<td>Over-Identification</td>
<td>.66 (.75)</td>
<td>7.40 (6.39)*</td>
<td>2.02 (1.83)</td>
</tr>
<tr>
<td>Total SCS-SF score</td>
<td>.88 (.86)</td>
<td>31.88 (36.00)*</td>
<td>8.68 (7.33)</td>
</tr>
</tbody>
</table>

*Note: Values given in parentheses are for the Raes et al. (2011) validation study sample.*

*p < .01, indicating that the values between the two samples are statistically different.*
Hypotheses 2-4

All correlations between study variables are shown in Table 2. As predicted, the SCS-SF was moderately correlated with self-esteem ($r = .59, p < .001$), 95% CI [.35-.76]. A significant relationship was not found between self-compassion and satisfaction with life ($r = .27, p = .08$). Self-compassion levels were significantly negatively related to endorsement of anxiety symptoms ($r = -.37, p = .02$, 95% CI [-.61- -.07]) and stress symptoms ($r = -.65, p < .001$, 95% CI [-.80- -.43]) but not depressive symptoms ($r = -.21, p = .20$).

Hypothesis 5

For the CFA, the sample size was smaller than expected and as a result, the total sample size was smaller than the number of parameters estimated, making the parameter estimates unreliable. The small sample size also resulted in several non-positive definite matrices. Therefore, although the CFA was tested, the results were not interpretable and are not included here.
**MEASURING SELF-COMPASSION IN A CLINICAL SAMPLE**

Table 2

*Correlations, Means, Standard Deviations, and Internal Consistency*

<table>
<thead>
<tr>
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<th>5</th>
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<tr>
<td>1. SCS-SF</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
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</tr>
<tr>
<td>2. RSES</td>
<td>.59**</td>
<td>--</td>
<td>--</td>
<td>--</td>
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<tr>
<td>3. SWLS</td>
<td>.27</td>
<td>.58**</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>4. Depression</td>
<td>-.21</td>
<td>-.42**</td>
<td>-.51**</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>5. Anxiety</td>
<td>-.37*</td>
<td>-.38*</td>
<td>-.04</td>
<td>.32*</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>6. Stress</td>
<td>-.65**</td>
<td>-.42**</td>
<td>-.11</td>
<td>.38*</td>
<td>.70**</td>
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<table>
<thead>
<tr>
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<th>1</th>
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<tbody>
<tr>
<td>$M$</td>
<td>31.88</td>
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<td>15.98</td>
<td>15.02</td>
<td>10.00</td>
<td>17.61</td>
</tr>
<tr>
<td>$SD$</td>
<td>8.68</td>
<td>5.55</td>
<td>7.25</td>
<td>10.06</td>
<td>8.49</td>
<td>9.99</td>
</tr>
<tr>
<td>$\alpha$</td>
<td>.88</td>
<td>.91</td>
<td>.88</td>
<td>.88</td>
<td>.80</td>
<td>.86</td>
</tr>
</tbody>
</table>

*Note: *$p < .05$, **$p < .01$. SCS-SF = Self-Compassion Scale Short-Form, RSES = Rosenberg Self-Esteem Scale, SWLS = Satisfaction with Life Scale, Depression = Depression Subscale of the Depression, Anxiety, and Stress Scale, Anxiety = Anxiety Subscale of the Depression, Anxiety, and Stress Scale, Stress = Stress Subscale of the Depression, Anxiety, and Stress Scale.*
Discussion

In this dissertation, I sought to address the need for clinical norms for the SCS. To this end, the SCS was administered to a help-seeking population along with measures intended to examine convergent and discriminant validity. This study also added to the literature by examining differences between previous non-clinical samples and the current clinical sample. It was hypothesized that the average SCS score would be significantly lower in the current clinical population than in previous validation samples. It was hypothesized that the SCS would be moderately positively correlated with self-esteem and satisfaction with life, while it would be negatively correlated with symptoms of depression, anxiety, and stress. Finally, a CFA was used to verify the six-factor model that has been found with the SCS with non-clinical samples. Due to the small sample size, statistical analyses were done using only items on the SCS that are included in the SCS-SF. The SCS-SF was only recently developed and given the practical benefits of parsimonious measurement options, examination of its suitability for use with clinical populations is valuable.

Overall, the SCS-SF showed good internal consistency with the current sample (.88). However, the internal consistency of the various subscales varied widely, from .38 (Isolation) to .80 (Mindfulness). Given that each of the subscales are composed of only 2 items, it is not surprising that some of the subscales showed poor internal consistency. This is certainly a drawback of using the short form over the full version.

The first hypothesis was supported with the finding that self-compassion levels were significantly lower in the current help-seeking clinical sample than in Raes et al.’s (2011) SCS-SF English-speaking validation sample. Given self-compassion’s demonstrated relationship with psychological well-being, this finding is not surprising. Fortunately, the research is also showing
that interventions aimed at increasing self-compassion have been successful. This study suggests that self-compassion may be an appropriate area to target in clinical populations, given their lower levels of self-compassion.

The current sample had significantly different scores than the validation study sample on four of the six subscales of the SCS-SF. Of interest, only one aspect of the original self-compassion definition (self-kindness) was significantly lower, while all three of the reverse aspects (self-judgment, isolation, over-identification) of the definition were significantly higher in the current clinical sample. When the full SCS was found to have six subscales instead of the anticipated three, Neff (2003a) wrote,

…it is not uncommon for positive and negative items in self-report measures to load on separate factors (Enos, 2001; Finney, 2001), and it is understandable why items did so in the present case. For instance, self-kindness and self-judgment are not mutually exclusive, so that having low levels of one behavior necessarily means having high levels of the other. A person may tend not to judge himself, but that doesn’t necessarily mean that he typically takes proactive steps to be kind to himself either (p. 234)

The current study suggests that people presenting to therapy may primarily engage in the negative reverse aspects of self-compassion, while not differing as much on the positive aspect of self-compassion.

The hypothesis that self-compassion would be moderately correlated to self-esteem was confirmed. This provides both convergent and discriminant validity for the SCS-SF, which had not yet been validated in this way. This also replicates previous studies that have found a moderate correlation between self-compassion and self-esteem (e.g., Neff, 2003a; Neff & Vonk, 2009).
Self-compassion did not show the same correlation to satisfaction with life that has been found using the full SCS with non-clinical samples (e.g., Neff, 2003a). However, Shapiro et al. (2007) found that changes in self-compassion from MBSR did not predict changes in satisfaction with life. It is possible that the SCS-SF does not demonstrate the same correlation with the SWLS that the SCS has, which would be problematic for the convergent validity of the SCS-SF. It is also possible that the correlation between self-compassion and satisfaction with life does not exist with clinical populations. Perhaps clinical issues interfere with some of the benefits that self-compassion typically demonstrates. To examine whether the nonsignificant results were due to the use of the short-form SCS versus the long-form, a Pearson $r$ correlation was calculated between the full SCS and the SWLS and a significant correlation was found ($r = .32, p < .05$). This suggests that either the SCS-SF is not sensitive enough to capture satisfaction with life, or that the current sample was too small to detect this correlation.

The hypothesis that self-compassion would be negatively related to mental health symptoms was only partially supported. Self-compassion levels were significantly negatively related to endorsement of anxiety symptoms and stress symptoms. This replicated Neff’s (2003a) previous findings that higher self-compassion is correlated with lower levels of anxiety, and Van Dam et al.’s (2011) findings that self-compassion levels are predictive of anxiety symptoms. There was no correlation between self-compassion and depressive symptoms. The reason for this is unclear, as Neff (2003a) demonstrated a significant negative correlation between self-compassion and two different measures of depression. However, this was found with non-clinical undergraduate samples, while the average score for depressive symptoms for the current sample fell into the moderate range. It is certainly possible that the current sample was too small to observe a correlation between self-compassion and depressive symptoms. Given that multiple
studies have found that interventions involving self-compassion reduce depressive symptoms 
(Kuyken et al., 2010; Neff & Germer, 2012; Van Dam et al., 2011), the relationship between 
self-compassion and depression should continue to be examined.

For exploratory reasons, correlations between self-compassion and gender, race, previous 
therapy, and having a current meditative practice were examined. In the current study, self- 
compassion was found to be unrelated to gender. The literature has been mixed as to whether 
there are differences in levels of self-compassion between men and women. Multiple studies 
(e.g., Neff, 2003a; Neff & Vonk, 2009) have found that women have less self-compassion than 
men. However, other studies (e.g., Neff, Rude, & Kirkpatrick, 2007) have not demonstrated 
gender differences, while others have found that gender differences are culturally dependent 
(Neff et al., 2008) or disappear with advanced meditative practices (Neff, 2003a). It is possible 
that self-compassion levels are broadly low in help-seeking clinical populations so that gender 
differences disappear. However, given that the research has been mixed, it is also possible that 
gender differences simply do not exist in the general population. More research is needed to 
determine if true gender differences exist.

The current dissertation found that self-compassion was also unrelated to age, though at 
least one study has found a significant positive correlation (Neff & Vonk, 2009). Self- 
compassion was also unrelated to race, though the current sample was predominantly (88%) 
Caucasian. Only five participants indicated they were multiracial.

Having a current meditative practice was also unrelated to self-compassion levels, though 
only seven of the 42 participants indicated they had current practice. Of interest, though, is that 
the average self-compassion score for the meditators was almost 7 points higher than the self- 
compassion score for the non-meditators. The small group size likely resulted in the insignificant
MEASURING SELF-COMPASSION IN A CLINICAL SAMPLE

results. Though the current results did not reach significance, Neff (2003a) found that a sample of Buddhist meditators had significantly higher self-compassion scores compared to an undergraduate sample. Also, given that self-compassion levels have been shown to increase with mindfulness-based interventions (Kuyken et al., 2010; Shapiro et al., 2007; Shapiro et al., 2005), the research supports the use of a meditation practice to cultivate self-compassion.

There were no differences in self-compassion levels between participants who had participated in therapy before and those who had not. This dissertation was designed to capture participants at the beginning of their treatment episode. However, the majority of participants in the current study indicated they had previously been in therapy (74%), often multiple times. It is possible that the current sample is composed of individuals who have recurrent or persistent mental health issues who may have particular difficulty having compassion for themselves.

Overall, this dissertation has provided some encouraging initial findings supporting the use of the SCS-SF with clinical populations. This will assist both researchers and clinicians in their use of the construct of self-compassion for intervention and outcome studies. However, as research and practice delve further into self-compassion intervention, some important factors should be considered.

First and foremost, several authors have commented on the hesitancy within the clinical population to engage in self-compassion. Neff has written extensively about the common blocks to engaging in self-compassion that seem part and parcel of American culture and can preclude even the desire to cultivate self-compassion. Many people confused self-compassion with self-pity, passivity, self-centeredness, or self-absorption. Indeed, Gilbert and Proctor (2006) observed that these fears were present in their patients who participated in their Compassionate Mind
Training. However, the misgivings about self-compassion can go further for some individuals, especially within a clinical population. Gilbert and Proctor wrote,

In the early sessions many participants had a real fear of becoming self-compassionate…Some participants believed that compassion…was dangerous because one would “let one’s guard down”. Some participants seemed to have a conditioned emotional response of anxiety to warmth – when in the past they had allowed themselves to feel cared for by another, this other person had turned abusive or rejecting” (p. 370-371).

Considering the commonality of experiences like this for people presenting for mental health treatment, one must be sensitive to their caution towards self-compassion. Such invalidating experiences can make it very difficult to engage in self-compassion. For some, self-compassion does not make sense.

Pauley and McPherson (2010) explored the experience and meaning of compassion and self-compassion for individuals with anxiety and depression. In their qualitative study, they found that participants identified compassion as kindness that is best expressed through action. Of interest, though, is that “although participants reflected at length on the concept of compassion, they did not mention self-compassion until prompted to do so” (p. 139). The authors concluded that people with mental health issues were either never able to develop of sense of self-compassion or they had lost it at some point. They also found that participants commonly offered their feeling that self-compassion would be difficult for them to practice because they did not feel capable of self-compassion or because they did not know how to be self-compassionate. Often, participants cited their psychological disorder and associated thinking patterns as major hindrances to being self-compassionate. However, the participants were also very receptive to
the idea of self-compassion and could readily see how self-compassion could be meaningful and helpful for them.

The prevalence of fear and doubt around the idea of self-compassion in clinical populations should significantly influence how clinicians approach introducing the concept and cultivation of self-compassion. Neff and Germer (2012) have addressed this in their Mindful Self-Compassion program by presenting the research that addresses the common misunderstandings about self-compassion, in the hope that this will alleviate people’s fears and give them permission to cultivate self-compassion. This may be sufficient for some people, but for those with complex, long-standing issues, the journey toward self-compassion may be slower going. The misgivings about self-compassion vary on an individual basis and should be explored. Also, given Pauley and McPherson’s (2010) findings, it appears that people with long-standing mental health issues need to be instilled with hope that they are capable of learning skills to cultivate self-compassion. These skills should be presented within the realistic frame that becoming self-compassionate, like any other practice, is a journey rather than a destination.

**Limitations**

During data entry, it was found that five participants marked all “yes’s” to the questions asked for informed consent, indicating that they were receiving inpatient or mandated treatment. These participants were included in data analysis because data was not collected at any inpatient settings and it was unlikely that these participants were mandated for treatment given the settings where data collection took place. However, this cannot be completely ruled out and is a limitation of the study.

A major limitation of this dissertation is its small sample size, which made the results of the CFA un-interpretable. Unfortunately, many researchers study easily captured samples (i.e.,
the college undergraduate participating for extra credit). More research is needed amongst populations with which the scale is likely to be used; however, this is often more difficult, as the current study shows. Nonetheless, research with such populations is crucial if the measure is going to be generalized beyond initial homogenous validation samples. Moreover, with the push to use outcome measures to demonstrate clinically significant change during therapy, such data is required.

Generalizability is also a concern for the current study. In particular, the current sample was 88% Caucasian. Cross cultural studies have shown general differences in self-compassion levels (e.g., Kwan, Kuang, & Hui, 2009; Neff et al., 2008). Self-compassion levels amongst diverse American groups (e.g., race, sexual orientation) should be investigated, especially if self-compassion intervention is going to be targeted to certain marginalized groups.

It may also not be appropriate to generalize to clinical populations that have not voluntarily sought treatment. One could imagine that help seeking individuals may actually have more self-compassion than non-help seeking individuals. Research with mandated patients may shed light on potential differences. Further, almost three-fourths of the current sample indicated they had previously attended therapy, often multiple times. It is possible that the current data better capture the self-compassion levels of individuals who have recurrent or persistent mental health issues. The current study should be replicated with a sample that includes more people who are presenting to therapy for the first time.

**Conclusions**

The construct of self-compassion appears to be very applicable to clinical populations. The current study demonstrated some encouraging findings suggesting that the Self-Compassion Scale – Short-Form is appropriate for use with clinical samples. This data also allows clinicians
to use the SCS-SF as an outcome measure to examine whether clinically significant change in
self-compassion levels has occurred during therapy. More research, particularly involving CFA,
should be done with the SCS-SF and clinical samples.
References


MEASURING SELF-COMPASSION IN A CLINICAL SAMPLE


Kraus, S., & Sears, S. (2009). Measuring the immeasurables: Development and initial validation of the self-other four immeasurables (SOFI) scale based on Buddhist teachings on loving


MEASURING SELF-COMPASSION IN A CLINICAL SAMPLE


MEASURING SELF-COMPASSION IN A CLINICAL SAMPLE


MEASURING SELF-COMPASSION IN A CLINICAL SAMPLE


Appendix A

Informed Consent

1. Study Title
An Examination of the Psychometric Properties of the Self-Compassion Scale Among a Help-Seeking Clinical Sample

2. Study Personnel

<table>
<thead>
<tr>
<th>Name</th>
<th>Sarah Voruz, MS</th>
<th>Michael Christopher, PhD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role</td>
<td>Graduate Student Investigator</td>
<td>Faculty Advisor</td>
</tr>
<tr>
<td>Institution</td>
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<td>Pacific University</td>
</tr>
<tr>
<td>Program</td>
<td>School of Professional Psychology</td>
<td>School of Professional Psychology</td>
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<td>Email</td>
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</tr>
<tr>
<td>Telephone</td>
<td>262-490-0083</td>
<td>503-352-2498</td>
</tr>
</tbody>
</table>

3. Study Invitation, Purpose, Location, and Dates
You are invited to participate in a study investigating the relevance of a measure of self-compassion with individuals who are presenting for mental health treatment. Other measures will also be administered in order to study possible connections between the various measures. The project has been approved by the Pacific University IRB and will be completed by December 2012. The study will take place at various mental health treatment sites. The results of this study will be used to inform research and mental health treatment involving self-compassion.

4. Participant Characteristics and Exclusionary Criteria
In order to participate, you should be an English-speaking adult (age 18 and older) presenting for mental health outpatient treatment. You should not be mandated by a court of law to receive treatment. You should also not be receiving inpatient treatment.

5. Study Materials and Procedures
We hope to collect data from about 260 individuals. Each participant will fill out five questionnaires: a short demographic questionnaire, the Self-Compassion Scale, the Satisfaction with Life Scale, the Rosenberg Self-Esteem Scale, and the Depression Anxiety Stress Scale. The four scales have a total of 61 items and it should take you about 10-15 minutes to fill them all out. You may do so before or after your first five sessions so it does not take away from your treatment time. The Self-Compassion Scale will ask you questions about how you treat yourself during difficult times. The Satisfaction with Life Scale will
ask you a few questions about how you feel about your life. The Rosenberg Self-Esteem Scale will ask you questions about how you feel about yourself. And the Depression Anxiety Stress Scale will ask you questions about possible symptoms you may be experiencing. If you believe any of this material could trigger a lot of distress for you, please do not participate.

Once you have filled out everything contained within the packet, you will put them (as well as the last page of this document once signed) into the attached envelopes and seal it. You should then return the packet to your clinician.

6. Risks, Risk Reduction Steps, and Clinical Alternatives

a. Unknown Risks:
It is possible that participation in this study may expose you (or an embryo or fetus, if you are or become pregnant) to currently unforeseeable risks.

b. Anticipated Risks and Strategies to Minimize/Avoid:
It is possible that you could experience some emotional distress triggered from content on the measures. If you experience some mild distress, talk to your clinician. They are trained in dealing with emotional distress and a discussion about what the questionnaires stirred up may help. However, if you notice while filling out the measures that you are getting really upset, please discontinue your participation and contact me, my faculty advisor, or the IRB. Remember that you can discontinue your participation at any time and for any reason.

It is also possible that someone could open your packet before I collect it. If it is your clinician, this could affect your therapy relationship by making your clinician privy to information that was not offered directly to him/her. This is hopefully unlikely because mental health professionals are trained in and follow an ethics code. If you are very concerned about this possibility, though, please do not participate. Thank you for your time!

c. Advantageous Clinical Alternatives:
This study does not involve experimental clinical trial.

7. Adverse Event Handling and Reporting Plan
The IRB office will be notified by the next normal business day if minor adverse events occur (e.g., feelings of distress triggered by questionnaire content, breaches in confidentiality, dissatisfaction with the study) and will be handled as follows:

If you are very distressed by the content on the questionnaires, you are encouraged to discontinue your participation. If you have completed all the measures but you do not want your data to be used, simply cross off the signed informed consent page and seal all your materials in the envelope and return the packet to your clinician. When it is returned to me, a crossed off informed consent page will let me know that I should destroy your data. If I find out that a clinician has broken confidentiality by opening completed measures, I will ask the clinician to cease offering my study to their clients and direct them to the sections pertaining to research in the American Psychological Association Ethics Code. If you are dissatisfied with the study, you have the option of having me leave your data out of the study. If this is the case, please use the instructions provided earlier in this paragraph. If any of these events occur, I will discuss them with my faculty advisor to determine any other steps that may be taken to reduce risks. In the event that there is a breach of confidentiality and your data is affected, I will notify you.
The IRB office will be notified within 24 hours if major adverse events occur and I am made aware of them (e.g., suicidal ideation that is triggered by questionnaire content) and will be handled as follows: I will discuss the matter with my faculty advisor and reevaluate the content and procedure of my study.

8. Direct Benefits and/or Payment to Participants
   a. Benefit(s):
      This study is non-beneficial.
   b. Payment(s) or Reward(s):
      Participants will not be paid for their participation. Participants have the option of entering themselves into a drawing for one of four $10 Amazon.com gift certificates.

9. Promise of Privacy
   Your data will be kept confidential. Once you have finished filling out the packet, please be sure to seal the signed informed consent page and the measures in their respective envelopes before returning them to your clinician. Paper documents will be stored in a locked filing cabinet, and electronic data files will be stored on a password protected computer. Data will be retained for 3 years, after which point it will be shredded/deleted. Any data that is shared or published will be in aggregate form only and will not include any information that could identify you.

10. Medical Care and Compensation In the Event of Accidental Injury
    If you are injured during your participation in this study and it is not due to negligence by Pacific University, the researchers, or any organization associated with the research, you should not expect to receive compensation or medical care from Pacific University, the researchers, or any organization associated with the study. Though you are receiving mental health care from Pacific University, that care is not related to your participation in this study and your treatment will not change in any way due to your participation in this study.

11. Voluntary Nature of the Study
    Your decision whether or not to participate will not affect your current or future relations with Pacific University or your respective agency/clinic. If you decide to participate, you are free to not answer any question or withdraw at any time without prejudice or negative consequences. If you choose to withdraw after beginning the study, please give your unfinished packet to your clinician (please make sure that even unfinished questionnaires are sealed in their envelopes and that you have crossed out your consent as indicated above in Section 7), who will return them to me to be destroyed.

12. Contacts and Questions
    The researcher will be happy to answer any questions you may have at any time during the course of the study. If you are not satisfied with the answers you receive, please call Pacific University’s Institutional Review Board, at (503) 352-1478 to discuss your questions or concerns further. If you become injured in some way and feel it is related to your participation in this study, please contact the investigators and/or the IRB office. All concerns and questions will be kept in confidence.

***Once signed please detach the next page and return it to the informed consent envelope. You may keep this and the previous pages for your own records***
13. Statement of Consent

<table>
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<tr>
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<th>No</th>
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| ☐   | ☐  | I am 18 years of age or over.  
| ☐   | ☐  | I am receiving inpatient or mandated (i.e., required by law) treatment.  
| ☐   | ☐  | All my questions have been answered.  
| ☐   | ☐  | I have read and understand the description of my participation duties.  
| ☐   | ☐  | I have been offered a copy of this form to keep for my records.  
| ☐   | ☐  | I agree to participate in this study and understand that I may withdraw at any time without consequence.  

Participant’s Signature                                                                 Date

Investigator’s Signature                                                                 Date

14. Participant Contact Information

This contact information is required in case any issues arise with the study and participants need to be notified and/or to provide participants with the results of the study if they wish.

Would you like to have a summary of the results after the study is completed?  ____Yes  ____No

Participant’s Name (Please Print)  _________________________

Street Address  _________________________

Telephone  _________________________

Email  _________________________

 Last but not least...

<table>
<thead>
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</thead>
</table>
| ☐   | ☐  | I’d like to be entered in a drawing for one of four $10 gift certificates to Amazon.com. You will be contacted by email if you are a winner! If you do not provide an email address, the gift certificate will be mailed to you.

***Once signed please detach this page and return it to the informed consent envelope. You may keep the rest of the informed consent for your own records***
Appendix B

Recruitment Poster

**Would you take 15 minutes of your time to help research self-compassion?**

- The Counseling Center is supporting a dissertation that is studying whether a measure of self-compassion is relevant for people coming to therapy.
- Participation is voluntary.
- You must be a new client of the Counseling Center who has had 5 or fewer sessions.
- What you will do:
  - Read the informed consent and direct any questions to the investigator.
  - Sign the informed consent if you would like to participate.
  - Answer demographic questions and fill out four brief questionnaires.
  - You will have the option to enter yourself into a drawing for four $10 amazon.com gift certificates.

If you are interested in participating, please ask the front desk staff for a study packet.

Please direct any questions to Sarah Voruz, M.S.
Appendix C

Self-Compassion Scale (SCS)

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:

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

Self-Compassion Scale – Short-Form (SCS-SF)

**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:

<table>
<thead>
<tr>
<th>Almost never</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Almost always</th>
</tr>
</thead>
</table>

_____1. When I fail at something important to me I become consumed by feelings of inadequacy.

_____2. I try to be understanding and patient towards those aspects of my personality I don’t like.

_____3. When something painful happens I try to take a balanced view of the situation.

_____4. When I’m feeling down, I tend to feel like most other people are probably happier than I am.

_____5. I try to see my failings as part of the human condition.

_____6. When I’m going through a very hard time, I give myself the caring and tenderness I need.

_____7. When something upsets me I try to keep my emotions in balance.

_____8. When I fail at something that’s important to me, I tend to feel alone in my failure.

_____9. When I’m feeling down I tend to obsess and fixate on everything that’s wrong.

_____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 disapproving and judgmental about my own flaws and inadequacies.

_____12. I’m intolerant and impatient towards those aspects of my personality I don’t like.
### Rosenberg Self-Esteem Scale (RSES)

**Instructions:**
Below is a list of statements dealing with your general feelings about yourself. Please check the box next to the statement which most closely represents your feelings.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. On the whole, I am satisfied with myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.* At times, I think I am no good at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I feel that I have a number of good qualities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I am able to do things as well as most other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.* I feel I do not have much to be proud of</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.* I certainly feel useless at times</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>7. I feel that I’m a person of worth, at least on an equal plane with others.</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>8.* I wish I could have more respect for myself.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>9.* All in all, I am inclined to feel that I am a failure.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>10. I take a positive attitude toward myself.</td>
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<td></td>
</tr>
</tbody>
</table>
Appendix F

Satisfaction with Life Scale (SWLS)

DIRECTIONS: Below are five statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by placing the appropriate number in the line preceding that item. Please be open and honest in your responding.

1 = Strongly Disagree
2 = Disagree
3 = Slightly Disagree
4 = Neither Agree or Disagree
5 = Slightly Agree
6 = Agree
7 = Strongly Agree

_____ 1. In most ways my life is close to my ideal.

_____ 2. The conditions of my life are excellent.

_____ 3. I am satisfied with life.

_____ 4. So far I have gotten the important things I want in life.

_____ 5. If I could live my life over, I would change almost nothing.
**Appendix G**

*Depression Anxiety Stress Scale-21 (DASS-21)*

- **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

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

Thank you for participating in my study!

Please answer the following questions. These and the following measures will be detached from your informed consent for confidentiality purposes.

Age _____________

Sex _____________

Race/ethnicity
  □ African-American
  □ Asian
  □ Caucasian/White
  □ Hispanic/Latino/a
  □ Native American
  □ Other _______________

Have you previously participated in mental health treatment?
  □ Yes
  □ No

If so, how many times? _______________

Do you currently have a meditative practice?
  □ Yes
  □ No
  □ No, but I have in the past