SELF-COMPASSION IN PSYCHOTHERAPY:
PREDICTING CHANGE IN COLLEGE COUNSELING CENTER CLIENTS

A Dissertation in
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by

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Abstract

College counseling centers are tasked with intervening in student personal problems in order to facilitate academic success (Sharkin, 2004). Student psychopathology, of which anxiety and depression are the two most common clinical presentations (American College Health Association, 2013; CCMH, 2014), has been shown to significantly interfere with academic performance in indirect ways (Brackney & Karabenick, 1995). Therefore, identifying factors that support healthy normal development expected in college students, yet are effective at intervening with depression and anxiety could be helpful in guiding therapists’ goals in psychotherapy. Self-compassion is a mindfulness-based positive self-attitude that has been touted as an important component of psychological well-being (Neff, 2012). Although there is a significant body of research linking self-compassion to indicators of psychological well-being (Neely, Schallert, Mohammed, Roberts, & Chen, 2009; Neff, 2003a, 2011, 2012; Yarnell & Neff, 2013) and it is associated with less psychological pathology (Lockard, Hayes, Neff, & Locke, in press; MacBeth & Gumley, 2012; Neff, 2003a, 2012; Neff, Kirkpatrick, & Rude, 2007; Van Dam, Sheppard, Forsyth, & Earleywine, 2011), research has yet to determine its importance in a psychotherapeutic context. The current study evaluated whether self-compassion predicts psychotherapy change and can moderate the relationship between initial distress and change in psychotherapy. Results supported previous research suggesting self-compassion is inversely related to distress at pre-treatment. Self-compassion predicted changes on most CCAPS change scores when used as the only predictor in the model; however, when initial distress was added, the self-compassion effect size dropped below significance. Interestingly, there was a significant interaction between initial distress levels of anxiety and eating concerns on change scores; self-compassion facilitated gains in therapy for those low in initial distress, but was associated with
less gains in therapy for those high in initial distress. Results are discussed relevant to the literature.

*Keywords*: self-compassion, psychotherapy, CCMH, collegiate mental health
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Chapter 1: Introduction

Students face a number of challenges when pursuing higher education. A primary mission of college counseling centers is to help students whose personal problems interfere with their academic functioning (Sharkin, 2004). Of students surveyed, anxiety and depression were the highest reported psychopathologies that were diagnosed and treated in the previous year (American College Health Association, 2013). Therefore, identifying factors that enhance student well-being and growth in the context of psychopathology is important in facilitating student learning and retention on college campuses (Douce & Keeling, 2014). Self-compassion may be an attribute that promotes growth, and alleviates distress in the face of psychological problems for college students. Self-compassion is a positive self-attitude that includes being a mindful observer of private experiences, feeling connected to others in suffering, and acting with kindness towards the self (Neff, 2003a). Self-compassion is correlated generally with less depression and anxiety (MacBeth & Gumley, 2012; Neff, 2003a; Van Dam et al., 2011; Werner et al., 2012) and with greater well-being and psychological health in general (Neff, 2011; Neff, Rude, & Kirkpatrick, 2007). However, self-compassion has yet to be examined in a college psychotherapy setting. This dissertation will examine the potential role self-compassion has in increasing gains for college students engaging in psychotherapy at college counseling centers.

Collegiate Mental Health

College students are at a pivotal developmental period typified by exploration and identity development that establishes important personal, social, and career related self-constructs for later in life (Arnett, 2000). Psychopathology can have a significant negative impact on college students’ academic success (Brackney & Karabenick, 1995). College
counseling centers are tasked to help students successfully navigate personal problems in order to reduce interference with academic performance (Sharkin, 2004).

College students present at college counseling centers with a diverse set of presenting concerns (Draper, Jennings, & Barón, 2003; National Survey of Counseling Center Directors, 2011; Nordberg, Hayes, McAllevey, Castonguay, & Locke, 2013). These can range from normal developmental concerns such as distress associated with family separation, academics, relationships, or finances (National Survey of Counseling Center Directors, 2011) to more severe psychological symptoms such as anxiety, depression, eating concerns, substance abuse and dependency, experiencing trauma, and suicidality (CCMH, 2013). Out of 14 common psychological disorders, anxiety (12.9%) and depression (11%) are the most commonly diagnosed and treated disorders among college students (American College Health Association, 2013). A large national sample of 25,475 college counseling center clinicians indicated that 19.6% of their client’s primary concerns were anxiety and 15.6% were depression, the two highest primary concerns. In addition, that same survey indicated that a full 55.1% had some anxiety concerns and 45.26% of clients had some depression concerns (CCMH, 2014).

A 1995 study of 326 college students found that psychological distress was a significant indirect predictor of academic performance (Brackney & Karabenick, 1995). Students with higher psychological distress had less self-efficacy, were less likely to have well regulated study environments, persisted less in the face of difficulty, and were less likely to utilize academic assistance. This in turn predicted lower course grades (Brackney & Karabenick, 1995). Further, a large study (N=5,877) found that individuals who have a prior psychological disorder (anxiety, mood, substance use and conduct disorders) had a 10% lower probability of graduating college than those who did not (Kessler, Foster, Saunders, & Stang, 1995). These authors also found that
4.7% of college students who do not complete college have psychiatric disorders and an estimated 2% would have graduated from college if they did not have the psychiatric disorders.

Research indicates that counseling centers are about as efficacious as community-based clinical trials in reducing psychological distress (Minami et al., 2009). Studies also indicate that counseling centers can have an impact on reducing academic distress (Lockard, Hayes, McAleavey, & Locke, 2012), increasing student’s academic commitment (Choi, Buskey, & Johnson, 2010), and improving student retention in colleges (Lee, Olson, Locke, Michelson, & Odes, 2009; Turner & Berry, 2000; Wilson, Mason, & Ewing, 1997). This demonstrates the importance of college student mental health and the critical role that college counseling centers can play in facilitating academic success.

**Self-compassion**

Given what college counseling centers are tasked with, and the potential importance of college student mental health on academic performance and retention, identifying factors that are associated with less anxiety and depression, and that enhance gains in psychotherapy, could be helpful for counseling center therapists. Self-compassion is a positive self-attitude comprised of three components: mindfulness, self-kindness, and a common sense of humanity (Neff, 2003a). In contrast to an avoidance orientation common in psychopathology (Barlow, 2007), mindfulness is an approach orientation attending to present mental states with an open, curious and accepting attitude, and it is associated with reduced rumination and elaborative processing of distressing stimuli common in anxiety and depression (Bishop et al., 2004). Self-kindness is a self-directed positive affective state offered to the self in moments of mistake or failure (Neff, 2009). This can help individuals face a difficult reality with less distress and self-criticism (Neff, 2012), while simultaneously expanding their behavioral options for problem solving (Fredrickson, 2001). The
last component of self-compassion is having a sense of common humanity in one’s suffering (Neff, 2003a). During periods of personal difficulty people can feel their uniqueness amplified leading to feelings of isolation (Yalom, 1995). By realizing one’s suffering and mistakes are part of the human experience, individuals can feel like their suffering is shared resulting in less feelings of isolation and a greater sense of connectedness (Neff, 2012).

**Self-compassion and well-being.** Generally, self-compassion is associated with factors of well-being such as positive life functioning, positive affect, and healthy psychological adjustment (Neff, 2011; Neff, Kirkpatrick, et al., 2007; Neff, Rude, et al., 2007). Another factor of well-being is mastery of one’s environment. This is defined as the ability to create environments that are congruent with individual’s psychological needs and values, while allowing them to take advantage of opportunities when they arise (Ryff & Keyes, 1995). Self-compassion in college students is positively associated with seeing failure as an opportunity to improve because they perceive themselves to be more competent and have less fear of failure (Neff, Hsieh, & Dejitterat, 2005). This facilitates greater environmental mastery and continued growth and development. Self-compassion is also positively associated with self-determination and the fulfillment of the psychological need for autonomy in college students (Neff, 2003a). Finally, self-compassion is positively associated with quality interpersonal relationships, in the family (Neff & McGehee, 2010; Yarnell & Neff, 2013), in romantic relationships (Neff & Beretvas, 2012; Yarnell & Neff, 2013), and with friends (Yarnell & Neff, 2013).

**Self-compassion and depression.** In addition to the positive association of self-compassion to dimensions of well-being, self-compassion is associated with less depression generally, and factors that cause and maintain depression specifically. Depression is associated with risk factors that include elaborative processing of negative stimuli, rumination, suppression
(Castonguay & Oltmanns, 2013), self-criticism, hopelessness (Young, Rygh, Weinberger, & Beck, 2007), and interpersonal rejection and isolation (Hames, Hagan, & Joiner, 2013). Self-compassion is often the antithesis of these factors. As was stated earlier, mindfulness prevents elaborative processing and can limit ruminations while at the same time eliciting an accepting attitude towards inner experiences (Bishop et al., 2004). Several investigations have found self-compassion to be negatively associated with rumination, thought suppression, negative affect (Neff, 2003a, 2009; Neff, Kirkpatrick, et al., 2007), and self-criticism (Neff, Kirkpatrick, et al., 2007). In addition, self-compassion is positively associated with positive affect, optimism (Neff, Rude, et al., 2007), and healthy relationships (Neff & Beretvas, 2012; Neff & McGehee, 2010; Yarnell & Neff, 2013).

Given that 45.26% of college students seeking help in college counseling centers have some depression-related concerns (CCMH, 2014), and that 31.7% of students report being so depressed it was difficult to function in the past year (American College Health Association, 2013), it is important to find strength based factors that protect against depression and that enhance gains in psychotherapy. It is hypothesized that self-compassion will be associated with less depression in college students. In addition, it seems reasonable to hypothesize that college students who have self-compassion may be able to better utilize counseling by being kind to themselves and approaching their problems with curiosity in therapy instead of dwelling in negative affect-laden ruminations.

**Self-compassion and anxiety.** Generalized anxiety is characterized as uncontrollable worry about future uncertain events (Castonguay & Oltmanns, 2013) and is associated with strong avoidance tendencies that can interfere with daily functioning (Clark & Beck, 2009). Worry filled ruminations and avoidance through thought suppression are thought to be the central
mechanisms that interfere with the full emotional processing necessary to cope adaptively with distress (Allen, McHugh, & Barlow, 2007; Neff, Kirkpatrick, et al., 2007). However, if one can approach distress with kindness, curiosity, understanding, and a sense of shared humanity then it is possible that negative experience can be transformed into a positive and adaptive feeling state (Neff, 2003b). Several studies have demonstrated a significant negative relationship between self-compassion, and rumination and suppression which in turn is associated with less anxiety (Neff, 2003a; Neff, Kirkpatrick, et al., 2007).

A full 55.1% of clients seeking help in college counseling centers have some anxiety concerns (CCMH, 2014). This is higher than any other reported psychological concern. Research indicates that self-compassion has a strong negative association with anxiety (Van Dam et al., 2011), and in college students it is negatively associated with academic worry, emotionality and procrastination (Williams, Stark, & Foster, 2008). Therefore, in this study, it is hypothesized that self-compassion will be associated with less anxiety. Although there have been no direct studies investigating self-compassion in a psychotherapy context, given its negative associations with maintenance factors of anxiety, and its positive, approach orientation to distress, it stands to reason that having self-compassion might enhance growth in college students seeking help in counseling centers.

**Self-compassion and psychotherapy.** Previously, self-compassion has been associated with factors of wellness and psychopathology, however it is also associated with some individual factors that impact the psychotherapy process and outcome. Bohart and Wade (2013) suggest that client factors such as motivation, attachment, emotional experiencing and self-criticism have demonstrated a significant impact on psychotherapy. Self-compassion is associated with these factors as well. In a study of smoking cessation, self-compassion training was positively
associated with a readiness for change that resulted in a reduction of smoking behavior after a three week self-monitoring course, particularly for those with low readiness for change and those high in self-criticism (Kelly, Zuroff, Foa, & Gilbert, 2010). In addition, self-compassion is associated with a more secure attachment which has been found to be a robust predictor of positive outcomes in three psychotherapy meta-analyses (Levy, Ellison, Scott, & Bernecker, 2011). Secure attachment is associated with the development of a therapeutic alliance (Diener & Monroe, 2011), increased self-disclosure (Saypol & Farber, 2010), exploration of emotions, and session depth (Romano, Fitzpatrick, & Janzen, 2008). Again, although no direct inferences can be made by these associations, it is reasonable to hypothesize that self-compassion will have a positive effect on psychotherapy itself and therefore psychotherapy outcomes.

Further, several studies have found that one of the most reliable client factors predicting psychotherapy outcomes are client levels of initial distress for both anxiety and depression (Beutler, Blatt, Alamohamed, Levy, & Angtuaco, 2006; Newman, Crits-Cristoph, Gibbons, & Erickson, 2006). This study will look to replicate this finding and see if self-compassion can moderate the relationship between initial distress level and change in psychotherapy.

Given the prevalence of anxiety and depression in college students (Brackney & Karabenick, 1995) and the importance of college counseling centers in promoting student mental health (Sharkin, 2004), identifying factors that support the alleviation of psychological distress is essential. The current study will investigate self-compassion and psychotherapy with the advantage of a large, nationally representative data set. The Center for Collegiate Mental Health (CCMH) is a national, practice-research network that is composed of 276 university and college counseling centers (Castonguay, Locke, & Hayes, 2011; Hayes, Locke, & Castonguay, 2011; Locke, Bieschke, Castonguay, & Hayes, 2012). CCMH incorporates a standardized set of intake
and outcome measures across campuses and offers a unique data set to focus on investigating trends, effective treatments, and risk factors helpful in serving college clinical populations. As a pilot program, during the 2012-2013 academic year, the CCMH Advisory Board added the Self-Compassion Scale-Short Form (SCS-SF; Raes, Pommier, Neff, & Van Gucht, 2011) to their electronic medical record system used by campuses across the country (Lockard et al., in press). This offers a unique opportunity to investigate self-compassion in the context of college student psychotherapy.

**Aims**

Based on the literature reviewed above and that which will be further examined in Chapter 2, the aim of this study is to examine the relationship between self-compassion and depression and anxiety prior to the start of counseling among college students seeking help in college counseling centers. A second aim of the study is to examine whether self-compassion and CCAPS measures at the start of treatment have an impact on the psychotherapy process such that it facilitates gains made in therapy. Although the literature points more directly to the relationship of self-compassion to anxiety and depression, as an exploratory research question, this study will examine the relationship self-compassion prior to the start of counseling has with other CCAPS measures of distress and their change scores at the end of therapy.
Chapter 2: Literature Review

In developing hypotheses for this study, the relevant literature for self-compassion and its relationship to psychotherapy outcomes is reviewed. Beginning with a description of collegiate mental health and the need to find factors associated with growth in college counseling, a review of what self-compassion is and what it is not is provided, as well as its association with well-being. This will provide the basis for a discussion of the relevance of self-compassion to factors causing and maintaining levels of depression and anxiety; specifically, how self-compassion might mitigate factors of depression such as self-criticism, social isolation, and rumination. In addition, how self-compassion might mitigate factors of anxiety such as avoidance and rumination tendencies is also discussed. Finally, the role that self-compassion might play in the psychotherapy process is reviewed.

Collegiate Mental Health

College clinical populations have recently gained more attention in the literature as an important clinical population to investigate (American College Health Association, 2013; Nordberg et al., 2013; Vovotney, 2014; Zivin, Eisenberg, Gollust, & Golberstein, 2009). College counseling center directors report that on average, 37.4% of clients have severe psychological problems with just about 6% of them so severe they cannot remain in school (National Survey of Counseling Center Directors, 2011). A large survey of 123,078 college students found that in the year prior to the survey, 31.3% of respondents reported feeling so depressed that it was difficult to function, 51% of respondents reported feeling overwhelming anxiety, 37% of respondents felt overwhelming anger, and 7.4% of respondents reported seriously considering suicide (American College Health Association, 2013). A total of 12.9% of college students report being diagnosed or treated specifically for anxiety, and 11% reported being diagnosed with or treated specifically
for depression in the past year. Anxiety and depression were the most common psychopathologies being diagnosed and treated among the students surveyed (American College Health Association, 2013). This is further supported by research conducted asking clinicians to indicate clients’ concerns seeking help in college counseling centers (CCMH, 2014). Clinicians indicated that anxiety was the most highly endorsed “primary concern” of clients (19.6%), and it was also the most highly endorsed concern among the “check all that apply” category (55.1%). Depression was second in the same categories with 15.6% and 45.26% respectively (CCMH, 2014).

The central function of college counseling centers has been, and continues to be, the provision of counseling services which enhance students’ ability to function academically (Sharkin, 2004). Out of 67,026 students at a Western state university, 70% reported personal issues negatively impacting their academic performance, and of those that received counseling, 60.7% retrospectively reported that counseling was helpful to their academic performance (Turner & Berry, 2000). However, other studies have failed to find more objective evidence that directly links counseling to academic performance (Illovsky, 1997; Lee et al., 2009).

One reason for this might be that psychopathology does not seem to be directly associated with academic performance. A study of 326 students suggests that psychopathology may impact academic performance indirectly (Brackney & Karabeneck, 1995). Using a structural equation model, the authors found a significant relationship between psychopathology and academic self-efficacy and resource management (e.g., regulating time and study environments). Self-efficacy also predicted higher order learning strategies such as elaboration, critical thinking, and organization that in turn, predicted resource management as well. Resource
management and self-efficacy significantly predicted academic performance (Brackney & Karabenick, 1995).

Others argue that GPA is not an ideal outcome to be measured since it is not the focus of counseling (Choi et al., 2010; Illovsky, 1997; Lockard et al., 2012; Sharkin, 2004). Instead, some researchers suggest using a standardized measure of academic distress as it is more directly related to counseling services (Lockard et al., 2012). Lockard et al., (2012) compared a small sample of clinical and non-clinical college students over the course of a 6 week period. The authors found that counseling was associated with significant reductions in student academic distress. In comparison, the non-clinical sample showed no reduction of academic distress over the course of the same 6 week period. This study demonstrates the positive impact that counseling can have on students experience in a college setting and may explain why students who receive counseling at college counseling centers seem to have greater retention rates than those who do not (Illovsky, 1997; Lee et al., 2009; Lockard et al., 2012; Sharkin, 2004; Turner & Berry, 2000).

Given that anxiety and depression are the most common psychopathologies (CCMH, 2014), the investigation of factors that mitigate anxiety and depression in psychotherapy may aid treatment efficacy. This in turn, may manifest in decreased academic distress, increased retention, and indirectly on improved academic performance. Identifying constructs that facilitate normal development while also mitigating factors of more severe pathology ought to be a focus in counseling center research. This would aide practitioners in zeroing in on and nurturing factors that can help with the broadest population. Self-compassion may be such a factor. Self-compassion has been linked to psychopathology and wellness in 15 college student samples. A recent meta-analysis concluded that having low self-compassion is associated with higher levels
of anxiety, depression, and stress in college students and community clinical samples (for a review see: MacBeth & Gumley, 2012). However, little attention has been paid to self-compassion in college clinical samples specifically (Lockard et al., in press), therefore self-compassion is defined, its nomological network is described, and its relationships with factors of well-being and psychopathology are explored.

**Eastern Influences on Western Conceptions of Health**

Eastern philosophies of health and well-being have been around for millennia. Only recently have Western philosophies started exploring the wisdom contained in these ancient practices and even more recently some of their ideas have made it into mainstream health literature (Barnes, Treiber, & Davis, 2001; P. C. Boswell & Murray, 1979; Büssing, Ostermann, Lüdtke, & Michalsen, 2012; David, Sheldon, Bruce, & Jeffrey, 1983; Davis & Hayes, 2011; Kalupahana, 1987; Langhorst, Klose, Dobos, Bernardy, & Häuser, 2013; Manheimer, White, Berman, Forys, & Ernst, 2005). Psychological and psychotherapy research has also recently started embracing Eastern ideas and philosophies (P. C. Boswell & Murray, 1979; Davis & Hayes, 2011; Kalupahana, 1987; Neff, 2003b). Eastern-based meditation techniques, including mindfulness (a Buddhist tradition; Eberth & Sedlmeier, 2012) and mantra-based meditation (a Hindu-based tradition; Sedlmeier et al., 2012) have been pervasive in the literature over the past decade. Mindfulness especially has received considerable attention recently (Hofmann, Sawyer, Witt, & Oh, 2010; Keng, Smoski, & Robins, 2011; Khoury et al., 2013) popularized by Mindfulness Based Stress Reduction programs (Kabat-Zinn, 1982; Ludwig & Kabat-Zinn, 2008). A recent meta-analysis by Khoury et al. (2013) found that mindfulness-based therapies (MBT) had a moderate effect on treatment outcomes of a variety of concerns in pre-post studies and waitlist controlled studies when compared to other treatments generally, and even when
compared to other psychological treatments specifically. However, MBT effect sizes did not differ significantly from traditional CBT or pharmacotherapies.

Most recently this literature base has been extended to the idea of self-compassion, a Buddhist concept which includes mindfulness but also has important additive components such as positive affect, and social connection (Neff, 2003a). In fact, research looking at a large community sample \((n=504)\) of individuals seeking help for anxious distress found that self-compassion explained up to ten times more unique variance than mindfulness in predicting anxiety, depression, worry, and quality of life. In addition, self-compassion is also a theoretically consistent extension of mindfulness, and has been considered an underlying, yet often ignored, essential ingredient of mindfulness (Van Dam et al., 2011).

**Self-Compassion**

Self-compassion is an extension of the Buddhist-based mindfulness literature that describes ways of relating to self in healthy, positive, and adaptive ways. Neff (2003a) defines the self-compassion construct as having three pairs of polar subscales: acting with loving kindness and understanding towards oneself instead of with judgment \((\text{kindness vs. self-judgment})\), seeing one’s experience as connected to common humanity instead of separated and isolated \((\text{common humanity vs. isolation})\), and keeping a mindfulness perspective of one’s difficult private experiences rather than over-identifying with them \((\text{mindfulness vs. overidentification})\;\text{Neff, 2003a})\). Neff (2003b) characterizes self-compassion as being a positive and healthy attitude towards self that promotes change in positive and patient ways. The following sections will elucidate the three main components of self-compassion: mindfulness, self-kindness, and a sense of common humanity.
Mindfulness. Mindfulness has been proposed to be a two component model that includes the self-regulation of attention on present mental states and having an open, curious and accepting orientation towards those mental states. The self-regulation of attention on the present moment and the mental activities of that moment facilitates sustained attention in the present which prevents ruminative or elaborative processing of the current experience common in psychological disorders such as depression and anxiety. In addition, mindfulness promotes attentional switching back to the present (i.e., breath or sounds) to further reduce the likelihood of post experience ruminations (Bishop et al., 2004). In other words, mindfulness allows a direct experience of mental states as opposed to the more common experience of mental states that are filtered through beliefs, assumptions, and desires. In Buddhism, this is sometimes referred to as the beginner’s mind.

Thoughts, feelings, and images that arise naturally can be explored and observed. In addition, one practices having an accepting orientation to those thoughts, feelings, and images instead of judgment, avoidance, and suppression. This openness requires individuals to disregard personal agendas related to private experiences (e.g., suppression, avoidance) and instead maintain an attitude of openness to whatever is in their field of awareness. This stance is thought to change the subjective meaning of distress, thereby facilitating individuals in their investigations to more deeply understand thoughts and feelings. This likely leads to greater affective tolerance, increased cognitive complexity in understanding private experiences, the ability to distinguish between thoughts and feelings, the ability to observe chains of personal experiences (e.g., “this critical thought led to feelings of hopelessness”), and greater emotional awareness. The mindfulness process can be generally thought of as a meta-cognitive process or “thinking about thinking” (Bishop et al., 2004).
In summary, mindfulness is thought to affect mental health through the mechanisms of increasing one’s ability to tolerate and cope with negative affect, decreasing ruminations commonly associated with depression and anxiety disorders, and reducing attachment to outcomes which is associated with distress when those outcomes are not achieved (Coffey, Hartman, & Fredrickson, 2010). Empirically, mindfulness has been associated with increased emotion regulation (both behaviorally and neurologically), decreased reactivity towards distress and the associated increased cognitive flexibility, increased ability to deal effectively with relational stress, and increased ability to express oneself and to develop greater self-insight (Davis & Hayes, 2011). The effects described are all important processes associated with psychotherapy change.

**Self-kindness.** Although mindfulness has proven to be an important concept in well-being and mental health, Van Dam, Sheppard, Forsyth, and Earleywine (2011) argue that some of the active ingredients of mindfulness are either not being addressed or are difficult to measure and that there are additional beneficial constructs that need further exploration. One area ripe for consideration is positive mental states such as lovingkindness, joy, compassion, and equanimity (Van Dam et al., 2011). These positive mental states have only recently received empirical attention and researchers have found them to be associated with wellness. For example, participants who had more positive emotions naturally occurring throughout a month and participants trained in lovingkindness meditations were associated with having increased psychological and social resources which in turn was associated with increased life satisfaction and reduced symptomology (Cohn, Fredrickson, Brown, Mikels, & Conway, 2009; Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008).
Self-compassion includes the aspect of being kind to oneself. Instead of being self-critical or judgmental, one’s self is offered warmth, caring, and understanding. This positive affective stance is offered to the self even, and especially, in the face of flaws, mistakes, or difficult life circumstances (Neff, 2009). By accepting the reality that one cannot always get or be what one wants, and cultivating a sense of benevolence in the face of that reality, individuals can experience less stress over their losses (Neff, 2012). By reducing the psychological distress of failure or mistakes, and replacing it with a positive affect towards the self, people are more capable of problem solving creatively, and expanding their behavioral repertoire. In contrast, the negative emotionality that accompanies self-criticism is associated with reduced behavioral choices and more automatic responding (Fredrickson, 2001).

Common sense of humanity. The final component of self-compassion is fostering a sense of common humanity in relation to suffering. Many clients develop a heightened sense of uniqueness in their suffering that precludes them from learning about others’ similar feelings and experiences, or taking opportunities to confide in others and receive validation for their suffering (Yalom, 1995). Often individuals become self-focused on their mishaps in the form of expressing self-criticism. This can happen in the context of personal failings or while navigating a stressful life circumstances. This leads to thoughts that the individual is the only person in the world going through such an experience, and can be attributed to the worthlessness of the individual while everyone else is leading “happy and perfect lives.” This thought process conjures up feelings of isolation and loneliness (Neff, 2009). In contrast, self-compassion leads one to realize that their suffering, their mistakes, and their failures are precisely a part of the human experience, and that suffering is shared (Neff, 2012). This is like Yalom’s (1995) concept of universality, where upon the realization that others suffer in similar ways, clients can develop a “feeling more
in touch with the world” (Yalom, 1995, p. 6). Self-compassion helps individuals keep a broad perspective, inclusive of difficulty and connected in struggle. This aids the individual to feel connected to others in their pain (Neff, 2009). These studies provide a basic conceptualization of self-compassion and some of its most important functions, providing a good basis for considering its nomological network.

**Self-Compassion and its Nomological Network**

**Self-compassion and well-being.** Self-compassion is associated with positive life functioning, positive affect, and healthy psychological adjustment (Neff, 2011; Neff, Kirkpatrick, et al., 2007; Neff, Rude, et al., 2007). These descriptors can generally be categorized under the construct of well-being. Well-being has been empirically demonstrated to be a multidimensional construct that generally includes positive attitudes toward the self, mastery of one’s environment, quality interpersonal relationships, continued growth and development, purposeful living, and a sense of autonomy (Ryff & Keyes, 1995). Interestingly, self-compassion has been associated with many if not all of these domains in various research projects (Leary, Tate, Adams, Batts Allen, & Hancock, 2007; Magnus, Kowalski, & McHugh, 2010; Neff, 2003a; Neff & Beretvas, 2012; Neff et al., 2005; Neff, Kirkpatrick, et al., 2007; Neff & McGehee, 2010; Neff, Pisitsungkagarn, & Hsieh, 2008; Neff, Rude, et al., 2007; Yarnell & Neff, 2013).

As stated previously, the very definition of self-compassion includes a positive attitude toward self and a sense of purposeful living (i.e., mindfulness). Acceptance of one’s inner experiences, non-judgmental attitudes towards self, and a recognition of one’s common humanity in a mindful way necessitates purposeful living; purposefully cultivating love, compassion, and kindness to yourself at times when it is most needed is an important part of developing psychological well-being. Having self-compassion has been associated with less self-
criticism and judgment, and being equally kind toward self and others (Neff, 2003a). Even in specific domains, self-compassion is associated with self-acceptance. For example, in a study of 252 women exercisers, having higher levels of self-compassion was associated with increased body image comfort and having less anxiety about others’ evaluations of one’s physique. In turn, this self-acceptance was associated with greater intrinsic motivation for exercising, an important part of developing and maintaining physical well-being (Magnus et al., 2010).

Environmental mastery is the ability to create and foster environments that are congruent with the psychological needs and values of individuals; it allows individuals to advance in their world by being able to take advantage of opportunities as they arise (Ryff, 1989; Ryff & Keyes, 1995). A study investigating self-compassion in 222 college students found that self-compassion was associated with learning goals in an academic context. Specifically, results from this study demonstrated that self-compassionate individuals can see failure as an opportunity to improve in the future (mastery goals) and were less likely to need to enhance their self-image through social comparisons (performance goals). In addition, the results indicated that self-compassion links to mastery goals because individuals with self-compassion have greater perceived competency and less fear of failure (Neff et al., 2005).

It is possible that self-compassion can lead to greater environmental mastery because the process of being kind to oneself in the face of difficulty allows individuals to not need to defend their ego. Being self-compassionate also allows them to be responsible for their role in the difficulty and in general there is more conscious self-awareness. Research suggests that people with higher levels of self-compassion had less emotional reactivity, were less likely to experience negative affect when confronted with their mistakes, and were less likely to attribute the cause of negative events to their personhood (Leary et al., 2007). Having less reactive appraisals to
difficult situations allows individuals to learn and adapt to situations more quickly than if they were defensive towards their role or if they would ruminate extensively about how bad they are. Not only does this facilitate individuals developing a sense of mastery, but it also promotes continued growth and development, another important aspect of well-being.

Another component of well-being is having a sense of autonomy or self-determination (Ryff, 1989; Ryff & Keyes, 1995). Self-compassion is associated with self-determination. In a study of 232 undergraduate students Neff (2003a) found that self-compassion was indeed positively correlated with a sense of self-determination as well as a fulfillment of the psychological need for autonomy. Neff concludes that “self-compassionate individuals are likely to have a sense of true self-worth that is not contingent on meeting set standards but is based simply on being one’s authentic self” (Neff, 2003a, p. 241). When one is free to be authentic then they are free to seek the things which they value in life and are not subject to focusing on the values of others at the risk of their own.

Lastly, there is evidence to suggest that self-compassion is an important factor in quality interpersonal relationships. Research has indicated that self-compassion is an important factor in family relationships. An investigation comparing adolescent (N=235) and adults (N=285) with factors associated with self-compassion found that the results were similar across groups. Specifically, self-compassion was associated with receiving maternal support. Also, adolescents and young adults who reported being from more harmonious and close families had higher levels of self-compassion. These higher levels of self-compassion associated with family functioning were also significantly correlated with secure attachment styles (Neff & McGehee, 2010). These results suggest that positive family relationships and secure attachments help foster a sense of self-compassion in adolescence and adulthood.
Another study of 104 adult couples found that individuals with higher self-compassion felt more worthy, were happier, felt more authentic, and were able to express themselves in their romantic relationships. In addition, individuals with higher self-compassion felt more accepting of their partners and more willing to grant their partners autonomy. These participants were described by their partners as more caring and as displaying more relatedness toward their partners (Neff & Beretvas, 2012). Another study of 506 college students found that individuals with greater self-compassion were better able to balance their own needs with those of others when resolving relationship conflicts. They were more likely to negotiate their needs (in comparison to subordinating their needs) in many different relationships including with mothers, fathers, best friends, and romantic partners (Yarnell & Neff, 2013). Finally, in a study investigating the effect of compassionate goals towards others, researchers found that compassion goals were associated with greater self-compassion, social support, and interpersonal trust (Crocker & Canevello, 2008). These studies suggest that self-compassion is associated with positive and connected relationship qualities essential to developing a sense of psychological and relational well-being.

**Self-compassion and self-esteem.** Although there are other “positive self-attitudes” that have received considerable academic attention, self-compassion seems to have important distinctions. Self-compassion is often compared with global self-esteem, a construct lauded by both academics and the media as being an important healthy and positive self-attitude (Neff, 2003a, 2003b, 2011). However, self-compassion is distinct from self-esteem in important ways critical to clinical populations. Self-esteem is an “evaluation of our worthiness as individuals, a judgment that we are good, valuable people” (Neff, 2011; p. 1) and often includes social comparisons and the need to feel special. Although global self-esteem is certainly associated with
positive factors such as buffering against psychological distress and depression, increasing wellbeing, increasing self-enhancement motives, and a multitude of coping behaviors (Rosenberg, 1979; Rosenberg, Schooler, Schoenbach, & Rosenberg, 1995), it is also associated with some negative outcomes (Baumeister, 1996). Self-esteem encompasses all positive self-appraisals including arrogance and narcissism. There is some evidence that suggests bullies and violent criminals have high self-esteem, and that they can turn violent when they experience ego-threats in their environment (Baumeister, 1996). Research suggests that individuals with high explicit (global) self-esteem but low implicit self-esteem display more defensiveness (Jordan, Spencer, Zanna, Hoshino-Browne, & Correll, 2003). Defensiveness likely means that individuals with low implicit self-esteem but who appear to have high self-esteem are going to seek help from counseling less, and find the process of self-reflection and growth more threatening.

Self-compassion on the other hand, requires no self-evaluations or social comparisons, and has less vulnerability to ego-threats (Neff, 2011; Neff & Vonk, 2009). Like self-esteem, self-compassion is associated with many positive outcomes but with few of the negative outcomes associated with self-esteem (for a review see: Neff, 2009). Unlike self-esteem, self-compassion is not correlated with measures of narcissism (Neff, 2003a). The important differences between self-esteem and self-compassion comes from the different cognitive and physiological states that the two positive self-attitudes employ. Self-esteem is predicated on self-evaluation and judgment which means it is vulnerable to performance problems and defensiveness, whereas self-compassion is generally about self-awareness and self-acceptance of the whole person, and has no need for self or other judgments (Neff & Vonk, 2009). When life is difficult, humans need a positive self-attitude most, and it is exactly when self-compassion can be employed most effectively. Conversely, when life is difficult, self-esteem is less effective at promoting growth.
Research indicates that self-compassion is more related to a stable sense of self-worth than self-esteem (Neff & Vonk, 2009). Neff and Vonk (2009) explain this result as likely because when people have feelings of inadequacy, self-compassion is linked to a sense of peace and calm, and therefore requires individuals to use fewer attentional resources to worrying what others are thinking about them, or ruminating on whether they are good or bad. In addition, their research suggests that self-compassion predicts happiness, optimism, and positive affect above and beyond self-esteem. (Neff & Vonk, 2009).

**Self-Compassion and Psychopathology**

Self-compassion has already been demonstrated to be an important concept related to psychological health and well-being distinct from, and more robust than self-esteem, especially in college-age students. The next section will focus on how self-compassion is related to factors associated with the onset and maintenance of depression and anxiety. General factors associated with depression and anxiety that will be covered include relationship to self, a sense of isolation, rumination, thought and feeling suppression, and avoidance. These domains are important trans-diagnostically in the etiology and maintenance of depression and anxiety (Harvey, 2004). They are therefore important to understand and target for change in psychotherapy. Self-compassion offers an alternative way of being that seems to combat many of the factors associated with psychopathology.

**Depression.** Depression is defined as a persistent depressed mood, or a lack of interest or pleasure in most things. It is associated with weight changes, sleeping issues, psychomotor agitation or retardation, fatigue, feelings of worthlessness or guilt, difficulty concentrating, and recurrent thoughts of death (American Psychiatric Association, 2013). Individuals with
depression are likely to have social skills deficits, are more likely to attempt suicide, and typically have significant role impairment in their life (Castonguay & Oltmanns, 2013).

*Cognitive and interpersonal aspects of depression.* People who struggle with depression are often characterized as having reduced cognitive control over processing negative information and ruminations (i.e., difficulty disengaging from negative stimuli). This results in the elaboration of negative information and contributes to negative memory bias that elicits negative mood states (Castonguay & Oltmanns, 2013). In addition, depression is sometimes characterized as a disorder of emotion regulation. For example, both depressed and non-depressed individuals feel sad sometimes, but depressed individuals have difficulty recovering from this mood state (Castonguay & Oltmanns, 2013). Several emotion regulation strategies such as rumination (repeatedly focusing on symptoms and consequences of symptoms) and suppression (trying to not think of the emotional stimuli or expressing emotions) have been shown to provoke an onset or maintain a depressed mood state. On the other hand, emotion regulation strategies such as distraction (attending to positive or neutral stimuli) and reappraisal (changing the way one thinks about a situation) have demonstrated efficacy in altering negative mood states (Castonguay & Oltmanns, 2013). People who suffer from depression often think of themselves with severe negativity, feel hopeless about the future, and their ability to deal with difficult circumstances (Young et al., 2007). College students are often faced with stress associated with overcoming difficult life circumstances, and they must maintain motivation within the academic context in order to strive for their future career goals. Depression can be interfere significantly with the motivation and capacity to succeed (Brackney & Karabenick, 1995).

Individuals with depression often lack a strong social support network. Family dysfunction, insecure attachment styles, social isolation, and difficult romantic relationships have
been demonstrated to be a risk factor for developing depression (Castonguay & Oltmanns, 2013). Specifically, behaviors such as social withdrawal, excessive reassurance seeking, dependency, and seeking negative feedback for self-verification purposes often elicit interpersonal rejection that results in further isolation from important social support systems (Hames et al., 2013). Indeed interpersonal conflict, relational transitions, grief, and interpersonal deficits are often targeted when treating depression (Bleiberg & Markowitz, 2007). College students face a particularly diverse array of social stressors, the ability to stay connected with others and nurture strong social supports from friends and family is imperative to their personal and academic success at college (Wei, Russell, & Zakalik, 2005).

**Self-compassion and depression.** Self-compassion is often the antithesis of the factors contributing to the development of depression and its maintenance. The mindfulness component alone of self-compassion prevents the elaborative processing of negative material and can limit ruminations. In addition, mindfulness begets a “beginner’s mind” which involves curiosity and an attitude of non-judgment towards internal and private experiences (Bishop et al., 2004). This is an approach orientation to negative inner experiences which is more effective at emotion regulation than cognitive suppression. Multiple investigations have found significant negative correlations between self-compassion and rumination, thought suppression, and negative affect (Neff, 2003a, 2009; Neff, Kirkpatrick, et al., 2007). In contrast, research suggests that self-compassion is associated with greater positive affective states such as happiness and optimism (Neff, Rude, et al., 2007).

Self-compassion is a purposeful cultivation of lovingkindness towards self that empowers a sense of authenticity. It does not require reassurances or negative feedback from others to maintain itself. Therefore, having self-compassion is more likely to result in successful conflict
resolutions, greater security, more intimacy in relationships (Neff & Beretvas, 2012; Neff & McGehee, 2010; Yarnell & Neff, 2013), and less self-criticism (Neff, Kirkpatrick, et al., 2007). In general, high levels of self-compassion are significantly associated with reduced levels of depression (Neff, 2003a, 2009; Neff, Kirkpatrick, et al., 2007; Neff & McGehee, 2010; Yarnell & Neff, 2013).

College students need to be kind to themselves in the face of personal, social, or academic failings in order to learn and grow from their suffering instead of falling into hopelessness and depression. It stands to reason then, that self-compassion might play an important role in psychotherapy. If a client can switch out of negative focused elaborative processing and rumination during therapy and approach their own suffering with curiosity and kindness, then they may be able to learn and grow more than someone who is avoidant and self-critical.

**Anxiety.** Generalized Anxiety is defined as excessive worry that is difficult to control. It is associated with feelings of restlessness, fatigue, difficulty concentrating, irritability, muscle tension and sleep disturbance (American Psychiatric Association, 2013). People with pathological anxiety typically have strong avoidance tendencies and can be constantly seeking reassurances of safety. These behaviors interfere with daily functioning and goal attainment (Clark & Beck, 2009).

**Cognitive aspects of anxiety.** Faced with a myriad of normal developmental and more severe stressors, over half of college students experience overwhelming anxiety (American College Health Association, 2013). Worry is the hallmark feature of generalized anxiety, it is a string of uncontrollable, negative affect-laden thoughts in an attempt to problem solve and avoid an uncertain but possibly negative future outcome (Castonguay & Oltmanns, 2013). Worry is the
ruminative style of thinking associated with anxiety. It is thought that worry itself is the avoidance function specific to generalized anxiety (all anxiety disorders feature avoidance prominently in the maintenance of the disorder) that helps individuals avoid further reactivity to a potential negative event while helping them be better prepared for the worst outcome (Castonguay & Oltmanns, 2013). Like other anxiety disorders, the avoidance function can block the emotional processing of negative stimuli that further exposure might engender and therefore maintains the disorder (Allen et al., 2007). Effectively, worry and its associated avoidance behaviors reduce affective distress in the moment (suppression) which further reinforces the worry and avoidance in the long-term. This interferes with individuals learning how to cope and be effective at handling future unpredictable events, and reinforces their beliefs about their incapability of handling such situations. This in turn invokes more worry and avoidance in future situations (Clark & Beck, 2009). An example is a student that fails a quiz early in the semester. Hopefully they learn from their mistakes and change their studying habits, but sometimes the worry of performing on the next quiz interferes in their concentration to study, or worse, causes them to just skip classes so as to avoid the distress of failing again.

Another prevalent cognitive feature in anxiety is an overactive threat system. Individuals with anxiety are constantly scanning their environment for threat related stimuli. In addition, anxious individuals demonstrate an attentional bias in that they see more threat related stimuli and dismiss or miss safety signals in their environment (Harvey, 2004).

**Self-compassion and anxiety.** Self-compassion requires one to have what Neff (2003b) considers a balanced approach to negative experiences. Self-kindness and feelings of connectedness may enhance one’s ability to be mindful and serve to decrease the impact of negative affect on one’s thinking and attention (Neff, 2003b). With less negative affect, people
are better able to maintain “balanced” awareness of their thoughts and feelings (Fredrickson, 2001). A balanced awareness of thoughts and feelings is in direct contradiction to the suppression (avoidance) and rumination (worry) associated with generalized anxiety. What’s more is that by developing some psychological distance from negative experiences, one is better able to fully experience, process, and learn from their experiences (Neff, Kirkpatrick, et al., 2007). Growing through difficulty is often thwarted by the avoidance and worry associated with anxiety (Allen et al., 2007). When one approaches their negative experiences with kindness, understanding, and a sense of shared humanity, a change happens where a negative experience can actually be transformed into a positive feeling state (Neff, 2003b).

In fact, several studies have demonstrated that self-compassion is associated with less rumination and suppression which in turn is associated with less anxiety (Neff, 2003a; Neff, Kirkpatrick, et al., 2007). Self-compassion appears to be a robust negative predictor of psychopathology. An international study of 504 adults found that self-compassion predicted anxiety and worry significantly more than just mindfulness. This suggests that self-compassion is a more important construct in psychopathology than mindfulness alone (Van Dam et al., 2011). Another study of 91 undergraduate students found that self-compassion was associated with lower levels of academic worry and emotionality, as well as procrastination (an avoidance process). The researchers explain these results by suggesting that individuals with higher self-compassion were better able to manage their academic worries which led to less fear of incompetence and ultimately to less avoidance behavior (i.e., procrastination; Williams et al., 2008).

In summary, self-compassion is associated with important cognitive and interpersonal benefits that seem to mitigate factors in the onset and maintenance of psychopathology generally
and depression and anxiety specifically. Sustaining attention in the present, switching attention when ruminating, cultivating positive affect in the face of difficulty, establishing connected relationships, and treating oneself with kindness all help foster psychological health and resilience. As such, self-compassion is likely a factor that promotes health, especially in college students who face stressful circumstances and external evaluations continuously. Although there have been no studies directly investigating the role self-compassion plays in psychotherapy, given its associations with these important factors related to psychopathology and well-being, self-compassion might play an enhancing role in facilitating growth in therapy. The next section extends the discussion of the relationship of self-compassion to psychological health into suggesting possible benefits of self-compassion in a psychotherapy change context.

**Self-compassion and general psychotherapy.** Many factors can impact client change in psychotherapy. Often, emphasis is placed on specific treatment modalities and active ingredients of interventions (i.e., exposure for anxiety; Barlow, 2007) or common factors like therapeutic alliance (Messer & Wampold, 2002) for explanations of therapeutic effectiveness. However, there is some evidence that suggests client variables may be strong contributors to psychotherapeutic outcomes. Specifically, it is suggested that client factors such as motivation, attachment, access of emotions, experiencing, and self-criticism have a demonstrated impact on the psychotherapy change process (Bohart & Wade, 2013).

Self-compassion has been associated with many of these factors. A study of 126 smokers found that self-compassion training was associated with an increase in clients’ readiness and motivation for change, as well as a reduction of smoking behavior greater than a three week self-monitoring training course. In addition, it was suggested that self-compassion training was especially effective for individuals who had a low readiness for change, and who were high in
Self-criticism (Kelly et al., 2010). Another study examined how self-compassion in 91 undergraduate students was associated with less motivational anxiety and less procrastination tendencies (Williams et al., 2008).

Self-compassion is associated with a secure attachment style and positive interpersonal relationships (Neff & McGehee, 2010). Having a secure attachment style facilitates the development of the therapeutic alliance (Diener & Monroe, 2011) and is associated with increased self-disclosure (Saypol & Farber, 2010), emotional exploration, and session depth (Romano et al., 2008). These factors likely explain why secure attachment has been associated with positive psychotherapy outcomes in three meta-analyses (Levy et al., 2011).

In addition to those client characteristics, the cultivation of positive affect is thought to expand attention and behavioral repertoire systems in individuals that can replace constricted attention and behavioral repertoires associated with negative affect, and lead to lasting positive affective dispositions (Garland et al., 2010). Self-compassion entails being kind towards self and it elicits positive affect in doing so (Neff, Rude, et al., 2007). Therefore, clients in psychotherapy who have high levels of self-compassion may be able to tap into positive affective states that allows for them to expand their thinking and behavioral options, and facilitate greater change in psychotherapy.

In summary, self-compassion is associated with factors that have been identified in other studies to be important for psychotherapy change (Bohart & Wade, 2013; Diener & Monroe, 2011; Garland et al., 2010). These factors include less motivational anxiety (Williams et al., 2008), more motivation and greater readiness for change (Kelly et al., 2010), secure attachment style and positive interpersonal relationships, and a general ability to cultivate positive affect.
Although no direct inferences can be made, it seems reasonable to hypothesize that given these associations, self-compassion may have a positive impact on the psychotherapeutic process.

**Self-compassion and initial distress.** Although the above mentioned factors have been found to contribute to psychotherapy outcomes, a reliable client factor related to psychotherapy outcomes is initial distress levels. In a review of the literature, Beutler, Blatt, Alamohamed, Levy, & Angtuaco (2006) found that clients’ level of functional impairment or initial distress levels was inversely related to client psychotherapy outcomes in depressed clients. Some 80% of 42 studies found that higher levels of functional impairment were associated with less benefit from psychotherapy when compared to those with less functional impairment at the start of therapy (Beutler et al., 2006).

Similar, yet less robust findings are found in the anxiety literature (for a review, see: Newman et al., 2006). In their review of the literature, Newman et al. (2006) found that over half of studies looked at also reported initial distress levels predicting outcome such that those with less distress at intake had a better prognosis. However there are problems in drawing general conclusions. First, some authors did not use initial distress to predict change in therapy, but rather distress at termination. Also, initial distress levels were operationalized differently. Some measured the same measure at intake and termination, and some measured functional impairment on a number of constructs and measured change in symptoms at termination (Beutler et al., 2006; Newman et al., 2006).

Despite these inconsistencies, it is hypothesized that in this study, like many others, initial distress levels will predict change in psychotherapy. Further, given the hypothesis that self-compassion will impact change in psychotherapy positively, it would be interesting to see if self-
compassion moderates the relationship between initial distress levels and change in distress through psychotherapy.

**Self-compassion and psychotherapy in college students.** Given the high prevalence of anxiety and depression in college students (American College Health Association, 2013), and the effectiveness that self-compassion has in promoting health and inhibiting psychopathology (Neff, 2012), it is important to investigate the role that self-compassion plays in psychotherapy. The Center for Collegiate Mental Health (CCMH) is a national, practice-research network of 276 university and college counseling centers that focuses research on college student mental health to identify trends, effective treatments, and risk factors that are helpful to clinicians providing clinical services to student populations (Castonguay et al., 2011; Hayes et al., 2011; Locke, Bieschke, et al., 2012). CCMH offers a large, standardized and nationally representative data set that allows researchers to explore the role self-compassion plays in. In 2012 the CCMH Advisory Board added the Self Compassion Scale - Short Form (SCS-SF; Raes et al., 2011) to Titanium Schedule, an electronic medical record system used in college counseling centers around the country, as a pilot program (Lockard et al., in press). The SCS-SF is a 12-item scale that has been empirically validated on an international sample of students and adults (Raes et al., 2011).

Recently, researchers established normative values for the SCS-SF in a clinical college counseling sample through the CCMH data set. The SCS-SF proved to be reliable in this setting with observed high internal consistency ($\alpha = .85$). Students in a clinical setting had on average lower scores of self-compassion when compared with the non-clinical samples used to validate the SCS and the SCS-SF, and these clinical scores were similar to scores of clinical samples in the community. In addition, self-compassion was lower for individuals who had prior histories of counseling than for those seeking help for the first time. This suggests that low levels of self-
Compassion may be implicated in chronic mental health concerns (Lockard et al., in press). Prior research using CCMH data revealed that students who had received previous treatment were likely to have slower growth rates in psychotherapy and were less likely to be labeled a “treatment responder” (J. F. Boswell, McAleavey, Castonguay, Hayes, & Locke, 2012).

Self-compassion is positively associated with many factors of well-being (Neely et al., 2009; Neff, 2003a, 2011; Neff, Kirkpatrick, et al., 2007; Neff & McGehee, 2010; Neff, Rude, et al., 2007; Yarnell & Neff, 2013) and negatively associated with factors that precede and maintain psychopathology (Lockard et al., in press; MacBeth & Gumley, 2012; Neff, 2003a; Neff, Kirkpatrick, et al., 2007; Neff, Rude, et al., 2007; Van Dam et al., 2011). Self-compassion has yet to be studied in the context of psychotherapy specifically, however, it stands to reason that being mindful, cultivating positive feeling towards oneself, and feeling connected to the world could facilitate growth and change within a psychotherapy relationship. This study will aim to examine whether self-compassion is related to initial severity of students seeking help in college counseling centers and if initial levels of self-compassion can predict psychotherapy outcomes on depression and anxiety.

**Hypotheses:**

I. There will be an inverse relationship between self-compassion and depression prior to the start of counseling among college students seeking help from campus counseling centers.

II. There will be an inverse relationship between self-compassion and anxiety prior to the start of counseling among college students seeking help from campus counseling centers.
III. There will be an inverse relationship between depression scores at intake and change in depression scores at the end of counseling among college students seeking help from campus counseling centers.

IV. There will be a positive relationship between self-compassion prior to the start of counseling and change in depression at the end of counseling among college students seeking help from campus counseling centers.

V. Self-compassion will moderate the relationship between initial levels of depression and change in depression scores at the end of therapy, such that those with higher self-compassion and high initial distress will change more than those with low self-compassion and high initial distress.

VI. There will be an inverse relationship between anxiety scores at intake and change in anxiety scores at the end of counseling among college students seeking help from campus counseling centers.

VII. There will be a positive relationship between self-compassion prior to the start of counseling and change in anxiety at the end of counseling among college students seeking help from campus counseling centers.

VIII. Self-compassion will moderate the relationship between initial levels of anxiety and change in anxiety scores at the end of therapy, such that those with higher self-compassion and high initial distress will change more than those with low self-compassion and high initial distress.

**Research Question**

Although the main aim of this study is to investigate self-compassion and its association with change on depression and anxiety outcomes in psychotherapy, we have the opportunity to
examine other distress data that is being collected simultaneously. CCMH uses the Counseling Center Assessment of Psychological Symptoms (CCAPS) to measure distress at intake and change in therapy (CCMH, 2012b). In addition to having depression and anxiety scales, the CCAPS also includes five other scales. These include Social Anxiety, Academic Distress, Eating Concerns, Hostility, and Alcohol Use (CCMH, 2012b). There is far less research linking self-compassion to these different constructs and their psychopathological maintenance factors, however there are preliminary and distal associations that indicate self-compassion might also be positively associated with change on these subscales.

Self-compassion is negatively associated with Social Anxiety Disorder (SAD), but within the group of people with SAD, self-compassion was not necessarily associated with severity but more specifically with a fear of positive and negative evaluations (Werner et al., 2012). Within the context of a positive and supportive therapeutic relationship, it stands to reason that individuals who have self-compassion but still have social anxiety, may be able to get in touch with their more compassionate side, thus facilitating growth and change.

Another study of self-compassion reveals results suggesting the possibility that self-compassion could be associated with the alleviation of academic distress in a counseling setting. A study of 110 college students who perceived their recent midterm exam as a failure showed a positive association between self-compassion and emotion-focused coping strategies and a negative association with anxious, avoidant based coping strategies (Neff et al., 2005). Even though the students all perceived their exam as a failure, self-compassion was associated with coping strategies such as positive reinterpretation, and growth and acceptance. It was also negatively associated with venting negative emotions, denial, and mental disengagement (Neff et al., 2005). These students felt distress, but their self-compassion led them to grow through it in a
more adaptive manner. Similarly, students seeking help in a counseling center for academic distress, but who also have self-compassion may be able to change more in psychotherapy. This measure has specific importance to the mission of college counseling centers (Lockard et al., 2012).

Self-compassion is negatively associated with distress and disinhibited compensatory eating among a sample of restricting eaters. When self-compassion was induced, restricting eaters who were given junk food did not eat more to suppress their distress over eating junk food, whereas those restricting eaters that did not have self-compassion induced tended to overeat in a compensatory manner. The authors suggest that having self-compassion led to less avoidant behavior and helped participants keep their eyes on their goals (Adams & Leary, 2007). Self-compassion in the context of eating concerns seems to help individuals have less distress when they do not follow their goals, but they can seemingly offer themselves more forgiveness that results in awareness and staying connected with their goals. This seems like a process that would fit with the psychotherapy context and aid individuals with eating concerns to resolve their issues more quickly than those with less self-compassion.

Self-compassion has a negative association with negative affect (Neff, Kirkpatrick, et al., 2007) as measured by the PANAS scales which include questions specific to hostility (Watson, Clark, & Tellegen, 1988) and self-compassion has a positive association with compassion for humanity, empathic concern and greater forgiveness (Neff & Pommier, 2013). While it is unclear if there will be any variability of self-compassion in individuals with hostility, if there is it seems plausible to think that those with self-compassion might be able to engender more compassion in psychotherapy than those who do not.
Finally, an interesting study on alcohol use and self-compassion suggests firstly that therapy focused on alcohol dependence increased self-compassion from baseline to a 15-week follow-up and that this increase in self-compassion was associated with a significant decline in alcohol consumption (Brooks, Kay-Lambkin, Bowman, & Childs, 2012). By reducing feelings of isolation, self-judgment, and over-identification in therapy, clients self-compassion improved as did their alcohol use.

In sum, there is a significantly less research literature suggesting that self-compassion will have a positive association with psychotherapy outcomes on the scales of Social Anxiety, Academic Distress, Eating Concerns, Hostility and Alcohol Use. However, given that at least one self-compassion study can be found for construct related to those measured by the CCAPS, it seems reasonable to stretch the aims of the current investigation in an exploratory fashion in order to examine whether self-compassion is positively associated with CCAPS measures change scores at the end of treatment. The analysis for this study will add the remaining five CCAPS change scores as the outcome into an additional 5 multilevel models. The results will be reported and discussed.
Chapter 3: Methods

Participants

The Center for Collegiate Mental Health (CCMH) is a collaborative comprising more than 270 college counseling centers across the United States. CCMH is a practice-based research network that uses a common electronic medical records (EMR) system that collects anonymized data that is used both as a clinical assessment and feedback tool as well as for scientific purposes (Hayes et al., 2011). During the 2012-2013 academic year, CCMH collected data from 132 college counseling centers (more than 95,000 students).

In the fall of 2012, all the counseling centers were invited to use a measure of self-compassion as part of their integrated assessments in the EMR. A total of 7 college counseling centers integrated the self-compassion measure and had CCAPS outcome data. These centers were located in the Southeast and Mid-Atlantic states. The colleges in the sample were 57% private.

For the present study, the outcome variable is psychotherapy change and the sample was limited to those participants who have completed at least two counseling sessions. In addition, the sample was limited to those schools that collected pre- and post- counseling data on the CCAPS and collected self-compassion data at intake. The total number of participants fulfilling these requirements is 534. Participant ages ranged from 18-53 ($M=23$, $SD=5.83$). Participants were 75% female, 25% male (1 identified as transgender, and 1 as “other”). The majority of participants identified as white (58%), 17% identified as African American, 10% identified as Latino/a, 9% identified as Asian, 0.4% identified as Pacific Islander, 4% identified as multiracial, and 2% identified as other. Most participants were undergraduate (81%), and 18% were graduate students. The majority of participants identified as heterosexual (86%), 4% identified as bisexual,
3% identified as lesbian, 3% identified as gay, and 2% identified as questioning. Treatment duration ranged from 5-304 days (M=100, SD=66).

There were 231 therapists with ages ranging from 26-71 (M = 43.85, SD = 13.32). The majority of therapists were female (59%). Most therapists identified as white (81%), 12% identified as Latino/a, and 7% identified as African American. The majority of therapists had achieved a doctorate (68%), and 32% achieved a master’s degree. Most therapists were professional staff (83%), 16% were pre-doctoral interns, and 1% were doctoral level trainees.

Measures

Counseling Center Assessment of Psychological Adjustment (CCAPS-62 and CCAPS-34). CCMH uses two instruments to measure distress and outcome in psychotherapy, the CCAPS-62 and a shorter form, CCAPS-34. The CCAPS-62 (Locke et al., 2011) is a 62-item self-report instrument measuring overall distress as well as distress in eight subscales in college populations. Participants respond to questions on a five-point Likert-type scale ranging from 0 (not at all) to 4 (extremely well). The subscales include Depression, Eating Concerns, Substance Use, Generalized Anxiety, Social Anxiety, Family Distress, Academic Distress and Hostility. A factor analysis was used to investigate the distinction among the eight subscales as constructs. The factor analysis supported the eight factors represented in the final CCAPS-62 (NNFI=0.97, CFI=0.97; Locke et al., 2011). Another factor analysis supported the eight factor structure as well as the presence of a higher order general distress factor (CCMH, 2012b; McAleavey et al., 2012). The CCAPS-62 has demonstrated good convergent validity with established measures of psychological symptoms indicating it is measuring the constructs in college students that it purports to measure (Locke et al., 2011; McAleavey et al., 2012). Subscales showed good internal consistency with Cronbach alphas ranging from 0.83 (Family Distress) to 0.96
The CCAPS-62 demonstrated good reliability with test-retest coefficients ranging from 0.782 (Generalized Anxiety) to 0.927 (Depression) across one week and from 0.759 (Academic Distress) to 0.917 (Depression) across two weeks (Locke et al., 2011). The CCAPS-62 demonstrated reliability across gender, ethnicity, and international students with internal consistency estimates ranging from .78 to .92 compared with .80 for the total sample (CCMH, 2012b).

The CCAPS-34 (Locke, McAleavey, et al., 2012) is a 34-item self-report measure intended to measure distress in 7 subscales present in the CCAPS-62. The CCAPS-34 is entirely contained within the CCAPS-62. Therefore all CCAPS-62 scores in this study will be recalculated into CCAPS-34 scores to assure reliable measuring across time points. Participants respond to questions on a five-point Likert-type scale ranging from 0 (not at all) to 4 (extremely well). The subscales include Depression, Anxiety, Eating Concerns, Alcohol Use, Social Anxiety, Academic Distress and Hostility. The CCAPS-34 dropped the Family Distress scale of the CCAPS-62 and the Substance Use Scale on the CCAPS-62 became the Alcohol Use Scale on the CCAPS-34. A confirmatory factor analysis indicated a good fit for the seven-factor structure of the CCAPS-34 (NNFI=0.98, CFI=0.98; Locke, McAleavey, et al., 2012). Subscales showed acceptable to good internal consistency with Cronbach alphas ranging from 0.760 (Academic Distress) to 0.892 (Depression). In addition, each subscale showed good convergent validity with established measures of psychological symptoms indicating it also is measuring the constructs in college students that it purports to measure (Locke, McAleavey, et al., 2012). The CCAPS-34 has demonstrated good reliability with test-retest coefficients ranging from 0.792 (Alcohol Use) to 0.866 (Depression) across one week, and from 0.742 (Academic Distress) to 0.864 (Depression) across two weeks (Locke, McAleavey, et al., 2012). The equivalent subscale
correlations between the CCAPS-34 and the CCAPS-62 were high ranging from 0.92 (Eating Concerns) to 0.98 (Hostility and Academic Distress; CCMH, 2012b).

**Self-Compassion Scale – Short Form, English Version (SCS-SF).** Students’ self-compassion will be measured at intake using the Self-Compassion Scale – Short Form (SCS-SF; Raes et al., 2011). The SCS is a 12-item self-report measure that includes items assessing self-kindness (e.g., “When I’m going through a very hard time, I give myself the caring and tenderness I need), self-judgment (e.g., “I’m intolerant and impatient towards those aspects of my personality I don’t like”), common humanity (e.g., “When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people”), isolation (e.g., “When I fail at something that’s important to me I tend to feel alone in my failure”), mindfulness (e.g., “When something painful happens I try to take a balanced view of the situation”), and over-identification (e.g., “When I’m feeling down I tend to obsess and fixate on everything that’s wrong”). Responses are recorded on a 5-point scale ranging from 1 = “almost never” to 5 = “almost always.” All negative items are reverse-coded and then means are created for each subscale. Mean scores of the six subscales are summed to create the overall self-compassion score (Raes et al., 2011).

The SCS-SF demonstrated an almost perfect correlation with the total score of the long form of the SCS (r=0.98) indicating that inferences drawn from research using the SCS should apply to the SCS-SF (Raes et al., 2011). The internal consistency of the SCS-SF total score are high ranging from .85 (Lockard et al., in press) to .86 (Raes et al., 2011) and the five month test-retest reliability was .71 (Raes et al., 2011). Among students presenting to college counseling centers, men are reported to have higher self-compassion than women but no other differences were observed between sexual identity, racial/ethnic, or academic year (Lockard et al., in press).
Procedures

The instruments in this study were administered through the CCMH research-practice network of counseling centers. Centers administered measures through the Titanium EMR system and data was collated by CCMH and cleaned of identifiable markers. Centers typically administered the CCPAS-62 and the SCS-SF at intake and then administered the CCAPS-34 at multiple points during treatment to assess change in psychotherapy (Hayes et al., 2011). Of the total data set, cases were selected by first identifying those institutions that administered the SCS-SF, and then by those participants who had more than one administrations of the CCAPS in order to assess change.

Analytic Plan

The present study tested eight hypotheses. The first two hypotheses stated that it was expected that there will be an inverse relationship between self-compassion, and depression and anxiety at the start of treatment. To test these hypotheses, correlations were conducted between self-compassion and depression at intake, as well as self-compassion and anxiety at intake.

Hypotheses 3-5 suggest that self-compassion and initial depression scores would predict change in depression at the end of therapy. In addition, it was hypothesized that self-compassion would moderate the relationship between initial depression scores and depression change scores at the end of treatment. To test these hypotheses a multilevel model was utilized. Multilevel modeling is designed to account for hierarchical structure in data, in this case clients are “nested” within therapists (Hox, 2002). The SCS-SF at intake, depression scores at intake, and the interaction between initial depression scores and self-compassion were entered as level 1 predictors of depression change scores. The preliminary analyses were used to identify other theoretically relevant variables to be included in the final models as covariates. Regression
standard models assume independence, because data is clustered by therapist, you must account for the standard errors in the data. Therefore a random effect for therapist was added.

Hypotheses 6-8 suggest that self-compassion and initial anxiety scores would predict change in anxiety at the end of therapy. In addition, it was hypothesized that self-compassion could moderate the relationship between initial anxiety scores and anxiety change scores at the end of treatment. To test these hypotheses another multilevel model was utilized. The SCS-SF at intake, anxiety scores at intake, and the interaction between initial anxiety scores and self-compassion were entered as level 1 predictors of anxiety change scores. In addition, preliminary analyses examined other theoretically relevant variables to be added as covariates to the model. A random effect for therapist was added to the model to account for nested data.

Finally, to examine the research questions, I explored whether initial distress (measured by the remaining 5 CCAPS measures), self-compassion, and their interaction had predictive value of CCAPS distress change at the end of treatment. Therefore, Social Anxiety, Academic Distress, Eating Concerns, Hostility, and Alcohol Use change scores were added as outcomes in the final 5 multilevel models. Each model included initial levels of distress at intake and other relevant covariates.

In a standard univariate multilevel model for predicting residualized change scores, the model is the following:

\[ y_{ij} = \beta_{0j} + \beta_{1j}(x_{ij}) + \beta_{2j}(z_{ij}) + \beta_{3j}(x_{ij}z_{ij}) + u_{0j} + e_{ij} \]  

(1)

Here \( y_{ij} \) is the CCAP change scores for depression at the end of counseling for individual \( i \) nested within therapist \( j \). \( \beta_{0j} \) is the mean intercept that represents the mean of the residualized depression scores at the end of therapy when all predictors are equal to 0, in this case when depression at time 1 \( (x_{ij}) = 0 \), self-compassion at time 1 \( (z_{ij}) = 0 \), and when the interaction of
depression and self-compassion at time 1 \( x_{ij} z_{ij} \) = 0. \( \beta_{1j} \) is the mean slope for depression at time 1, \( \beta_{2j} \) is the mean slope for self-compassion at intake, and \( \beta_{1j} \) is the mean slope for the interaction between depression at time 1 and self-compassion at intake. The predictors, depression at time 1, self-compassion at intake and the interaction between them are fixed effect in the model. Regression standard models assume independence, because data is clustered by therapist in this sample, you must account for the standard errors in the data. Therefore a random effect for therapist \( u_{0j} \) was added and \( e_{ij} \) is residual error. When using separate univariate multilevel models for the seven outcome measures, the equations would be the following:

\[
\begin{align*}
y_{ij} &= \beta_{10j} + \beta_{11j}(x_{ij}) + \beta_{12j}(z_{ij}) + \beta_{13j}(x_{ij}z_{ij}) + u_{0j} + e_{ij} \\
y_{ij} &= \beta_{20j} + \beta_{21j}(x_{ij}) + \beta_{22j}(z_{ij}) + \beta_{23j}(x_{ij}z_{ij}) + u_{0j} + e_{ij} \\
y_{ij} &= \beta_{30j} + \beta_{31j}(x_{ij}) + \beta_{32j}(z_{ij}) + \beta_{33j}(x_{ij}z_{ij}) + u_{0j} + e_{ij} \\
y_{ij} &= \beta_{40j} + \beta_{41j}(x_{ij}) + \beta_{42j}(z_{ij}) + \beta_{43j}(x_{ij}z_{ij}) + u_{0j} + e_{ij} \\
y_{ij} &= \beta_{50j} + \beta_{51j}(x_{ij}) + \beta_{52j}(z_{ij}) + \beta_{53j}(x_{ij}z_{ij}) + u_{0j} + e_{ij} \\
y_{ij} &= \beta_{60j} + \beta_{61j}(x_{ij}) + \beta_{62j}(z_{ij}) + \beta_{63j}(x_{ij}z_{ij}) + u_{0j} + e_{ij} \\
y_{ij} &= \beta_{70j} + \beta_{71j}(x_{ij}) + \beta_{72j}(z_{ij}) + \beta_{73j}(x_{ij}z_{ij}) + u_{0j} + e_{ij}
\end{align*}
\]

Results will be reported and discussed in the context of their conceptual, methodological and clinical implications.
Chapter 4: Results

Preliminary Analyses

Self-compassion. Descriptive statistics for study variables are reported in Table 1. Self-compassion scores ($M=2.72, SD=.73$) were consistent with previously reported counseling center clients scores ($M=2.80, SD=.73$; Lockard et al., in press). Self-compassion scores trended lower than general population scores with means ranging from 3.08-3.11 and standard deviations ranging from .83-.85 (Neff, 2003a). This is consistent with research that suggests clinical populations have lower self-compassion (MacBeth & Gumley, 2012; Van Dam et al., 2011). In addition, there were no significant differences in self-compassion by gender ($t = -1.75, p> 0.05$), which is different than what has been reported in other research on American participants that found women tend to have lower self-compassion scores than men (Neff, 2003a; Neff et al., 2008).

Pre-Treatment CCAPS. CCAPS scale scores at intake in this sample (see Table 1) tended to fall between lower level CCAPS cut points derived to differentiate between clinical and non-clinical populations, and the higher cut points designed to indicate further diagnostic assessment. All cut points are empirically derived except the high cut points for Academic Distress, and Hostility which are distributionally derived at the 70th percentile (CCMH, 2012b). CCAPS-34 cut points for Depression are 1.0 (38th percentile) and 1.75 (56th percentile; CCMH, 2012b). Depression scores within this sample, on average, approached the higher cut points ($M=1.68, SD=1.02$). CCAPS-34 cut points for Generalized Anxiety are 1.30 (36th percentile) and 2.1 (65th percentile; CCMH, 2012b). Generalized Anxiety scores in this sample, on average, were between the lower and higher cut points ($M=1.89, SD=.99$). CCAPS-34 cut points for Social Anxiety are 1.65 (50th percentile) and 2.5 (76th percentile; CCMH, 2012b). Social
Anxiety scores in this sample, on average, were between the lower and higher cut points ($M=1.98$, $SD=1.02$). CCAPS-34 cut points for Academic Distress are 1.45 (35th percentile) and 2.5 (70th percentile; CCMH, 2012b). Academic Distress scores in this sample, on average, were between the lower and higher cut points ($M=1.91$, $SD=1.09$). CCAPS-34 cut points for Eating Concerns are 1.07 (68th percentile) and 1.5 (74th percentile; CCMH, 2012b). Eating concern scores in this sample, on average, were the only measure in this sample below the lower cut point ($M=1.01$, $SD=1.17$). CCAPS-34 cut points for Hostility are .74 (53rd percentile) and 1.33 (70th percentile; CCMH, 2012b). Hostility scores in this sample, on average, were between the lower and higher cut points ($M=.93$, $SD=.85$). CCAPS-34 cut points for Alcohol Use are .64 (60th percentile) and 1.1 (74th percentile; CCMH, 2012b). Alcohol Use scores in this sample, on average, were close to the lower cut point ($M=.65$, $SD=.89$).

**CCAPS Change Scores.** Scores on the CCAPS that are above the lower cut point are considered in the clinical range. Scores below the lower cut point are considered in the sub-clinical range (CCMH, 2012b). Change scores were created by subtracting intake from termination CCAPS scores, so that larger scores represented greater change. All scores in this sample trended in the expected direction with some measures dropping into the sub-clinical range at termination.

On average ($M=.53$, $SD=.93$), participant scores dropped from a mean Depression score of 1.68 to a mean of 1.15, but remained in the clinical range at termination (above 1.0; CCMH, 2012b). On average ($M=.38$, $SD=.83$), participant scores dropped from a mean Generalized Anxiety score of 1.89 to a mean of 1.5, but remained in the clinical range at termination (above 1.3; CCMH, 2012b). On average ($M=.22$, $SD=.66$), participant scores dropped from a mean Social Anxiety score of 1.98 to a mean of 1.76, but remained in the clinical range at termination (above 1.65; CCMH, 2012b). On average ($M=.26$, $SD=.96$), participant scores dropped from a mean
Academic Distress score of 1.91 to a mean of 1.65, but remained in the clinical range at termination (above 1.45; CCMH, 2012b). On average ($M=.06$, $SD=.83$), participant scores

Table 1.

*Descriptive Statistics of Study Variables*

<table>
<thead>
<tr>
<th>Measures</th>
<th>$M$</th>
<th>$SD$</th>
<th>Range</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Predictors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Duration</td>
<td>100.04</td>
<td>66.93</td>
<td>2,304</td>
<td>.83</td>
<td>-.12</td>
</tr>
<tr>
<td>Self-compassion at Intake</td>
<td>2.72</td>
<td>.73</td>
<td>1,492</td>
<td>.31</td>
<td>.07</td>
</tr>
<tr>
<td>Depression at Intake</td>
<td>1.68</td>
<td>1.02</td>
<td>0,4</td>
<td>.14</td>
<td>-.88</td>
</tr>
<tr>
<td>Anxiety at Intake</td>
<td>1.89</td>
<td>.99</td>
<td>0,4</td>
<td>.11</td>
<td>-.78</td>
</tr>
<tr>
<td>Social Anxiety at Intake</td>
<td>1.98</td>
<td>1.02</td>
<td>0,4</td>
<td>-.01</td>
<td>-.85</td>
</tr>
<tr>
<td>Academic Distress at Intake</td>
<td>1.91</td>
<td>1.09</td>
<td>0,4</td>
<td>.03</td>
<td>-.96</td>
</tr>
<tr>
<td>Eating Concerns at Intake</td>
<td>1.01</td>
<td>1.17</td>
<td>0,4</td>
<td>1.03</td>
<td>-.06</td>
</tr>
<tr>
<td>Hostility at Intake</td>
<td>.93</td>
<td>.85</td>
<td>0,4</td>
<td>.97</td>
<td>.40</td>
</tr>
<tr>
<td>Alcohol Use at Intake</td>
<td>.65</td>
<td>.89</td>
<td>0,4</td>
<td>1.53</td>
<td>1.71</td>
</tr>
<tr>
<td>SC x Depression</td>
<td>-.62</td>
<td>1.09</td>
<td>-5.13,2.77</td>
<td>-1.5</td>
<td>2.82</td>
</tr>
<tr>
<td>SC x Anxiety</td>
<td>-.44</td>
<td>1.04</td>
<td>-5.75,3.24</td>
<td>-1.59</td>
<td>4.79</td>
</tr>
<tr>
<td>SC x Social Anxiety</td>
<td>-.50</td>
<td>1.03</td>
<td>-5.81,2.41</td>
<td>-1.52</td>
<td>4.01</td>
</tr>
<tr>
<td>SC x Academic Distress</td>
<td>-.36</td>
<td>1.12</td>
<td>-5.26,3.34</td>
<td>-1.22</td>
<td>3.32</td>
</tr>
<tr>
<td>SC x Eating Concerns</td>
<td>-.27</td>
<td>1.03</td>
<td>-5.12,3.47</td>
<td>-.98</td>
<td>3.76</td>
</tr>
<tr>
<td>SC x Hostility</td>
<td>-.34</td>
<td>1.04</td>
<td>-6.79,4.04</td>
<td>-1.31</td>
<td>5.13</td>
</tr>
<tr>
<td>SC x Alcohol</td>
<td>-.09</td>
<td>.97</td>
<td>-6.27,5.08</td>
<td>-1.05</td>
<td>10.41</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression Change</td>
<td>.53</td>
<td>.93</td>
<td>-2.5,3.67</td>
<td>.38</td>
<td>.61</td>
</tr>
<tr>
<td>Anxiety Change</td>
<td>.38</td>
<td>.83</td>
<td>-2.17,3.67</td>
<td>.57</td>
<td>1.16</td>
</tr>
<tr>
<td>Social Anxiety Change</td>
<td>.22</td>
<td>.66</td>
<td>-2.00,2.60</td>
<td>.2</td>
<td>.6</td>
</tr>
<tr>
<td>Academic Distress Change</td>
<td>.26</td>
<td>.96</td>
<td>-2.75,3.25</td>
<td>.01</td>
<td>.79</td>
</tr>
<tr>
<td>Eating Concerns Change</td>
<td>.06</td>
<td>.83</td>
<td>-3.67,3.33</td>
<td>.17</td>
<td>2.39</td>
</tr>
<tr>
<td>Hostility Change</td>
<td>.29</td>
<td>.73</td>
<td>-2.50,3.50</td>
<td>.85</td>
<td>2.78</td>
</tr>
<tr>
<td>Alcohol Change</td>
<td>.11</td>
<td>.68</td>
<td>-2.50,3.75</td>
<td>.88</td>
<td>4.88</td>
</tr>
</tbody>
</table>

Note: SC = Self-compassion

dropped from a mean Eating Concerns score of 1.01 to a mean of .95, and remained in the sub-clinical range at termination (below 1.07; CCMH, 2012b). On average ($M=.29$, $SD=.73$),
participant scores dropped from a mean Hostility score of .93 to a mean of .64, and dropped into the sub-clinical range at termination (below .74; CCMH, 2012b). Finally, on average \((M=.11, SD=.68)\), participant scores dropped from a mean Alcohol Use score of .65 to a mean of .54, and dropped into the sub-clinical range at termination (below .64; CCMH, 2012b).

**Covariates.** Previous research has found that self-compassion is associated with gender differences in samples from the United States (Neff, 2003a; Neff et al., 2008). In this previous research, women consistently have lower levels of self-compassion than men. The relationship of gender to self-compassion and CCAPS outcomes was investigated for use as a covariate in the multilevel models. Gender was surprisingly unrelated to self-compassion or any of the CCAPS change scores (see Table 2). Therefore, gender was not included in the final multilevel models.

In addition to gender, time in treatment is sometimes related to psychotherapy outcomes. Although most people show clinically significant improvement in 15 sessions; those that stay in therapy longest are

Table 2.

**T-Tests Comparing Gender on Study Variables**

<table>
<thead>
<tr>
<th>Measures</th>
<th>(t)-test</th>
<th>(M) Men</th>
<th>(M) Women</th>
<th>(p) Value</th>
<th>(df)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCS-SF</td>
<td>-1.75</td>
<td>2.68</td>
<td>2.81</td>
<td>.08</td>
<td>214</td>
</tr>
<tr>
<td>Depression Change</td>
<td>0.60</td>
<td>0.56</td>
<td>0.50</td>
<td>.55</td>
<td>224</td>
</tr>
<tr>
<td>Anxiety Change</td>
<td>0.33</td>
<td>0.39</td>
<td>0.37</td>
<td>.74</td>
<td>259</td>
</tr>
<tr>
<td>Social Anxiety Change</td>
<td>0.25</td>
<td>0.23</td>
<td>0.21</td>
<td>.80</td>
<td>202</td>
</tr>
<tr>
<td>Academic Distress Change</td>
<td>0.71</td>
<td>0.28</td>
<td>0.21</td>
<td>.48</td>
<td>223</td>
</tr>
<tr>
<td>Eating Concerns Change</td>
<td>0.89</td>
<td>0.08</td>
<td>0.02</td>
<td>.38</td>
<td>279</td>
</tr>
<tr>
<td>Hostility Change</td>
<td>-.91</td>
<td>0.27</td>
<td>0.34</td>
<td>.36</td>
<td>211</td>
</tr>
<tr>
<td>Alcohol Use Change</td>
<td>0.53</td>
<td>0.12</td>
<td>0.07</td>
<td>.60</td>
<td>181</td>
</tr>
</tbody>
</table>
sometimes considered to be treatment resistant, and possibly a different population (Lambert, Hansen, & Finch, 2001). Treatment duration, a count of every consecutive day during the defined beginning and end of treatment, was examined for its relationships with CCAPS change scores. Treatment duration was significantly related to depression change scores \( (r=-.10, p<.05) \), anxiety change scores \( (r=-.11, p<.05) \),

Table 3.

**Correlations Between Treatment Duration and CCAPS Change Scores**

<table>
<thead>
<tr>
<th>CCAPS Measures</th>
<th>( r )</th>
<th>CI Low</th>
<th>CI High</th>
<th>( p ) Value</th>
<th>df</th>
<th>( r^2 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression Change</td>
<td>-.10*</td>
<td>-.19</td>
<td>-.02</td>
<td>.02</td>
<td>532</td>
<td>-.01</td>
</tr>
<tr>
<td>Anxiety Change</td>
<td>-.11*</td>
<td>-.19</td>
<td>-.02</td>
<td>.01</td>
<td>532</td>
<td>-.01</td>
</tr>
<tr>
<td>Social Anxiety Change</td>
<td>-.05</td>
<td>-.13</td>
<td>.04</td>
<td>.27</td>
<td>532</td>
<td>-.003</td>
</tr>
<tr>
<td>Academic Distress Change</td>
<td>-.10*</td>
<td>-.18</td>
<td>.02</td>
<td>.02</td>
<td>532</td>
<td>-.01</td>
</tr>
<tr>
<td>Eating Concerns Change</td>
<td>-.02</td>
<td>-.10</td>
<td>.07</td>
<td>.68</td>
<td>532</td>
<td>-.0004</td>
</tr>
<tr>
<td>Hostility Change</td>
<td>-.03</td>
<td>-.12</td>
<td>.05</td>
<td>.42</td>
<td>532</td>
<td>-.0009</td>
</tr>
<tr>
<td>Alcohol Use Change</td>
<td>-.03</td>
<td>-.12</td>
<td>.05</td>
<td>.44</td>
<td>532</td>
<td>-.0009</td>
</tr>
</tbody>
</table>

Note: CI stands for 95% Confidence Interval; *indicates statistical significance < .05

and academic distress change scores \( (r=-.10, p<.05) \). For these CCAPS measures there was a small but significant inverse relationship between treatment duration and change at the end of therapy. The remaining CCAPS associations were insignificant (See Table 3). Treatment duration was included as a covariate in the depression, anxiety, and academic distress multilevel models.

**CCAPS Initial Distress and Change Scores.** Correlations between CCAPS scores at intake and CCAPS change scores are reported in Table 4. Results suggest that initial levels of
distress are significantly associated with change scores over the course of treatment. Effect sizes ranged from small (Alcohol use; $r=.09, p<.001$) to large (Hostility; $r=.63, p<.001$). These results suggest that initial distress levels are significantly associated with change scores over treatment such that high levels of initial distress are related to greater change in treatment.

Table 4.

*Correlations Between CCAPS Measures at Intake and CCAPS Change Scores*

<table>
<thead>
<tr>
<th>CCAPS Measures</th>
<th>$r$</th>
<th>CI Low</th>
<th>CI High</th>
<th>$p$ Value</th>
<th>$df$</th>
<th>$r^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression Change</td>
<td>0.60**</td>
<td>0.54</td>
<td>0.65</td>
<td>&lt;.001</td>
<td>532</td>
<td>0.36</td>
</tr>
<tr>
<td>Anxiety Change</td>
<td>0.48**</td>
<td>0.41</td>
<td>0.54</td>
<td>&lt;.001</td>
<td>532</td>
<td>0.23</td>
</tr>
<tr>
<td>Social Anxiety Change</td>
<td>0.42**</td>
<td>0.35</td>
<td>0.49</td>
<td>&lt;.001</td>
<td>532</td>
<td>0.18</td>
</tr>
<tr>
<td>Academic Distress Change</td>
<td>0.53**</td>
<td>0.47</td>
<td>0.59</td>
<td>&lt;.001</td>
<td>532</td>
<td>0.28</td>
</tr>
<tr>
<td>Eating Concerns Change</td>
<td>0.49**</td>
<td>0.42</td>
<td>0.55</td>
<td>&lt;.001</td>
<td>532</td>
<td>0.24</td>
</tr>
<tr>
<td>Hostility Change</td>
<td>0.63**</td>
<td>0.57</td>
<td>0.68</td>
<td>&lt;.001</td>
<td>532</td>
<td>0.39</td>
</tr>
<tr>
<td>Alcohol Use Change</td>
<td>0.56**</td>
<td>0.49</td>
<td>0.61</td>
<td>&lt;.001</td>
<td>532</td>
<td>0.31</td>
</tr>
</tbody>
</table>

Note: CI stands for 95% Confidence Interval; **indicates statistical significance < .001

**Self-Compassion and CCAPS Change.** Correlations between self-compassion and CCAPS change scores are reported in Table 5. Results suggest that self-compassion was significantly and negatively associated to CCAPS change scores on all measures except Alcohol Use. Effect sizes ranged from small (Eating Concerns; $r=-.10, p<.05$) to moderate (Depression; $r=-.35, p<.001$). Results suggest that higher levels of self-compassion was associated with less change over treatment, except when assessing Alcohol Use change where no statistically significant association was observed.
Table 5.

**Correlations Between Self-Compassion and CCAPS Change Scores**

<table>
<thead>
<tr>
<th>CCAPS Measures</th>
<th>$r$</th>
<th>CI Low</th>
<th>CI High</th>
<th>$p$ Value</th>
<th>$df$</th>
<th>$r^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression Change</td>
<td>-0.35**</td>
<td>-0.42</td>
<td>-0.27</td>
<td>&lt;.001</td>
<td>532</td>
<td>0.12</td>
</tr>
<tr>
<td>Anxiety Change</td>
<td>-0.22**</td>
<td>-0.30</td>
<td>-0.14</td>
<td>&lt;.001</td>
<td>532</td>
<td>0.05</td>
</tr>
<tr>
<td>Social Anxiety Change</td>
<td>-0.21**</td>
<td>-0.29</td>
<td>-0.12</td>
<td>&lt;.001</td>
<td>532</td>
<td>0.04</td>
</tr>
<tr>
<td>Academic Distress Change</td>
<td>-0.19**</td>
<td>-0.27</td>
<td>-0.10</td>
<td>&lt;.001</td>
<td>532</td>
<td>0.03</td>
</tr>
<tr>
<td>Eating Concerns Change</td>
<td>-0.10*</td>
<td>-0.18</td>
<td>-0.01</td>
<td>.02</td>
<td>532</td>
<td>0.009</td>
</tr>
<tr>
<td>Hostility Change</td>
<td>-0.17**</td>
<td>-0.25</td>
<td>-0.09</td>
<td>&lt;.001</td>
<td>532</td>
<td>0.03</td>
</tr>
<tr>
<td>Alcohol Use Change</td>
<td>-0.06</td>
<td>-0.14</td>
<td>0.03</td>
<td>.20</td>
<td>532</td>
<td>0.003</td>
</tr>
</tbody>
</table>

Note: CI stands for 95% Confidence Interval; ** indicates statistical significance < .001; *indicates statistical significance <.05.

**Primary Analysis**

Hypothesis I stated there will be an inverse relationship between self-compassion and depression prior to the start of counseling among college students seeking help from campus counseling centers. Results supported this hypothesis, Self-Compassion scores showed a strong negative relationship to CCAPS Depression scores prior to the start of counseling, $r = -.64$, $p < .001$ (See Table 6). The results suggest that individuals who have higher scores on the Self-Compassion Scale- Short Form report lower levels of Depression on the CCAPS at the start of therapy.

Hypothesis II stated there will be an inverse relationship between self-compassion and anxiety prior to the start of counseling among college students seeking help from campus counseling centers. Results also supported this hypothesis, Self-Compassion scores showed a strong negative relationship to CCAPS Generalized Anxiety scores prior to the start of
counseling, $r = -0.48$, $p < .001$ (See Table 6). The results suggest that individuals who have higher scores on the Self-Compassion Scale-Short Form report lower levels of Generalized Anxiety on the CCAPS at the start of therapy.

Table 6.

Correlations Between Self-Compassion and CCAPS Measures at the Start of Therapy

<table>
<thead>
<tr>
<th>CCAPS Measures</th>
<th>$r$</th>
<th>CI Low</th>
<th>CI High</th>
<th>$p$ Value</th>
<th>$df$</th>
<th>$r^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypotheses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>-0.64**</td>
<td>-0.67</td>
<td>-0.62</td>
<td>&lt;.001</td>
<td>2187</td>
<td>0.42</td>
</tr>
<tr>
<td>Anxiety</td>
<td>-0.48**</td>
<td>-0.52</td>
<td>-0.45</td>
<td>&lt;.001</td>
<td>2187</td>
<td>0.23</td>
</tr>
<tr>
<td>Research Questions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Anxiety</td>
<td>-0.57**</td>
<td>-0.60</td>
<td>-0.54</td>
<td>&lt;.001</td>
<td>2187</td>
<td>0.33</td>
</tr>
<tr>
<td>Academic Distress</td>
<td>-0.44**</td>
<td>-0.48</td>
<td>-0.41</td>
<td>&lt;.001</td>
<td>2187</td>
<td>0.20</td>
</tr>
<tr>
<td>Eating Concerns</td>
<td>-0.29**</td>
<td>-0.33</td>
<td>-0.25</td>
<td>&lt;.001</td>
<td>2187</td>
<td>0.08</td>
</tr>
<tr>
<td>Hostility</td>
<td>-0.39**</td>
<td>-0.42</td>
<td>-0.35</td>
<td>&lt;.001</td>
<td>2187</td>
<td>0.15</td>
</tr>
<tr>
<td>Alcohol Use</td>
<td>-0.09**</td>
<td>-0.13</td>
<td>-0.05</td>
<td>&lt;.001</td>
<td>2187</td>
<td>0.01</td>
</tr>
</tbody>
</table>

Note: CI stands for 95% Confidence Interval; ** indicates statistical significance where $p < 0.001$.

Hypothesis III stated there will be an inverse relationship between depression scores at intake and change in depression scores at the end of counseling. Hypothesis IV stated that there will be a direct relationship between self-compassion at intake and change in depression at termination. Hypothesis V stated that self-compassion will moderate the relationship between initial levels of depression and change in depression scores at termination such that those with higher self-compassion and high initial distress will change more than those with low self-compassion and high initial distress. To test hypotheses III, IV, and V a multilevel model was completed with pre-treatment depression scores and self-compassion scores adjusted to z scores.
Results did not support the hypotheses (see Table 7). The intercept, or the predicted post-treatment depression score for a client with average treatment duration, pre-treatment depression, self-compassion, and interactions between pre-treatment depression and self-compassion was significant ($\beta_{11} = .54$, 95% CI= .47,.62). Treatment duration did not significantly predict depression change scores ($\beta_{12} = -.001$, 95% CI=. -.002, .0004). Pre-treatment depression scores significantly predicted depression change scores ($\beta_{13} = .56$, 95% CI= .48,.64) suggesting a 1 point increase in depression change is a 1 standard deviation increase in pre-treatment depression. The greater the pre-treatment depression, the greater the change in depression at the termination of treatment. When entered into the model without initial distress, pre-treatment self-compassion scores significantly predicted depression change scores ($\beta=-.32$, 95% CI= -.40,-.24). However, when initial distress was added to the full model, the pre-treatment self-compassion effect size dropped below significance ($\beta_{14} = .03$, 95% CI= -.06,.11). The results suggest that self-compassion does not predict change above and beyond the variance that is explained by initial depression related distress. In addition, the interaction between pre-treatment depression scores and self-compassion did not significantly predict depression change scores at termination ($\beta_{15} = -.04$, 95% CI= -.10,.05).

Hypothesis VI stated there will be an inverse relationship between pre-treatment anxiety scores at intake and change in anxiety scores at the end of counseling. Hypothesis VII stated that there will be a direct relationship between self-compassion at intake and change in anxiety at termination. Hypothesis VIII stated that self-compassion will moderate the relationship between initial levels of anxiety and change in anxiety scores at termination such that those with higher
self-compassion and high initial distress will change more than those with low self-compassion and high initial distress.

To test hypotheses VI, VII, and VIII a multilevel model was completed with pre-treatment anxiety scores and self-compassion scores centered. Results did not support the hypotheses (see Table 7). The intercept, or the predicted post-treatment anxiety score for a client with average treatment duration, pre-treatment anxiety, self-compassion, and interactions between pre-treatment anxiety and self-compassion was significant ($\beta_{21} = .38, 95\% CI=.31, .46$). Treatment duration did not significantly predict anxiety change scores ($\beta_{22} = -0.001, 95\% CI=-.002,.07$).
Table 7.
Estimates of Multilevel Models Predicting Change on CCAPS Change Scores

<table>
<thead>
<tr>
<th>CCAPS Measures</th>
<th>Estimate</th>
<th>SE</th>
<th>95 % CI</th>
<th>t Value</th>
<th>Hypotheses</th>
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<tr>
<td><strong>Depression Change Model</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Intercept</td>
<td>.54*</td>
<td>.04</td>
<td>.47,.62</td>
<td>13.71*</td>
<td></td>
</tr>
<tr>
<td>Treatment Duration</td>
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<td>.005</td>
<td>-.002,.08</td>
<td>-2.77</td>
<td></td>
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<tr>
<td>Depression</td>
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<td>.04</td>
<td>.48,.64</td>
<td>13.63*</td>
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<tr>
<td>Self-compassion</td>
<td>.03</td>
<td>.04</td>
<td>-.06,.11</td>
<td>.59</td>
<td></td>
</tr>
<tr>
<td>Self-compassion × Depression</td>
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<td>.03</td>
<td>-.10,.05</td>
<td>-1.17</td>
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<td></td>
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</tr>
<tr>
<td>Intercept</td>
<td>.38*</td>
<td>.04</td>
<td>.31,.46</td>
<td>10.10*</td>
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</tr>
<tr>
<td>Treatment Duration</td>
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<td>.005</td>
<td>-.002,.07</td>
<td>-2.37</td>
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<tr>
<td>Anxiety</td>
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<td>.04</td>
<td>.33,.47</td>
<td>10.94*</td>
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<td>-.10,.04</td>
<td>-.74</td>
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<tr>
<td>Self-compassion × Anxiety</td>
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<td>.03</td>
<td>-.13,.004</td>
<td>-2.46*</td>
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<tr>
<td><strong>Social Anxiety Change Model</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td>.24*</td>
<td>.03</td>
<td>.18,.30</td>
<td>7.68*</td>
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</tr>
<tr>
<td>Social Anxiety</td>
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<td>.23,.36</td>
<td>9.00*</td>
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<tr>
<td>Self-compassion</td>
<td>.00</td>
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<td>-.06,.06</td>
<td>.01</td>
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</tr>
<tr>
<td>Self-compassion × Social Anxiety</td>
<td>-.04</td>
<td>.03</td>
<td>-.09,.02</td>
<td>-1.50</td>
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</tr>
<tr>
<td><strong>Academic Distress Change Model</strong></td>
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<td></td>
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</tr>
<tr>
<td>Intercept</td>
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<td>.07</td>
<td>.31,.59</td>
<td>6.48*</td>
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</tr>
<tr>
<td>Treatment Duration</td>
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<td>.005</td>
<td>-.002,.003</td>
<td>-2.50*</td>
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</tr>
<tr>
<td>Academic Distress</td>
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<td>.04</td>
<td>.43,.58</td>
<td>13.30*</td>
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<td>Self-compassion</td>
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<td>-.09,.07</td>
<td>-.21</td>
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<td>Self-compassion × Academic Distress</td>
<td>-.04</td>
<td>.005</td>
<td>-.10,.03</td>
<td>-1.20</td>
<td></td>
</tr>
<tr>
<td><strong>Eating Concerns Change Model</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
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<td>.04</td>
<td>-.01,.13</td>
<td>1.70</td>
<td></td>
</tr>
<tr>
<td>Eating Concerns</td>
<td>.40*</td>
<td>.03</td>
<td>.33,.46</td>
<td>11.74*</td>
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</tr>
<tr>
<td>Self-compassion</td>
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<td>.03</td>
<td>-.04,.09</td>
<td>.63</td>
<td></td>
</tr>
<tr>
<td>Self-compassion × Eating Concerns</td>
<td>-.07*</td>
<td>.03</td>
<td>-.13,.005</td>
<td>-2.22*</td>
<td></td>
</tr>
<tr>
<td><strong>Hostility Change Model</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
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<td>.03</td>
<td>.21,.33</td>
<td>8.97*</td>
<td></td>
</tr>
<tr>
<td>Hostility</td>
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<td>.03</td>
<td>.39,.49</td>
<td>17.14*</td>
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<tr>
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<td>.03</td>
<td>-.03,.07</td>
<td>.81</td>
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</tr>
<tr>
<td>Self-compassion × Hostility</td>
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<td>.02</td>
<td>-.08,.02</td>
<td>-1.45</td>
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<td><strong>Alcohol Use Change Model</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Intercept</td>
<td>.13*</td>
<td>.04</td>
<td>.06,.20</td>
<td>3.65*</td>
<td></td>
</tr>
<tr>
<td>Alcohol Use</td>
<td>.38*</td>
<td>.03</td>
<td>.33,.43</td>
<td>14.67*</td>
<td></td>
</tr>
<tr>
<td>Self-compassion</td>
<td>.00</td>
<td>.02</td>
<td>--</td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>Self-compassion × Alcohol Use</td>
<td>-.02</td>
<td>.03</td>
<td>-.07,.03</td>
<td>-.80</td>
<td></td>
</tr>
</tbody>
</table>

Note: CI stands for 95% Confidence Interval; * indicates statistical significance.
Pre-treatment anxiety scores significantly predicted anxiety change scores
\((\beta_{23} = .40, 95\% \text{ CI}= .33,.47)\) suggesting a 1-point increase in anxiety change is a 1 standard deviation increase in pre-treatment anxiety. The greater the pre-treatment anxiety, the greater the change in anxiety at the termination of treatment. When entered into the model without initial distress, pre-treatment self-compassion scores significantly predicted anxiety change scores
\((\beta=-.19, 95\% \text{ CI}=-.24,-.12)\). However, when initial anxiety distress was added to the full model, the pre-treatment self-compassion effect size dropped below significance \((\beta_{24} = -.03, 95\% \text{ CI}= -.10,.04)\). These results imply that initial levels of anxiety is a better predictor of change than self-compassion is when comparing the two. Interestingly, the interaction between pre-treatment anxiety scores and self-compassion did significantly predict anxiety change scores at termination \((\beta_{25} = -.08, 95\% \text{ CI}=-.13,-.04)\). Specifically, for individuals with high initial anxiety, lower self-compassion was associated with greater gains in therapy than participants with higher self-compassion. Conversely, for individuals with low pre-treatment anxiety, individuals who have higher self-compassion change more than participants with low self-compassion (see Figure 1).

**Research Questions**

In addition to the previously mentioned hypotheses, several exploratory research questions were put forth. The first set stated that self-compassion might be associated with the remaining CCAP measures at the start of therapy. Data supported this question. Self-compassion scores ranged in significant negative associations with CCAPS distress measures from negligible (Alcohol Use) to strong (Social Anxiety; see Table 6). Specifically, Self-Compassion scores showed a strong negative relationship to CCAP Social Anxiety scores prior to the start of counseling \((r = -.57, p < .001)\). Self-Compassion scores showed a strong negative relationship to CCAP Academic Distress scores prior to the start of counseling, \(r = -.44, p < .001\) (See Table 6).
Self-Compassion scores showed a weak negative relationship to CCAP Eating Concerns scores prior to the start of counseling, $r = -.29$, $p < .001$. Self-Compassion scores showed a moderate negative relationship to CCAP Hostility scores prior to the start of counseling, $r = -.39$, $p < .001$. Finally, self-compassion scores showed a negligible, albeit significant, negative relationship to CCAP Alcohol Use scores prior to the start of counseling, $r = -.09$, $p < .001$.

Another research question was what, if any, predictive value did initial distress levels, self-compassion, and their interaction have for the remaining CCAPS measures. Like the primary analyses, pre-treatment CCAPS levels did significantly predict CCAPS change scores, but self-compassion did not predict CCAP change at termination uniquely. Five separate multilevel models were conducted to investigate these questions.

In the social anxiety model, the intercept was significant ($\beta_{31} = .24$, 95% CI= .18,.30). Pre-treatment social anxiety scores significantly predicted social anxiety change scores ($\beta_{32} = .29$, 95% CI= .23,.36) suggesting that the greater the pre-treatment social anxiety, the greater the change in social anxiety at the termination of treatment. In a similar fashion to the primary analysis models of depression and anxiety, pre-treatment self-compassion scores were only significantly predictive of social anxiety change when initial distress levels of social anxiety were not entered into the model ($\beta = -.14$, 95% CI= -.19,-.08). When social anxiety initial distress scores were added to the model, self-compassion did not significantly predict social anxiety change scores at termination ($\beta_{33} = .00$, 95% CI= -.06,.06). In addition, the interaction between pre-treatment social anxiety scores and self-compassion did not significantly predict social anxiety change scores at termination ($\beta_{34} = -.04$, 95% CI= -.09,.02).

In the academic distress model, the intercept was significant ($\beta_{41} = .45$, 95% CI= .31,.59). Treatment Duration was also statistically significant, albeit with an extremely small
effect size ($\beta_{42} = -0.001, 95\% \text{ CI} = 0.002, -0.003$). Pre-treatment academic distress scores significantly predicted academic distress change scores ($\beta_{43} = 0.50, 95\% \text{ CI} = 0.43, 0.58$). The greater the pre-treatment academic distress, the greater the change in academic distress at the termination of treatment. Also like previous models, pre-treatment self-compassion scores went from being significant ($\beta = -0.18, 95\% \text{ CI} = -0.27, -0.10$) when initial distress levels were not added to the model, and then dropping to non-significance when they were added ($\beta_{44} = -0.01, 95\% \text{ CI} = -0.09, 0.07$). In addition, the interaction between pre-treatment academic distress scores and self-compassion did not significantly predict academic distress change scores at termination ($\beta_{45} = -0.04, 95\% \text{ CI} = -0.10, 0.04$).

In the eating concerns model, the intercept was not significant ($\beta_{51} = 0.06, 95\% \text{ CI} = -0.01, 0.13$). However, pre-treatment eating concerns scores significantly predicted eating concerns change scores ($\beta_{52} = 0.40, 95\% \text{ CI} = 0.33, 0.46$) suggesting a 1 point increase in eating concerns change is a 1 standard deviation increase in pre-treatment eating concerns. The greater the pre-treatment eating concerns, the greater the change in eating concerns at the termination of treatment. Pre-treatment self-compassion scores did not significantly predict eating concerns change scores at termination ($\beta_{53} = 0.02, 95\% \text{ CI} = -0.04, 0.09$) when initial distress scores were included in the model, but they did have a small but significant effect size when initial distress scores were left out of the model ($\beta = -0.08, 95\% \text{ CI} = -0.15, -0.01$). The interaction between pre-treatment eating concerns scores and self-compassion did significantly predict eating concerns change scores at termination ($\beta_{54} = -0.07, 95\% \text{ CI} = -0.13, -0.05$). Interestingly, like generalized anxiety, self-compassion significantly interacted with pre-treatment eating concerns in predicting eating concerns change. Specifically, for individuals with high initial eating concerns, lower self-compassion was associated with greater gains in therapy than participants with higher self-
compasion. Conversely, for individuals with low pre-treatment eating concerns, individuals who have higher self-compassion change more than participants with low self-compassion (see Figure 2).

In the hostility model, the intercept was significant ($\beta_{61} = .27$, 95% CI= .21,.33). Pre-treatment hostility scores significantly predicted hostility change scores ($\beta_{62} = .38$, 95% CI= .33,.43) suggesting a 1 point increase in hostility change is a 1 standard deviation increase in pre-treatment hostility. The greater the pre-treatment hostility, the greater the change in hostility at the termination of treatment. In the self-compassion only model, like previous models, self-compassion significantly predicted hostility change scores ($\beta = -.13$, 95% CI= -.19,.07). However, when initial hostility scores were entered into the model. Pre-treatment self-

Figure 2. Interaction Between Initial Anxiety and Self-Compassion Predicting Eating Concern Change in Psychotherapy
compassion scores did not significantly predict hostility change scores at termination ($\beta_{63} = 0$, 95% CI= 0,0). In addition, the interaction between pre-treatment hostility scores and self-compassion did not significantly predict hostility change scores at termination ($\beta_{64} = -.03$, 95% CI= -.08,.02).

In the alcohol use model, the intercept was significant ($\beta_{71} = .13$, 95% CI= .06,.20). Pre-treatment alcohol use scores significantly predicted alcohol use change scores ($\beta_{72} = .44$, 95% CI= .39,.49) suggesting the greater the pre-treatment alcohol use, the greater the change in alcohol use at the termination of treatment. Pre-treatment self-compassion scores did not significantly predict alcohol use change scores at termination either in the self-compassion only model ($\beta = -.04$, 95% CI= -.09,.02) or in the full model ($\beta_{73} = .02$, 95% CI= -.03,.07). In addition, the interaction between pre-treatment alcohol use scores and self-compassion did not significantly predict alcohol use change scores at termination ($\beta_{74} = -.02$, 95% CI= -.07,.03).

Results will be discussed in the context of the literature in the following section. In addition, theoretical, clinical, and research implications will be discussed in the next section. Finally, limitations of the current research, and future directions will be expounded on.
Chapter 5: Discussion

Reintegration with the Literature

College counseling centers are tasked with helping prevent and reduce students’ problems that interfere with academic functioning (Sharkin, 2004). Psychological distress in college students can affect academic functioning (Brackney & Karabenick, 1995). In addition, students and clinicians both report that depression and anxiety are the most commonly diagnosed and treated psychopathologies in a given year (American College Health Association, 2013; CCMH, 2014) suggesting that further understanding the constructs relevant to treatment of depression and anxiety is necessary.

In this study, CCAPS measures at intake were, on average, mostly observed to be above the empirically established cut points to identify sub-clinical from clinical populations (CCMH, 2012b). CCAPS Depression scores were just below the higher cut point that indicates significant distress and suggest a possible diagnosis (CCMH, 2012b). Generalized Anxiety, Social anxiety, Academic Distress, and Hostility measures were all generally in the middle of the lower and higher cut points. Alcohol Use was bordering just above the low cut point, and Eating Concerns was the only measure in this sample to, on average, score just below the lower cut point. This indicates sub-clinical Eating Concern levels of distress in this sample (see Table 1; CCMH, 2012b).

Change scores, created by subtracting pre-treatment CCAPS measures from end of treatment CCAPS measures, were all in the expected direction with, on average, less distress reported at the end of treatment. However, most measures remained above the clinical cut point at the end of treatment including Depression, Generalized Anxiety, Social Anxiety, and Academic Distress. Hostility and Alcohol Use dropped into the sub-clinical range at the end of treatment.
Finally, Eating Concerns did also drop by the end of treatment and so they remained in the sub-clinical range (see Table 1).

The tasks of college counseling centers, and the clinical presentations of students seeking help in them, highlight the need for college counseling centers to identify factors that contribute to students’ well-being, and prevent and reduce student psychological distress. This investigation asked whether self-compassion could fit this need. Self-compassion is a positive self-attitude whose components include mindfulness, self-kindness, and connecting with a sense of human suffering (Neff, 2003a). These components are thought to fight against factors that contribute to the development and maintenance of psychopathology like depression and anxiety (Barlow, 2007; Bishop et al., 2004; Castonguay & Oltmanns, 2013; Clark & Beck, 2009; Davis & Hayes, 2011; Hallion & Ruscio, 2011; Leary et al., 2007; McLaughlin & Nolen-Hoeksema, 2011; Neff, 2003a, 2012; Yalom, 1995; Young et al., 2007).

Although not a lot of research has been conducted on college clinical populations (Lockard et al., in press), self-compassion has garnered considerable attention in research on healthy college students (Crocker & Canevello, 2008; Neff et al., 2005; Neff, Kirkpatrick, et al., 2007; Neff & McGehee, 2010; Neff & Pommier, 2013) and in clinical adult populations (Adams & Leary, 2007; Brooks et al., 2012; Kelly et al., 2010; MacBeth & Gumley, 2012; Van Dam et al., 2011; Werner et al., 2012). In both healthy and clinical samples, self-compassion is associated with less psychological distress and greater well-being (MacBeth & Gumley, 2012; Neff, 2003a, 2011; Neff et al., 2005; Neff & McGehee, 2010; Neff, Rude, et al., 2007; Van Dam et al., 2011; Werner et al., 2012; Yarnell & Neff, 2013).

Self-compassion was significantly associated with CCAPS measure pre-treatment as hypothesized. Higher self-compassion was associated with less distress and psychopathology in
general. This is consistent with previous research that has found a significant inverse relationship between self-compassion and distress measures of anxiety and depression (Lockard et al., in press; MacBeth & Gumley, 2012; Neff et al., 2005; Neff, Kirkpatrick, et al., 2007; Van Dam et al., 2011; Werner et al., 2012). In this sample specifically, hypotheses I and II were supported. Self-compassion had a significant and inverse relationship with pre-treatment CCAPS Depression and Generalized Anxiety. In addition, pre-treatment CCAPS Social Anxiety, Academic Distress, Eating Concerns, Hostility, and Alcohol Use were also significantly and inversely related self-compassion. In summary, higher self-compassion is significantly associated with less psychological distress across all CCAPS measure at the start of therapy. Having self-compassion is a psychological trait associated with greater well-being in college students (see Table 6).

To further the self-compassion literature, an aim of this investigation was to examine the potential impact self-compassion has on the psychotherapy process. Previous research has indicated that client traits can be related to outcome in psychotherapy (Bohart & Wade, 2013). Self-compassion is associated with the factors that fight the maintenance of psychopathology and is generally thought of as facilitating an approach orientation to individual’s problems (Neff, 2012). It was therefore hypothesized that self-compassion might facilitate greater gains in psychotherapy. In addition, previous research had identified initial levels of functioning as an important client characteristic predictive of client outcomes in psychotherapy, such that lower levels of functioning at intake were predictive of less change in psychotherapy (Beutler et al., 2006; Newman et al., 2006). It was therefore also hypothesized that initial distress levels would be associated with less change in therapy.
Initial distress levels were significantly associated with depression and anxiety change scores in therapy, but in the opposite direction than expected. Higher levels of distress at the start of treatment was associated with greater change at the end of treatment. Although this is counter to research suggesting that pre-treatment functional impairment would be negatively associated with change in therapy (Beutler et al., 2006; Newman et al., 2006), other research has found effects similar to the ones observed in this study. In a large psychotherapy study, researchers found that pre-treatment functioning was significantly related to change, such that higher levels of initial distress was associated with greater change at the end of treatment (Lambert et al., 2001). It is possible that functional impairment and pre-treatment functioning are measuring different constructs as they relate to psychotherapy. In addition, although self-compassion was significantly related to change at the end of therapy in the expected direction, when initial distress levels were added to the model, it better accounted for the variance of change scores. The same effect was found in the remaining CCAPS measures explored in this study; except for alcohol use which self-compassion was unrelated to in even the reduced parameters model.

In this study, self-compassion was only significantly predictive of depression and anxiety change in the reduced parameters model that did not include initial distress. However, even in the reduced parameters models, the direction of the effect was in the unexpected direction. Higher pre-treatment self-compassion was associated with less change in psychotherapy, not more. The association between self-compassion and changes scores dropped to below significance when initial distress was added in the full model. Self-compassion did not predict distress change above and beyond the variance that was accounted for by initial distress levels. The same effect was observed for the majority of the remaining CCAPS change models where self-compassion predicted change scores only when initial distress was left out of the models. The only model that
did not suggest this pattern of effects was alcohol use, where even in the reduced parameters model, self-compassion did not predict change scores.

In general, these results suggest that the individuals who were the most distressed and the least self-compassionate, were the individuals who changed most in therapy. In a sense, this is hopeful, those that need therapy the most, benefit the most from participating in it. They enter therapy with plenty of room to grow as individuals, and therapy seems to be an effective mechanism to facilitate personal gains and increase functioning across a broad array of presenting concerns. Since self-compassion is highly correlated with measures of distress, it might be that participants who entered therapy with high self-compassion had less room to go higher so less change can occur. It is possible that clients are being taught and modeled self-compassion in therapy. Clients who enter therapy with low self-compassion may be developing it throughout the therapy process and it might be corresponding to the gains that were observed with lower distress levels at the termination of therapy. Future research that could model changes in self-compassion in psychotherapy would be able to study this important question.

Lastly, there were only two distress measures (generalized anxiety and eating concerns) that had a significant interaction with self-compassion on predicting change in therapy. In both cases, self-compassion at high levels of distress was associated with less change. Conversely, self-compassion was associated with more change in individuals experiencing lower levels of distress. This is interesting in a few ways. For example, like previously stated, for those who need the therapy the most (i.e., individuals with high distress and low self-compassion) benefit the most from therapy. However, at low levels of distress, self-compassion seems to facilitate gains in therapy. There are several possible explanations to these interaction findings. It could be that having an approach orientation, a positive self-attitude, and a sense of connection to others
in their suffering allows individuals to take better advantage of the work the psychotherapy offers them even when they aren’t as motivated by personal suffering. Another possibility is that self-compassion is helpful if you “worry well,” but becomes less useful as you hit clinical levels of distress in a curvilinear fashion. An alternate explanation is that if one has high self-compassion and still has high levels of distress, then the psychological problems they are experiencing may be more severe than others’ concerns. Carefully designed future research could tease out the differences between the possible scenarios presented here.

**Limitations**

The sample in this study was representative of college students seeking help in college counseling centers. Therefore, the inferences drawn from this study should be limited to individuals seeking counseling from college campuses. Generalizations outside the parameters of this sample should be made cautiously. Another limitation of the current study was having a single point of observation for self-compassion at the start of therapy. In addition, CCAPS measures were only observed at two time points in this sample; pre-treatment, and at the end of treatment. As a result, this study has no information about self-compassion change in psychotherapy, and has limited information about nuances in the change observed for distress measures during the course psychotherapy. Having more observations of self-compassion and CCAPS measures throughout the course of therapy would be helpful in understanding how self-compassion and distress operate and influence each other through the psychotherapy process. Additionally, although treatment duration was accounted for as a covariate, number of sessions might be a better indicator of treatment length. For example, treatment duration tells us no information about how much of a dose of psychotherapy clients had. Some clients could have had 4 sessions in 30 days while other clients could have had 2 sessions in 200 days. Greater
specificity is required to make clearer inferences about the relationship amount of therapy has with study variables.

**Theoretical Implications**

In line with the theory of self-compassion, self-compassion scores were consistent with another clinical college sample (Lockard et al., in press) and were lower than those observed in non-clinical populations (Neff, 2003a). In addition, all the CCAPS measures of distress observed, except eating concerns, were consistent with clinical presentations of distress (CCMH, 2012b). The results of this investigation lend further support to previous research findings that found a significant associations between self-compassion and measures of distress (MacBeth & Gumley, 2012; Neff, 2012; Van Dam et al., 2011), and specifically in college students (Neff, 2003a; Neff et al., 2005; Neff, Kirkpatrick, et al., 2007; Neff & McGehee, 2010; Neff & Pommier, 2013; Yarnell & Neff, 2013) where higher self-compassion is associated with less psychological distress.

This study contributed to the extension of the self-compassion literature by examining the impact self-compassion, as a client trait, had on psychotherapy outcomes. The results suggest that self-compassion at intake did not predict psychotherapy outcomes *above and beyond* the variance it shares with initial distress levels. However, it is important to note that in every model except the alcohol use outcome model, self-compassion was a significant predictor of change without initial distress levels added into the models. Further research is needed to determine the intricate interplay self-compassion and psychological distress have throughout the course of psychotherapy.

Self-compassion was significantly associated with alcohol use at intake, but the effect size was extremely small. Other research has found that self-compassion is unrelated to
problematic drinking and it was suggested that this might be because alcohol dependent people sometimes consider drinking as “taking care of myself,” and therefore along the lines of being self-compassionate (Brooks et al., 2012). This research also found that changes in the SCS subscales of isolation and self-kindness were respectively positively and inversely associated with reduced drinking over a 15 week course (Brooks et al., 2012). Since self-compassion was only measured at intake in this study, a similar effect may be at play. This is especially true in college populations where heavy drinking is considered normal and positive by students. A question this interpretation raises is whether the self-compassion construct is being measured accurately in the SCS-SF. For example, Neff (2003b) states that self-compassion is not a way for people to make excuses for their behavior but rather a way for people look closely at their failings, with kindness and curiosity and to be responsible for their role in growth and better behavior in the future. That is a very nuanced point on the self-compassion construct that may not be accurately captured in the 12-item SCS-SF.

Although the self-compassion results in the full models were null, it still helps shape the self-compassion literature to be more specific with what it is, and is not, associated with. Interestingly, self-compassion did have an interaction effect with initial distress on outcomes in the generalized anxiety and eating concern models. This suggests that although there is more “room for change” in participants with less self-compassion and greater distress, at low levels of distress, self-compassion was associated with more change. Perhaps this indicates that people, who present with less distress, can get more out of therapy because they have more self-compassion.

Research suggests that self-compassion in individuals who are clinically depressed is negatively associated with depression symptoms, illness-focused ruminations, as well as
cognitive and behavioral avoidance (Krieger, Altenstein, Baettig, Doerig, & Holtforth, 2013). However, individuals struggling with clinical levels of depression and anxiety both feel like self-compassion is important, and that it is something they want, but also something that they feel is difficult to enact (Pauley & McPherson, 2010). Targeted self-compassion interventions in non-clinical participants is associated with elevated self-compassion and decreased depression and anxiety post treatment and in follow ups (Neff & Germer, 2013), but no research to date has studied the effect of self-compassion targeted interventions in clinical populations. More research is needed to understand how self-compassion operates in clinical populations.

**Future Research Directions**

Although self-compassion for the most part was found to not impact psychotherapy outcomes in this study above initial distress levels, future efforts to understand self-compassion in the context of therapy are important. Repeated measures of self-compassion and distress could tease out the longitudinal interaction of self-compassion growth curves and distress growth curves. This would further elucidate the nuances of these measures in the psychotherapy process.

Although not in traditional psychotherapy settings, some research has found that targeting self-compassion in interventions leads to better outcomes in contexts such as smoking cessation (Kelly et al., 2010), eating concerns (Adams & Leary, 2007), and in a self-compassion specific clinical trial of non-clinical adults (Neff & Germer, 2013). Research is needed to investigate whether a targeted focus on self-compassion by therapists, or even passive development of self-compassion through modeling by therapists during therapy might lead to clinically useful results. In addition, research should investigate whether the utility of self-compassion has a ceiling effect in working with clinical levels of distress. In other words, in severely distressed individuals, does focusing on self-compassion have similar benefits to those documented in non-clinical samples?
Given that self-compassion is associated with measures of wellness and reduced distress, does the development of it during psychotherapy result in reduced relapse? Is it a useful tool to develop resilience in clients for future stressors?

Another question is whether or not self-compassion has benefit for specific populations of clients within the severely distressed group. For example, is self-compassion helpful in clients who struggle with suicidal ideation? Or might it help discriminate between suicidal clients and non-suicidal clients in highly depressed individuals?

Finally, we know that psychological distress is related to academic functioning (Brackney & Karabenick, 1995), and that self-compassion was associated with less academic distress in this sample. We also know that counseling centers are helpful in alleviating academic distress (Lockard et al., 2012), increasing student’s academic commitment (Choi et al., 2010), and improving student retention in colleges (Lee et al., 2009; Turner & Berry, 2000; Wilson et al., 1997). It would be useful to understand what, if any, relationship self-compassion has with these important college counseling center outcomes (Sharkin, 2004). For example, we know that college counseling is associated with a reduction of academic distress (Lockard et al., 2012), and from this study and others (Lockard et al., in press) that having self-compassion is associated with less academic distress and better academically related coping (Neely et al., 2009; Neff et al., 2005; Williams et al., 2008). Future research is needed to explore whether targeted interventions on student’s self-compassion can translate into better academic functioning and retention.

**Implications for Clinical Practice**

There are a few things that clinicians can take away from this study. First, self-compassion is associated with less distress in a college counseling setting. Counseling center clients in this sample were largely consistent with clinical populations as identified in the
CCAPS manual (CCMH, 2012a). In addition, clients high in distress are likely to change more in therapy than those with low distress. However, self-compassion at the start of treatment does not seem to be related to changes made by clients at the end of treatment. This does not mean therapists should not target self-compassion in psychotherapy as there is a shared variance between self-compassion and measures of distress, such that increasing one’s self-compassion might mean decreases in distress. This is consistent with the few studies that have targeted self-compassion in a therapeutic context (Adams & Leary, 2007; Kelly et al., 2010; Neff & Germer, 2013). It is possible that self-compassion is being taught or modeled in therapy so those who start lower in self-compassion develop more throughout the process. In addition, previous research has indicated that self-compassion can help in a variety of student related contexts including resilience from a bad test experience (Neff et al., 2005), intervening in procrastination behaviors (Williams et al., 2008), increasing social support from families and friends (Neff & Pommier, 2013; Werner et al., 2012; Yarnell & Neff, 2013), and generally promoting wellness and adaptive functioning (Neely et al., 2009; Neff, Kirkpatrick, et al., 2007; Neff, Rude, et al., 2007; Yarnell & Neff, 2013).

Conclusions

Counseling centers are tasked with reducing problems that interfere with student functioning, and support academic functioning, commitment, and retention (Sharkin, 2004; Sharkin & Coulter, 2005). Over the last two decades, there has been an increasing focus on positive interventions that not only help remediate psychopathology, but also increase functioning (Fredrickson, 2001; Fredrickson et al., 2008; Fredrickson & Joiner, 2002; Garland et al., 2010; Seligman, 2012). Self-compassion is a psychological characteristic that has gained recent empirical attention for its potential as such a factor, and one that fits into the well-
established mindfulness literature (Neff, 2012). This investigation examined whether self-compassion was associated with less distress and whether or not it impacted college counseling outcomes. Self-compassion was related to client CCAPS scores on depression, generalized anxiety, social anxiety, eating concerns, hostility, and alcohol use. However, self-compassion was not predictive of change on the CCAPS distress scales at the end of therapy above the shared variance with initial distress levels. However, anxiety and eating concerns interacted with self-compassion in predicting anxiety and eating concern change in therapy suggesting that at lower levels of distress, self-compassion may be helpful in facilitating gains in therapy. More research is needed to examine the potential impact self-compassion has on college counseling center psychotherapy, and whether targeted interventions for building self-compassion during therapy would be useful in a college counseling center context.
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