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Variations in self-compassion among a chronically mentally ill population

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VARIATIONS IN SELF-COMPASSION AMONG A CHRONICALLY MENTALLY
ILL POPULATION

Thesis

Submitted to

The Graduate School of the
UNIVERSITY OF DAYTON

In Partial Fulfillment of the Requirements for

The Degree

Master of Arts in Clinical Psychology

By

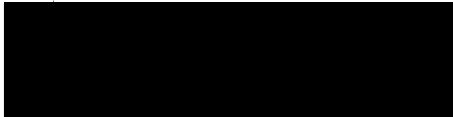
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UNIVERSITY OF DAYTON

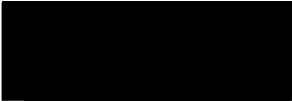
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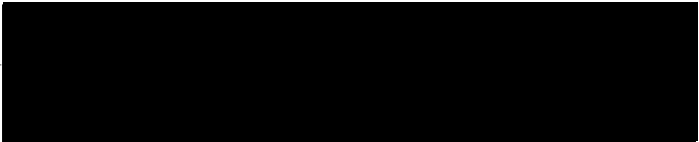
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ABSTRACT

VARIATIONS IN SELF-COMPASSION AMONG A CHRONICALLY MENTALLY ILL POPULATION

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This study examined variations in self-compassion across a clinical population; specifically, how self-compassion related to dispositional affect and mood disorders, narcissistic or borderline personality traits, and global assessment of functioning scores. Those with self-compassion do not dismiss pain and suffering, instead they experience it, attempt to understand it, and relive it to increase well-being. They accept their limitations and imperfections realizing that many others experience similar feelings and difficulties (Neff, 2004b). Participants consisted of 64 clients and 9 staff (who served as a non-disorder control group) from a local community mental health services agency. Each client was placed in a group based on their primary diagnosis: mood disorders, consisting of 28 participants, and non-mood disorders, consisting of 27 participants. The study found that self-compassion positively correlated with positive affect and inversely correlated with negative affect, and self-compassion scores were significantly lower in participants with mood disorders than participants with non-mood disorders. When controlling for positive and negative affect, self-compassion scores remained significantly lower in those with mood disorders. Self-compassion positively correlated with narcissistic traits and inversely correlated with borderline personality traits. There

was no relation between self-compassion scores and Global Assessment of Functioning. This study has expanded the research on self-compassion into a new, clinical, population. The findings suggest that diagnosable affect states as well as narcissistic and borderline traits are related to one's level of self-compassion, but self-compassion does not seem to be related to one's level of functioning.

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CHAPTER ONE

INTRODUCTION

Positive psychology is a growing movement in the field of psychology and in society generally (Seligman & Csikszentmihalyi, 2000). One of the newer topics of positive psychology is self-compassion. Self-compassion is fundamentally the same as compassion, but instead having compassionate feelings towards others, the feelings are expressed toward oneself (Neff, 2003b). However, little is known about self-compassion, and no one has examined self-compassion in a clinical population. Contrary to the general population, individuals with severe and chronic mental illness have many symptoms (e.g. depression, anxiety and isolation) that may deter them from experiencing healthy levels of self-compassion—and indeed low levels of self-compassion may exacerbate mental illness. By examining self-compassion in the severely and chronically mentally ill population, we bring together positive psychology, which focuses on human strengths, with some of the more undesirable aspects of psychological functioning. In addition, not only is new information gathered concerning self-compassion itself, but more information is also gained that may allow for professionals to assist the mentally ill more efficiently in treatment, recovery, and maintenance of a healthy lifestyle.

This study examined variations in self-compassion across a severely and chronically mentally ill population. Specifically, the following questions were addressed: (1) How does self-compassion relate to dispositional affect and mood disorders? (2) Does

self-compassion relate to narcissistic or borderline personality traits? (3) Does one's global assessment of functioning relate to their level of self-compassion?

The review of literature will be organized in the following manner. First, the general conceptualization of self-compassion will be presented. Second, research relating to self-compassion and mental illness will be reviewed. Third, the relation between self-compassion and global assessment of functioning will be examined.

Self-Compassion

The concept and measure of self-compassion is based on Buddhist principles of psychological health in general and of self-understanding in particular—a stance that places primary importance on compassion. Self-compassion is fundamentally the same as compassion, but instead of compassionate feelings towards others, the focus is on feelings expressed toward oneself. Individuals with self-compassion do not dismiss their pain and suffering but instead attempt to experience and understand it. They strive to relieve pain and improve their well-being. Individuals with self-compassion accept their limitations and imperfections instead of harshly judging themselves. These individuals realize that they are not alone and that others have experienced similar difficulties and feelings. Self-compassion consists of three main components. It involves a sense of common humanity, or recognizing that pain and failures are unavoidable aspects of the shared human experience instead of seeing them as isolating. Also, it involves self-kindness, or being kind and understanding toward oneself in instances of suffering and perceived inadequacy instead of harsh judgment. Lastly, it entails mindfulness, or being able to face painful thoughts and feelings without exaggeration or self-pity (Neff, 2003b).

Each of these three main components of self-compassion has opposing characteristics. When one lacks feelings of common humanity he or she tends to be isolative, isolation. When one lacks self-kindness he or she tends to be overly harsh and judgmental, self-judgment. Lastly, when one is not mindful he or she tends to exaggerate feelings of worthlessness and self-pity, over-identification (Neff, 2003a).

These aspects of self-compassion are conceptually distinct and are experienced differently by each individual, but they also interact to mutually augment and stimulate one another. Self-kindness and common humanity can increase mindfulness. If one stops judging themselves he or she is better able to experience some degree of self-acceptance, leading to a more balanced awareness of thoughts and feelings. Similarly, by remembering that suffering and failure are things that everyone experiences one decreases the likelihood of over-identifying with these thoughts and feelings, enhancing mindfulness. A certain degree of mindfulness is needed in order for one to place enough emotional distance from one's negative experiences to allow the feeling of self-kindness and common humanity. Mindfulness decreases self-criticism and increases understanding because of its nonjudgmental and detached stance which increases self-kindness. Also, with a more balanced perspective of mindfulness, feelings of isolation and separation decrease leading to a greater feeling of interconnectedness. Common humanity and self-kindness interact as well. Kindness toward oneself decreases self-judgment which allows for feelings of interconnectedness, and realizing that personal failures are universal lessens the amount of blame placed on oneself (Neff, 2003b).

Self-Compassion and Healthy Psychological Functioning

Much of the research on self-compassion has focused on healthy psychological functioning. Neff, Rude, and Kirkpatrick (2007) examined self-compassion in relation to positive psychological functioning. They found that those with higher levels of self-compassion were significantly happier, had a more optimistic mindset, and seemed to grow, explore, and understand oneself with greater ease. They found that reflective wisdom strongly and affective wisdom modestly correlated with self-compassion.

In a validation study Neff (2003a) found those with higher self-compassion scores were significantly better at emotional processing and coping, while those with low self-compassion scores ruminated and thought suppressed. Neff, Kirkpatrick, and Dejitthirat (2004) found self-compassion was positively correlated with positive-focused coping strategies.

When examining academic achievement, Neff, Hseih, and Dijitthirat (2005) found that self-compassion positively correlated to mastery goals and negatively correlated with performance goals. Mastery goals are those that focus on learning for the enjoyment and sake of learning. Performance goals focus on maintaining or enhancing self-worth. These relations were mediated by a greater perceived competence and lesser fear of failure by those with self-compassion. In addition, it was found that those with higher self-compassion scores utilized higher levels of emotion-focused coping strategies of positive reinterpretation/growth and acceptance. These results suggest that more self-compassion a student has, the greater the emotional resiliency in the face of failures. These individuals are more likely to adopt more productive and healthier learning styles in the classroom.

Self-Compassion Versus Self-Esteem

In western culture, psychologically healthy self-attitudes are most often associated with high self-esteem. Self-esteem is the experience of positive feelings about oneself and the belief that one is valued and viewed in a good light by others (Leary & McDonald, 2003). Emphasis on increasing and maintaining high levels of self-esteem have been repeatedly pushed for in both the popular press and academia (Hewitt, 1998; Steinem, 1992), but recently such strong promotion of self-esteem has been criticized (Damon, 1995; Seligman, 1995). One of the major criticisms is that self-esteem seems to be very difficult to raise (Swann, 1996). For those who have high self-esteem come disadvantages as well. Because self-esteem is associated with the belief that one is valued and viewed in a positive light by others, those with high self-esteem may maintain altered perceptions of him or herself and must constantly strive to be above average. This continued focus on the self can lead to such things as narcissism, self-centeredness, and self-obsession (Baumeister, Bushman, & Campbell, 2000).

Neff argues that self-compassion, on the other hand, is not based on direct comparisons to others. Theoretically, since self-compassion involves being kind and compassionate toward oneself purely because one is human, one should have no need to compare him or herself to others to feel better. For this reason there should be no relation between self-compassion and social comparisons or narcissism. In addition, unlike self-esteem, self-compassion should be less difficult to raise because there is no need to alter one's perception of self and constantly be above average (Neff, 2004). Instead, self-compassion allows for the recognition of short-comings. Because self-compassion involves caring for and desiring the best for the self and others, self-compassion may

facilitate attempts to modify such shortcomings (Neff, Kirkpatrick & Rude, 2007). When change is possible, self-compassion should motivate an individual because of the desire to enhance well-being, not out of need to improve self-worth (Neff, 2004).

Although they are not the same construct, self-compassion and self-esteem have been found to be significantly related in a number of studies (Neff, 2003; Neff, Kirkpatrick, & Rude, 2007). However, self-compassion does not seem to be merely a derivative of self-esteem; instead, it seems that self-esteem is a derivative of self-compassion. Leary, Tate, Adams, Allen, and Hancock (2007) conducted a study examining self-compassion, self-esteem, and narcissism among 123 college students. They also read three hypothetical scenarios that involved getting a poor grade on an important test, being responsible for losing an athletic competition, and forgetting their role while performing on stage causing the performance to come to a grinding halt. After reading each scenario participants were asked to rank the likelihood of how good or bad they felt about what happened, how they would react, and how likely they would think certain thoughts. Self-compassion significantly related to measures of emotional, cognitive, and behavioral reactivity independently of self-esteem. When self-compassion and self-esteem were entered into a simultaneous regression analysis it was found that self-compassion accounted for unique variance of the outcome variables, but self-esteem did not. Had the researchers not measured self-compassion, and only self-esteem, they would have likely attributed their results to self-esteem. With these findings the researchers proposed that many underlying factors previously identified under self-esteem research may actually be a function of self-compassion rather than self-esteem.

Self-Compassion and Mental Illness

To date, self-compassion literature has remained focused on positive characteristics such as happiness, optimism, coping, and academic achievement of those in the normal population. Little has focused on less positive aspects of one's character, which may be more salient in those with severe and chronic mental illness. To address this issue the researcher expanded the literature reviewed to similar constructs measured to date: affect and self-compassion, affect variation in those clinically diagnosed, narcissism and self-compassion, and self-esteem and narcissistic and borderline traits.

Self-Compassion, Affect, and Mood Disorders

No self-compassion research has been conducted on those with clinical disorders, and in particular, mood disorders. The closest phenomenon to mood disorders examined in past self-compassion research is positive and negative affect. Positive affect describes an individual's tendency to experience positive moods, such as cheerfulness or pleasure, across a variety of situations. Negative affect describes the individual's tendency to experience negative moods, such as distress, anger, or irritability over time and across situations (Barsade & Gibson, 2007). Variations and extremes in positive and/or negative affect is the predominant feature in mood disorders. The criteria for most mood disorders require a presence or absence of a mood episode of mania, hypomania, or depression. During mania and hypomania individuals have an abnormally and persistently elevated or positive, irritable, and expansive mood. These individuals may have inflated self-esteem, decreased need for sleep, and may be more talkative than usual. They may become easily distracted and excessively take part in pleasurable activities that may have high potential for negative consequences. The major difference between hypomania and mania is the

level of impairment. Hypomania is not severe enough to cause marked impairment in social or occupational functioning, does not require hospitalization, and individuals do not experience psychotic features. Mania, on the other hand, significantly impairs occupational and social functioning, may require hospitalization, and there may be psychotic features. On the other side of the spectrum is a major depressive episode. A major depressive episode lasts at least a period of two weeks during which an individual either experiences a depressed mood, increased negative affect, or loss of interest or pleasure in nearly all activities. In addition, individuals in a major depressive episode may have significant weight gain or loss, need a large amount of sleep or not be able to sleep, and may have a difficult time concentrating. They may lack energy, have excessive feelings of guilt or worthlessness and thinks often of death. Their symptoms cause significant distress or impairment in social and occupational areas. Mood disorders which involve at least one of these episodes include: Major Depressive Disorder, Dysthymic Disorder, Bipolar I/II, and Mood or Depressive Disorder Not Otherwise Specified (American Psychological Association, 1994). This section begins with research that directly examined self-compassion in relation to mood research followed by related mood research.

Previous findings on self-compassion and affect. Although research is very limited, past relations between self-compassion and positive and negative affect, as well as mood states, have been found. Neff, Rude, and Kirkpatrick (2007) conducted an examination of the relation of self-compassion to positive psychological functioning and the five factor model personality traits. Using 177 undergraduate participants (32% male,

68% female), the study found that, in general, those with higher self-compassion scores experienced significantly more positive and less negative mood.

Neff, Kirkpatrick, and Rude (2007) conducted a study on adaptive psychological functioning to examine whether changes in self-compassion was correlated with changes in well-being. Forty undergraduate students (2 male, 38 female) were told they were actually participating in two studies: one that measured self-compassion over a month interval and another that examined conflict resolution. Results indicated that the participants who experienced an increase in self-compassion also experienced increased social connectedness and decreased anxiety and depression.

A series of studies conducted by Neff (2003a) to validate the Self-Compassion Scale found similar results. Depression and anxiety were significantly inversely correlated with levels of self-compassion.

Affect in those clinically diagnosed. Research on affect and clinical diagnoses has not directly examined self-compassion. However, the groundwork has been set for the empirical examination of self-compassion and those clinically diagnosed since self-compassion has been linked to increased positive affect and decreased negative affect, and inversely related to anxiety and depression among normal populations.

Hoffmann and Meyer (2006) conducted a study on mood fluctuations in individuals at risk for developing Bipolar Disorder. The Hypomanic Personality Scale was used as a risk indicator. High scorers had more fluctuations on both positive and negative affect, and had higher levels of manic symptoms and negative affect. Those with more hypomanic temperament reported higher levels of positive affect.

When examining positive trait affect, Loverjoy and Steuerwald (1995) found that individuals with intermittent depression had significantly lower scores than individuals with no affect disorder. Negative trait affect was significantly higher in the intermittent depressed group than in those with no affect disorder.

Peeters, Nicolson, Berkhof, Delespaul, and Devries (2003) conducted a study examining the interplay between minor events and mood states in individuals suffering from Major Depressive Disorder. They found that baseline negative affect levels were higher and baseline positive affect levels were lower in the depressed participants. More specifically, negative affect levels were significantly higher the more severe the depression and the longer the depressive episode.

Blanchard, Horan, and Brown (2001) conducted a longitudinal study of positive and negative affect in Major Depressive Disorder and Schizophrenia. At baseline, schizophrenics and depressed patients had lower positive trait affect and higher trait negative affect than the control subjects. In addition, patients with depression had less positive trait affect and greater negative trait affect than their schizophrenic counterparts. At a one year follow-up both groups had decreased affect disturbance. Depressed patients had recognizably higher levels of affect intensity across both assessments.

Another study examined emotional reactivity in participants with non-affective psychosis, Bipolar Disorder, and Major Depressive Disorder. Individuals with Major Depressive Disorder in a current episode of depression reported significantly higher levels of negative affect and lower levels of positive affect than any of the other groups. Non-affective psychotic individuals also reported higher negative affect and lower positive affect than the control group. Lastly, participants with Bipolar Disorder had no

significant differences in negative affect levels from the control group but did report lower levels of positive affect (Mylin-Germeys, Peeters, Havermans, Nicolson, DeVries, Delespaul, & VanOs, 2003).

In general, these findings show that those with depression or similar disorders tend to have higher levels of negative affect and lower levels of positive affect than those without. These findings closely relate to those found by Neff and her colleagues when examining the college population. Neff's participants with higher levels of negative affect and lower levels of positive affect had significantly lower levels of self-compassion (Neff, Rude, & Kirkpatrick, 2007).

Self-Compassion and Personality Disorders

There has been no research examining the relation between personality disorders and self-compassion, but there have been a few studies that examine of self-compassion and certain personality traits. Personality disorders are an enduring pattern of inner experience and behavior that manifest in cognitions, affect, interpersonal functioning or impulse control that causes marked disturbances in regular functioning. These characteristics are inflexible and pervasive, remain stable over time, and most often lead to distress and impairment. Individuals with many personality disorder characteristics but who do not meet diagnostic criteria may be identified as having those personality disorder tendencies or traits (APA, 1994). This section focuses on self-compassion in relation to narcissistic and borderline personality traits. Only two studies have examined the relation between self-compassion and narcissistic traits, and none have examined the relation between self-compassion and borderline traits. Since there is such little research

on the area, the researcher reviews prior literature on narcissistic and borderline tendencies in relation to self-esteem, a related construct to self-compassion.

Narcissism. Those with Narcissistic Personality Disorder have a pattern of grandiosity, a strong need for admiration, and lack empathy. These individuals often feel a sense of entitlement, fanaticizes about unlimited success, power, or beauty, and may be interpersonally exploitive. Similarly, individuals with many of these characteristics, but not all required to meet the diagnostic criteria may be identified as having narcissistic tendencies (may also be called traits or features) (APA, 1994).

One of the studies that examined the relation between self-compassion and narcissism used the 40-item Narcissistic Personality Inventory. The results indicated no correlation between narcissism and self-compassion scores (Neff, 2003a).

Leary et al. (2007) conducted a series of studies on self-compassion. In one of these studies they examined the relation of self-compassion, self-esteem, and narcissism. One-hundred, twenty-three students completed the self-compassion scale, a measure of self-esteem and a measure of narcissism. Like Neff (2003a), the researchers found that there was a significant relation between self-compassion and self-esteem, but not between self-compassion and narcissism.

Although little research has examined the relation between narcissism and self-compassion, self-esteem has been consistently found to be positively related to narcissism (Campbell, Rudich, & Sedikides, 2002; Kernis & Sun, 1994; Rhodewald & Morf, 1995; Sedikides, Rudich, Gregg, Kumashiro, and Rusbult, 2004). As stated earlier, although self-compassion and self-esteem are not the same construct, they are related. When examining a severely and chronically mentally ill population these tendencies will likely

be exaggerated, which would increase scores. Since self-compassion is related to self-esteem it is expected that these exaggerations in personality will lead to a significant relation between narcissism and self-compassion.

Borderline. Those with Borderline Personality Disorder have a pattern of instability in interpersonal relationships, self-image, and affect. They tend to avoid abandonment, real or imagined, may chronically feel empty, and have suicidal behavior and marked impulsivity. Similarly, individuals with many of these characteristics, but not all required to meet the diagnostic criteria may be identified as having borderline tendencies (may also be called traits or features) (APA, 1994).

Tolpin, Gunthert, Cohen, and O'Neill (2004) used daily journals to examine how borderline personality features influence day-to-day stability of 296 college students negative affect, self-esteem, and reactivity to interpersonal stress. They found that participants' day-to-day stability and predictability of self-esteem was inversely correlated with borderline features. In addition, state self-esteem was found to carry over from one day to the next suggesting continuous mood and self-esteem instability of those with borderline features. On average, it was found that those with borderline features had significantly lower levels of self-esteem and poorer mood.

Zeigler-Hill and Abraham (2006) conducted a similar study examining borderline personality features and self-esteem. They found that participants with unstable self-esteem tended to have higher borderline personality features than those with either stable low or high self-esteem. Those with low self-esteem reported higher levels of borderline personality features across both stable and unstable self-esteem. Thus, participants with

unstable, low self-esteem had the greatest number of borderline personality features, and those with stable high self-esteem had the least number of borderline personality features.

These findings suggest that those with borderline features tend to have either low or unstable self-esteem. Since self-esteem is related to self-compassion, and borderline tendencies will be more exaggerated and predominant in a clinical population it was expected that self-compassion scores will also be lower in those with borderline tendencies.

Self-Compassion and Global Assessment of Functioning

Since self-compassion has only been studied within the realm of a normal population, there has been no research examining the relation between self-compassion and ones' global assessment of functioning. Neff et al. (2003a) did find a significant positive correlation between self-compassion scores and life satisfaction scores. Life satisfaction has also not been related to global assessment of functioning scores, but one might assume that one with greater life satisfaction would be functioning at higher levels. Therefore, it was suspected that self-compassion scores will positively correlate with global assessment of functioning scores.

Hypotheses of the Current Study

Hypothesis I. Self-compassion will positively correlate with positive affect and negatively correlate with negative affect.

Hypothesis II. Participants with a primary diagnosis of a mood disorder will have lower self-compassion scores than participants with a primary diagnosis of a non-mood disorder. Since affect is hypothesized to be the primary link between self-compassion and mood disorders, and mood disorders have extremes in affect, affect is expected to

mediate the relation between primary mood and primary non-mood disorders and self-compassion. There should be no difference between primary non-mood disordered participants and control participants.

Hypothesis III. Self-compassion will relate to two Axis II personality traits. Self-compassion will positively correlate with narcissistic trait scores and will negatively correlate with borderline trait scores. This is based on the premises that extreme narcissistic tendencies involve high levels of self-kindness whereas many borderline tendencies lead to harsher self-judgment, and greater isolation with little self-kindness, mindfulness, and common humanity. Also, this study population by nature is more likely to have more severe personality characteristics, including narcissism and borderline traits.

Hypothesis IV. Global Assessment of Functioning scores will positively correlate with self-compassion.

Since little research has been done in this area, exploratory analyses were conducted in an effort to explore and gain the most knowledge possible from the data collected.

CHAPTER TWO

METHOD

Participants

A total of 136 surveys were returned, but only 64 were applicable for use in the study. Surveys were disregarded if they were incomplete, had multiple answers chosen for the same questions, had answers written in, or the case managers wrote "void" if the participant did not seem to comprehend what was being asked while filling out the survey packets. Participants consisted of fifty-five chronically and severely mentally ill and 9 staff members (who served as a non-disorder control group) from Eastway Behavioral Healthcare, a community mental health services agency located in Dayton, Ohio. Clinical participants were required to be actively receiving treatment from the agency's psychiatrists and have an up-to-date diagnostic assessment in their chart. In addition, clinical participants were excluded if their case managers believed that they were actively psychotic, were in intense crisis or extreme distress, or not in the state of mind to understand the questions. Although most severe and chronically mentally ill participants had more than one diagnoses, each clinical participant was placed in a group based on their primary diagnosis: primary mood disorders and primary non-mood disorders. The primary mood disorder group contained 28 participants (Major Depressive Disorder $n = 15$, Bipolar Disorder $n = 11$, Mood Disorder NOS $n = 1$, Dysthymic Disorder $n = 1$), and the primary non-mood disorder group contained 27 participants (Schizophrenia $n = 7$, Schizoaffective Disorder $n = 13$, Anxiety Disorder NOS $n = 3$, Post Traumatic Stress

Disorder $n = 2$, Major Depressive Disorder, in full remission $n = 2$). Since those with a diagnosis of Major Depressive Disorder in full remission were not experiencing any significant mood symptoms, they were placed in the non-mood group. In addition to Axis I disorders, six participants were diagnosed with Borderline Personality Disorder. Five of these participants had primary mood disorders, and one had a primary non-mood disorder. Although some participants did have personality disorder diagnoses, this study focuses only on personality characteristics not those with a personality diagnoses. Demographics can be viewed in Table 1.

ANOVAS were conducted to identify any significant differences in demographic variables. The control group was significantly younger, $F(2, 61) = 6.20$, $MSE = 165.62$, $p < .01$, had completed more schooling, $F(2, 60) = 8.52$, $MSE = 5.60$, $p < .01$, and was more likely to be employed, $F(2, 58) = 36.38$, $MSE = .31$, $p < .001$, than both primary mood and primary non-mood disorder participants. The control group also had a significantly greater percentage of Caucasian participants, $F(2, 59) = 3.26$, $MSE = .43$, $p < .05$, was more likely to be single, $F(2, 61) = 3.67$, $MSE = 3.02$, $p < .05$, and live in their own home, $F(2, 60) = 3.77$, $MSE = .44$, $p < .05$, than non-mood participants. Regression analyses were computed between these variables and major test variables. These factors did not affect the levels of significance of results reported below. There were no significant differences between sex or functional status between groups.

Procedures

Once approved by the University of Dayton's Institutional Review Board, packets including a consent form (Appendix A), Self-Compassion Scale, Positive Affect Negative Affect Schedule, Narcissistic Personality Inventory-16, Identity Diffusion and Primitive

Table 1

Demographic Differences of Participants by Primary Diagnosis Group

Variable	Mood (n=28)		Non-Mood (n=27)		Control (n=11)		Total (N=66)	
	n (%)	Mean SD	n (%)	Mean SD	n (%)	Mean SD	N (%)	Mean SD
Age (range = 20 to 72 years)	28	47.25 13.70	27	50.07 12.80	9	32.78 9.86	64	46.41 13.89
Highest Grade Completed	28	12.04 2.43	26*	12.04 2.25	9	15.56 2.51	63	12.54 2.64
Sex								
Male	6(25)		12(45)		3(33)		21(35)	
Female	18(75)		15(55)		6(67)		39(65)	
Race								
Caucasian	20(74)		19(73)		5(56)		44(71)	
African American	6(22)		7(27)		2(22)		15(24)	
American Indian	1(4)		0(0)		0(0)		1(2)	
Asian/Pacific Is.	0(0)		0(0)		2(22)		2(3)	
Employment Status								
Full Time	1(4)		0(0)		8(89)		9(15)	
Part Time	4(15)		2(8)		0(0)		6(10)	
Unemployed	19(70)		21(84)		1(11)		41(67)	
Retired	3(11)		2(8)		0(0)		5(8)	

Marital Status				
Single	10(36)	8(30)	5(56)	23(36)
In a Relationship	4(14)	1(3.5)	0(0)	5(8)
Married	3(10.5)	1(3.5)	4(44)	8(13)
Widowed	3(10.5)	1(3.5)	0(0)	4(6)
Divorced	7(25)	15(56)	0(0)	22(34)
Separated	1(4)	1(3.5)	0(0)	2(3)
Living Situation				
In Own Home	18(64)	13(50)	9(100)	40(63.5)
W/ Family/Friends	8(29)	8(31)	0(0)	16(25.5)
In Group Home	2(7)	5(19)	0(0)	7(11)
Functional Status				
Independent	22(79)	19(70)	9(100)	50(78)
Requires Assistance	3(10.5)	7(26)	0(0)	10(16)
Dependant	3(10.5)	1(4)	0(0)	4(6)

NOTE: Variation in participant numbers are due to number of participants who completed demographic information.

Defenses Subscales of the Borderline Personality Inventory, demographics sheet, and debriefing (Appendix B) were distributed to the Eastway Behavioral Healthcare case managers. Case managers were directed to review the consent form, explain the research, and assist in the completion of the packet with clinical participants who did not meet any of the exclusion criteria and agreed to participate. The packets were then returned to the researcher, who, with the clinical participant's approval, located the most recent diagnostic assessment from the chart to verify diagnoses and obtain the Global Assessment of Functioning score. Data were entered into SPSS as they were received and then analyzed.

Measures

Self-Compassion Scale (Neff, 2003a; Appendix C). Participants were given the 26-item Self-Compassion Scale, which measures six aspects of self-compassion: Self-Kindness (e.g. I am kind to myself when I'm experiencing suffering), Self-Judgment (e.g. I am disapproving and judgmental about my own flaws), Common Humanity (e.g. I try to see my failings as part of the human condition), 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 I fail at something important to me I try to keep things in perspective), and Over-Identification (e.g. When something painful happens I tend to blow the incident out of proportion). Self-Judgment, Isolation, and Over-Identification are negative aspects and are therefore reverse-coded. Participants indicated their rating for each item on a 5-point likert scale which ranged from "almost never" to "almost always." To compute a total self-compassion score, means of each subscale are calculated and then summed. Past research has found that all six subscales are highly inter-correlated, suggesting that self-

compassion is a second-order trait that arises from a combination of these sub-traits, instead of the cause of these sub-traits. The Self-Compassion Scale has good internal consistency and test-retest reliability over a three week period (Neff, 2003a). Cronbach's alpha for this measure was .88.

Positive and Negative Affect Schedule (Watson & Clark, 1988; Appendix D).

Participants were asked to rate 20 emotions experienced in the past week. Participants indicated their rating for each item on a 5-point likert scale which ranged from "very slightly or not at all" to "extremely." Ten of these affects are positive (e.g. excited, strong, proud, alert) and ten negative (e.g. afraid, scared, hostile, irritable). The positive ranks were summed to get the positive affective score and the negative ranks were summed to get the negative affective score. The scale has high internal consistency and is stable at appropriate levels over a two-month time period. It also has excellent convergent and discriminant validity in comparison to lengthier measures of underlying mood factors (Watson & Clark, 1988). Chronbach's alpha for the positive affect schedule was .85 and for the negative affect schedule was .90.

Narcissistic Personality Inventory-16 (Ames, Rose, & Anderson, 2006; Appendix E).

The Narcissistic Personality Inventory is a 16-item scale which measures narcissistic traits. Participants were given 16 pairs of sentences of which they were asked to select which sentence in each pair best described their own feelings and beliefs (e.g. "I insist upon getting the respect that is due me/ I usually get the respect that I deserve," or "I am much like everybody else/ I am an extraordinary person"). Each pair consists of a narcissistic and non-narcissistic response. Each narcissistic sentence received a score of 1, non-narcissistic answers received a score of zero. Scores were summed to get the

narcissism score. The inventory has notable face, internal, discriminant, and predictive validity (Ames, Rose, & Anderson, 2006). Cronbach's alpha for this measure was .58.

Identity Diffusion and Primitive Defenses Subscales of the Borderline Personality Inventory (Leichsenring, 1999; Appendix F). The Borderline Personality Inventory is a 53-item true-false self-report instrument that measures borderline traits. Due to length, and the population of interest, only the Identity Diffusion and Primitive Defenses Subscales were used. Identity diffusion is the feeling of experiencing depersonalization or derealization. Primitive defenses tend to involve distortions between the self and the outer world. They operate in a global, undifferentiated manner, influencing a person's cognitive, affective, and behavioral functioning. Some examples of primitive defenses are projection and splitting. These subscales consist of a total of 18 items and were chosen because Kernberg (1984) distinguished borderline personality organization from neurotic organization by their strong predominance within borderline organization. He distinguishes psychotic organization from borderline organization by the borderlines ability to reality test. The inventory had satisfactory internal consistency and test-retest reliability (Leichsenring, 1999). Cronbach's alpha for this measure was .85.

Global Assessment of Functioning (GAF Global Assessment of Functioning (GAF)). For participants who were receiving treatment from Eastway Behavioral Healthcare and consented access to their chart, Global Assessment of Functioning was recorded. The GAF is the fifth axis in the method of diagnosis endorsed by the American Psychiatric Association. The GAF score is based with respect to the psychological, social, and occupational functioning of the individual and is reported by the clinician as a judgment of the overall level of functioning of the individual. The GAF scale is broken

down into 10 ranges, from “superior functioning in a wide range of activities, life problems never seem to get out of hand, is sought by others because of his or her many positive qualities, no symptoms” to “persistent danger of severely hurting self or others or persistent inability to maintain minimal personal hygiene or serious suicidal act with clear expectations of death” (APA, 1994; Appendix G). Inter-rater reliability has been found to be very good, even with only a brief introduction to the use of the instrument (Startup, Jackson, & Bendix, 2002).

Diagnosis. The Diagnostic and Statistical Manual (APA, 1994) is one of the most widely used systems of diagnosis of mental disorders. Each clinical participant has received their diagnoses using the Diagnostic and Statistical Manual’s criteria from their primary psychiatrist.

Demographics. Participants were asked to fill out a demographics sheet describing their age, sex, race, marital status, living situation, educational background, employment, and functional status (Appendix H).

CHAPTER THREE

RESULTS

Descriptive Statistics

Correlations were computed between continuous demographic variables and major test variables. As shown in Table 2, there was a significant negative correlation between age and self-judgment. There were significant positive correlations between highest grade completed and self-judgment, isolation, and self-compassion scores. Highest grade completed correlated significantly and negatively with primitive defenses.

ANOVAS were computed between each categorical demographic variable and major test variables. Since there was such a small number in each employment status group (retired, full-time, and part-time), the data was collapsed into the dichotomous variable of unemployed versus employed. As shown in Table 3, those who were employed had significantly less borderline traits and negative affect than their unemployed counterparts. Those who were employed also had significantly higher levels of self-compassion, isolation, and positive affect. Those whose functional status was dependant had significantly less common humanity, mindfulness, and positive affect. These significant differences were controlled for when running analyses for the following findings.

Table 2

Correlations between Continuous Demographic Variables and Test Variables

Variable Completed	Age	Highest Grade
Self-Compassion Score	-.17	.29*
Common Humanity	-.01	.03
Self-Kindness	-.17	.21
Mindfulness	-.06	.19
Self-Judgment	-.26*	.27*
Over-Identification	-.05	.24
Isolation	-.22	.37**
Positive Affect Score	-.01	.22
Negative Affect Score	.24	-.25
Narcissism Score	-.18	.09
Identity Diffusion Score	.13	-.20
Primitive Defenses Score	-.01	-.39**
GAF Score	-.05	-.08

* $p < .05$. ** $p < .01$.

Table 3

Significant ANOVAS for Categorical Demographic Variables and Major Test Variables

Major Test Variable	F-Values	
	Employment Status	Functional Status
Self-Compassion Score	7.28**	2.33
Common Humanity	1.32	3.53*
Mindfulness	2.56	4.15*
Isolation	11.71**	2.79
Positive Affect Score	10.33*	3.44*
Negative Affect Score	14.74***	3.88*
Identity Diffusion	6.18*	.980
Primitive Defenses	23.02***	2.41

* $p < .05$. ** $p < .01$. *** $p < .001$.

Major Study Questions

Hypothesis I. It was hypothesized that self-compassion scores would relate to affect. Self-compassion scores correlated significantly both with positive affect scores and with negative affect scores inversely (see Table 4). When examining the self-compassion subscales positive affect correlated significantly with all positive subscales, and inversely with all the negative subscales (see Table 5). Thus, as hypothesized, self-compassion showed strong correlations with affect.

Hypothesis II. It was hypothesized that self-compassion scores would be lower for individuals with primary mood rather than primary non-mood disorders. Participants with primary mood disorders ($M = 2.47$, $SD = .82$) had significantly lower scores on the self-compassion scale than those with primary non-mood disorders ($M = 3.05$, $SD = .51$). There was no significant difference in primary non-mood and control participants' ($M = 3.57$, $SD = .53$) self-compassion scores, $F(2,60) = 10.97$, $MSE = 4.89$ $p < .001$. Since affect is a predominant feature in mood disorders, it was believed that affect would mediate the relation between primary mood and primary non-mood disorders and self-compassion. A simultaneous regression of self-compassion scores on positive affect scores, negative affect scores and primary mood-versus-non-mood disorder groups showed that primary mood-versus-non-mood disorders continued to predict self-compassion scores significantly, $\beta = -.33$, $p < .01$, even when controlling for affect, positive, $\beta = .28$, $p < .05$; negative, $\beta = -.44$, $p < .001$. Thus, as hypothesized, those with primary mood disorders had lower self-compassion scores than those who did not, but contrary to the reasons for the hypothesis, affect levels were not the driving reason for these variations.

Table 4

Correlations of Major Test Variables

	SCS	PAS	NAS	NAR	ID	PD
PAS	.52***					
NAS	-.64***	-.40**				
NAR	.28*	.21	-.31*			
ID	-.41**	-.19	.50***	-.06		
PD	-.60***	-.45***	.66***	-.18	.61***	
GAF	-.02	.06	-.12	.22	-.34*	-.11

* $p < .05$. ** $p < .01$. *** $p < .001$.

NOTE: SCS = self-compassion scores, PAS = positive affect score, NAS = negative affect score, NAR = narcissism score, ID = identity diffusion scores, PD = primitive defenses score, GAF = global assessment of functioning score. The control group ($n = 9$) did not have GAF scores.

Table 5

Correlations between Self-Compassion Subscales and Major Test Variables

	CH	SK	MI	SJ	OI	IS	M	SD
PA	.44**	.58**	.48**	-.38**	-.36**	-.36**	29.44	8.62
NA	-.40**	-.53**	-.49**	.49**	.48**	.59**	27.95	10.30
NAR	.05	.22	.19	-.30*	-.26*	-.26*	3.25	2.40
ID	-.13	-.26*	-.27*	-.28*	-.43***	-.46***	3.77	2.56
PD	-.32*	-.47***	-.40**	-.42**	-.59***	-.58***	3.84	2.53
GAF	.15	.07	.01	-.06	-.09	-.12	55.04	9.02

* $p < .05$. ** $p < .01$. *** $p < .001$.

NOTE: CH = common humanity, SK = self-kindness, MI = mindfulness, SJ = self-judgment, OI = over-identification, IS = isolation, M = mean, SD = standard deviation, PA = positive affect, NA = negative affect, NAR = narcissism score ID = identity diffusion score, PD = primitive defenses score, GAF = global assessment of functioning

Hypothesis III. It was hypothesized that self-compassion scores would relate to Axis II personality traits. Specifically, self-compassion scores would positively correlate with narcissistic trait scores and would negatively correlate with borderline trait scores. Self-compassion scores significantly correlated directly with narcissism scores. When examining the self-compassion subscales, those with narcissistic traits had significantly lower scores on isolation, self-judgment, and over-identification (see Table 5). In other words, participants with higher levels of narcissistic characteristics had higher levels of self-compassion. Self-compassion inversely correlated with both the Identify Diffusion and Primitive Defenses subscales of the Borderline Personality Inventory (see Table 4). When Identity Diffusion and Primitive Defense measures were combined to form a borderline dimension, all self-compassion subscales inversely and significantly correlated with this dimension: common humanity: $r = -.25, p < .05$; self-kindness: $r = -.40, p < .01$; mindfulness: $r = -.37, p < .01$; isolation: $r = -.58, p < .01$; self-judgment: $r = -.39, p < .01$; over-identification: $r = -.56, p < .01$. In other words, participants with higher levels of borderline characteristics had lower levels of self-compassion.

Hypothesis IV. It was hypothesized that GAF scores would positively correlate with higher self-compassion scores; however, GAF scores did not significantly correlate with self-compassion scores or any of its subscales. In other words, there was not a relation between one's global assessment of functioning and their amount of self-compassion.

Relation Between Diagnoses

Relations between disorders within each grouping (e.g., depression and bipolar, in mood disorders; schizophrenia and schizoaffective in non-mood disorders) were also examined. No significant differences were found.

CHAPTER FOUR

DISCUSSION

This study was designed to further enhance the understanding of self-compassion by adding to the very limited amount of research already conducted in the area. It also examined variations in self-compassion in a clinical population. Up to this point, self-compassion has only been studied within the realm of the general population, and most often among college students. Although positive and negative affect have been studied in relation to self-compassion, this is the first known study to examine individuals actually diagnosed with mood and non-mood disorders. Similarly, since those in the general population do not have GAF scores, this was the first study to examine ones' overall level of functioning in relation to self-compassion. This study also continued to build on past research findings regarding self-compassion and narcissistic tendencies as well as borderline tendencies. This research offers new insight into the levels of self-compassion of those suffering from severe and chronic mental illness, as well as identifying personality traits of those with high self-compassion scores, narcissists, and those with low self-compassion scores, borderlines.

Relation Between Self-Compassion and Positive and Negative Affect

Results supported the hypothesized relations between positive affect, negative affect, and self-compassion. Consistent with the major hypothesis, participants with higher levels of positive affect also had higher levels of self-compassion and participants with higher levels of negative affect had lower levels of self-compassion. These results

support Neff, Rude and Kirkpatrick's (2007) findings that those with higher self-compassion scores experienced significantly more positive and less negative mood.

Relation Between Self-Compassion and Mood and Non-Mood Disorders

Past research has found significantly lower levels of self-compassion in those who have elevated scores on depressive measures (e.g., Neff, 2003a; Neff, Kirkpatrick, & Rude, 2007) but none have examined individuals with actual diagnoses of depression or in a clinical population. Based on Neff and her colleagues' findings, as well as the belief that those who have disorders with increased or unstable affective levels would have lower self-compassion than those who did not, it was hypothesized that those with primary mood disorders, which include those with depression, would have lower levels of self-compassion. Consistent with the hypothesis, those with primary mood disorders had significantly lower levels of self-compassion than those with primary non-mood disorders. In addition, those with primary non-mood disorders did not have significantly lower self-compassion scores than the non-disordered participants. These findings support previous research which found affect is related to self-compassion—and extended it by finding that those with unstable affective levels tend to be less self-compassionate. The results emphasize the strong link between affect problems and low self-compassion in those with primary mood disorders, not just clinical versus non-clinical participants.

The regression analysis found that, even when controlling for positive and negative affect, self-compassion scores were significantly lower in those with primary mood disorders than their primary non-mood counterparts. This raises possible research opportunities to identify characteristics among those with mood disorders, besides lower

levels of positive affect and higher levels of negative affect that influences levels of self-compassion.

If one examines all of the sub-facets of self-compassion he or she may better see the relation between increased positive affect and decreased negative affect. Neff and her colleagues (Neff, Kirkpatrick & Rude, 2007; Neff, Rude & Kirkpatrick, 2007) argue that self-compassion is not merely a lack of negative affect states, but instead there are less negative affect states because of the ability to acknowledge and accept difficult emotions in non-judgment awareness (Neff, Kirkpatrick & Rude, 2007). These emotions are then approached with kindness and a sense of shared humanity, transforming them into a more positive feelings state, which increases positive affect states (Neff, 2003b). As Neff and her colleagues argue, individuals with the ability to realize that negative moods and emotions are part of the shared human experience are less likely to dwell on such feelings. They are more likely to be kind to themselves and not judge such feeling harshly, decreasing the focus on those feelings. What focus does occur in one with self-compassion, will likely be one that is not exaggerated or full of self-pity; all characteristics that may lead to less negative affect and increased positive affect.

Similarly, those with positive affect may be more likely to be self-compassionate because they are less likely to judge themselves harshly and more likely to realize that pain is unavoidable and work hard to relieve feelings of negativity to restore their positive attitude. Those with negative affect might have lower levels of self-compassion because they become more easily irritated, causing increased anger and anxiety, and leading to ruminations that make them feel isolated. They are more likely to dwell on these feelings leading exaggeration, self-pity, and self-judgment.

The findings show that although self-compassion is related to positive affect, negative affect remains present. Ultimately, one with self-compassion should not have all positive affect and no negative affect. Instead, he or she should be to find an optimum balance between positive and negative affect. Self-compassion, by definition can not exist without both positive and negative affect. If no positive affect is present, one will have no self-compassion. One will isolate, wallowing in self-pity and judgment. One with all positive affect cannot be self-compassionate either, for he or she can not feel common humanity, be kind to him or herself, see things clearly if they have no pain, suffering, or negative emotion to process. It is a symbiotic relationship. With self-compassion one will increase positive affect and decrease negative affect, and with greater positive affect and less negative affect, self-compassion will grow.

Past studies have found lower levels of self-compassion scores in those who have increased levels of anxiety (e.g., Neff, 2003a; Neff, Kirkpatrick, & Rude, 2007). Unlike these findings, this study did not find any significant differences between primary non-mood participants, which include those with anxiety disorders, and the control group. These findings may have differed because of such grouping. It is also possible that those within a normal population who have increased levels of anxiety fall toward either extreme of self-compassion scores, but when compared to those in the clinical population, with more extreme symptomatology, those with increased levels of anxiety may have more centralized self-compassion scores.

Relations Between Self-Compassion and Narcissistic and Borderline Traits

Results supported the hypothesis that participants with higher levels of narcissistic characteristics would have higher levels of self-compassion. This finding contradicts

those of the past (e.g., Neff et al., 2003; Leary et al., 2007) which have found no significant relation between narcissism and self-compassion scores. There may be a number of reasons for such findings. This may be because of the study population. Past studies have not examined the chronically and severely mentally ill, which by their nature are likely to have more severe personality characteristics, including narcissism. By examining this population this study examines those who are less likely to fall within the mainstream of answers. Similarly, but less likely, those within a severely mentally ill population may be suffering from delusions of grandeur which may lead to similar answers of a narcissist. The relation between narcissism, which is generally viewed as negative, and self-compassion, which is viewed as positive, may create some dissonance, but offers great insight. The participants with high narcissistic tendencies had significantly lower levels of the negative sub-facets of self-compassion than those with normal or low scores. These high scorers tended to self-judge, over-identify, and isolate less than their counterparts. Although they may take such acts to extremes, their practice helps researchers to identify traits that may assist in increasing self-compassion in others.

Results also supported the hypothesis that participants with higher levels of borderline characteristics would have lower levels of self-compassion. This hypothesis had not been examined in past research but was hypothesized because those with borderline tendencies often have many of the characteristics of the negative sub-facets of self-compassion (e.g., over-identification and self-judgment) and lack many of the positive sub-facets of self-compassion (e.g., self-kindness and common humanity). Having identifying the characteristics of those with low self-compassion scores, individuals with borderline traits, and those with high self-compassion scores, individuals

with narcissistic traits, open many avenues for future research. By developing a way to counter these extremes, researchers will be able to assist everyone in between in finding healthier levels of self-compassion.

Relation Between Self-Compassion and Global Assessment of Functioning

There was no significant correlation between GAF scores and self-compassion scores. It is possible that there truly is no relationship between one's global assessment of functioning and their amount of self-compassion. It may also be possible that the lack of relation might have occurred because of a time lapse between the most recently charted GAF score and completion of the survey packet. Since clinical participants were in treatment, it is expected that there would be a continual increase in GAF scores. These changes are supposed to be evaluated during every encounter between the psychiatric and clinical participant, the maximum lapse for the study participants of three months. Unfortunately, psychiatrists seldom maintain these standards. To control for this problem current diagnostic assessments were used because their purpose is to attain a full axonal assessment, including GAF score. These full diagnostic assessments may have occurred up to one year and 11 months earlier, which would not truly show the participants current GAF score and not accurately reflect the participant's actual level of functioning at the time of completion of the survey packet.

Relation Between Diagnoses

Relations between disorders within each grouping (e.g., depression and bipolar, in mood disorders; schizophrenia and schizoaffective in non-mood disorders) were also examined. Surprisingly, no significant differences were found. Although the sample size was adequate for the primary mood and primary non-mood groupings, the sample size for

individual disorders was relatively small. Thus, there may not have been enough statistical power to detect some of the differences that might exist between individual disorders. It is the hope that future researchers will attempt to attain a larger sample size so that it may be possible to study variations in self-compassion between each disorder instead using broad groupings.

Study Limitations

There are a number of inherent limitations in this study. First, and most obvious, is the population on which the study focuses. While all participants were competent enough to consent to participate, some struggled with the actual meanings of the questions being asked. Others had difficulty understanding the set up of the likert scales, while others were unsure which answer most represented their opinion. Also, the survey packet itself was rather long for the population of interest. Although it was anticipated that completion would take an average of 25 minutes, it often took participants nearly 60 minutes to complete. Many individuals who were asked to participate did not wish to partake because of the length and many who did start the survey packets became frustrated and decided not to finish them because of the length.

Another possible limitation was that Cronbach's alpha for the NPI-16 did not meet previous alpha levels attained for this measure. This suggests a lack of internal consistency in comparisons to past measures and raises questions to the validity of the correlations found. Still, the .NPI-16 did correlate with other variables as expected.

Another major barrier is the general inconsistency with completing the axonal system, particularly of diagnoses and GAF scores. As mentioned earlier, each time a participant saw a psychiatrist, they were supposed to receive the most appropriate

diagnosis and most current GAF score. When examining charts, this seldom happened. Although diagnoses may vary they tend to stay in their diagnostic group, meaning primary mood or non-mood categorization, in those with severe and chronic mental illness, so the variations in diagnoses most likely would not have an effect on the findings. Unlike diagnoses, since the clinical participants were in treatment, their GAF scores are expected to change, but since the GAF scores were not charted regularly, the clinical participants GAF score may not necessarily have been the most current, and may not have accurately reflected the participants' actual level of functioning at the time of participation.

Another barrier with using the GAF within the severely mentally ill population is a likely restriction in range. To be in treatment at Eastway Behavioral Healthcare, one's GAF scores has to be less than 70. One with extremely low GAF scores, perhaps 35 or below, would not likely be able to coherent enough to consent to participate. Those with higher GAF scores may have been more likely to have higher levels of self-compassion, but because of the range restrictions, we just do not know.

Summary and Conclusions

This study has expanded the research on self-compassion into clinical population. In doing so, it examined variations in self-compassion in those with clinical diagnoses, particularly mood and non-mood disorders. The study also expanded the very limited amount of research on self-compassion in those with increased narcissistic or borderline tendencies. The relations between self-compassion and narcissism contradicts those of the past, suggesting that the underlying essence of self-compassion may vary in a clinical population from those in the normal population.

It is the hope that researchers will continue to study the topic of self-compassion, in particular, self-compassion among those suffering from mental illness. As expected, findings vary significantly from those in the normal population. This shows that past self-compassion findings may not be as generally categorized as past researchers may have hoped. Future research would be beneficial both within the clinical population and across both the clinical and "normal" population to better understand the concept of self-compassion in its entirety.

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Appendix A

Informed Consent

Study Title: Self-Compassion

Principle Investigator: Stephanie E. Zolomij, B.A.

Faculty Advisor: Jack J. Bauer, Ph.D

Description of Study: This study is designed to enhance the knowledge of self-compassion in a variety of ways. First and foremost, it will add to the very limited amount of research on self-compassion in western culture. In addition, up to this point, self-compassion is most often studied among college students. This study focuses on broader populations. The researcher hopes to be able to identify variations in self-compassion to better assist in the maintenance of healthy lifestyles. You will be asked to complete a number of short scales which has a variety of questions including topics about feeling of possible strengths and weaknesses both within yourself and in comparison to others, how you deal with these comparisons, recent moods you have experienced, and general demographic information.

Adverse Effects and Risks: It is possible that you may experience some distress in response to certain questions asked in the surveys. However, you are free to abstain from answering any questions that you might find distressing. If feelings of distress continue to occur after completing the surveys we encourage you to discuss these thoughts and feelings with your case manager or therapist.

Duration of Study: It takes an average of about 25 minutes to complete the questionnaire packet. The actual amount of time may vary from individual to individual.

Confidentiality of Data: Neither your name nor any other identifying information will appear on your answer sheets. Your response to the questionnaires used in this exercise will instead be assigned an identification number.

Contact Person: If you have any questions concerning your participation in this exercise now or in the future, leave a message at 937-229-2713 for Stephanie E. Zolomij, and she will return to call promptly. You may also contact Dr. Jack J. Bauer at 937-229-2617.

Consent to Participate: I have voluntarily decided to participate in this study. The investigator has adequately answered any and all questions I have about this study, the procedures involved, and my participation. I understand that the investigator named above will be available to answer any questions about procedures throughout this study. I also understand that I may voluntarily terminate my participation in this study at any time. I also understand that the investigator may terminate my participation in this study if she feels it is in my best interest. In addition, I certify that I am 18 years of age or older.

Signature of Participant
Date

Participant's Name (Printed)

Signature of Witness

Witness' Name (Printed)

Date

EASTWAY CLIENTS: Consent to Access Chart: I voluntarily decided to allow the primary researcher access to my chart to attain my diagnoses and Global Assessment of Functioning score from my most current Diagnostic Assessment. **YES**____**NO**____

Appendix B

Debriefing

Information about the Study:

Self-compassion consists of three main components. It involves a sense of common humanity, recognizing that pain and failures are unavoidable aspects of the shared human experience. Also, it involves being kind and understanding toward oneself in instances of suffering and perceived inadequacy. Lastly, it entails being able to face painful thoughts and feelings without exaggeration or self-pity.

This study is designed to enhance the knowledge of self-compassion in a variety of ways. First and foremost, it will add to the very limited amount of research on self-compassion. In addition, up to this point, self-compassion is most often studied among college students. This study focuses on broader, adult population. The researcher hopes to be able to identify variations in self-compassion in relation to affect, personality characteristics (in particular, borderline and narcissistic tendencies), and Global Assessment of Functioning scores. It is hypothesized that self-compassion will positively correlate with positive affect and negatively correlate with negative affect. More specifically, it is believed that participants with mood disorders will have lower self-compassion scores than those without mood disorders and clinical participants will have lower self-compassion scores than their non-clinical counterparts. It is also hypothesized that self-compassion will positively correlate with narcissistic trait scores and will negatively correlate with borderline trait scores. Lastly, it is believed that Global Assessment of Functioning scores will positively correlate with higher levels of self-compassion.

References:

- American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders*. (4th ed.). Washington DC: American Psychiatric Press.
- Neff, K. (2004). Self-Compassion and Psychological Well-Being. *Constructivism in the Human Sciences* 9(2), 27-37.
- Neff, K. (2003). The Development and Validation of a Scale to Measure Self-Compassion. *Self and Identity*, 2, 223-250.
- Neff, K., Kirkpatrick, K., & Rude, S. (In press). Self-compassion and Adaptive Psychological Functioning. *Journal of Research in Personality*.

Assurance of Privacy:

The purpose of this study is to obtain more knowledge on general principles of self-compassion. All the information you have given will remain strictly confidential, and neither your name nor any other identifying information will appear on your answer sheets. Your responses to the questionnaires used in this exercise will be identified by a number, not by your name.

Contact Information:

If you have any questions or concerns please leave a message for Stephanie E. Zolomij at 937-229-2713, and she will return to call promptly. You may also contact Dr. Jack J. Bauer at 937-229-2617.

Thanks:

Thank you for participating in furthering the understanding of self-compassion. Your time and cooperation is greatly appreciated. Your participation in this study will help advance psychological understanding of these important issues.

Appendix C

Self-Compassion Scale

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

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

5. I try to love towards myself when I am feeling emotional pain.

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

19. I'm kind to myself when I'm experiencing suffering.

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost				Almost
Never				Always
1	2	3	4	5

23. I'm tolerant of my own flaws and inadequacies.

Almost				Almost
Never				Always
1	2	3	4	5

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

Almost

Never

1

2

3

4

Almost

Always

5

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

Almost

Never

1

2

3

4

Almost

Always

5

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

Almost

Never

1

2

3

4

Almost

Always

5

Appendix D

PANAS

This scale consists of a number of words that describe different feelings and emotions. Read each item and then circle the appropriate answer next to that word. Indicate to what extent you have felt this way during the past week.

Use the following scale to record your answers.

(1) = Very slightly or not at all (2) = A little (3) = Moderately (4) = Quite a bit (5) = Extremely

	Very slightly or not at all	A little	Moderately	Quite a bit	Extremely
1. Interested	1	2	3	4	5
2. Distressed	1	2	3	4	5
3. Excited	1	2	3	4	5
4. Upset	1	2	3	4	5
5. Strong	1	2	3	4	5
6. Guilty	1	2	3	4	5
7. Scared	1	2	3	4	5
8. Hostile	1	2	3	4	5
9. Enthusiastic	1	2	3	4	5
10. Proud	1	2	3	4	5
11. Irritable	1	2	3	4	5
12. Alert	1	2	3	4	5
13. Ashamed	1	2	3	4	5
14. Inspired	1	2	3	4	5
15. Nervous	1	2	3	4	5
16. Determined	1	2	3	4	5
17. Attentive	1	2	3	4	5
18. Jittery	1	2	3	4	5
19. Active	1	2	3	4	5
20. Afraid	1	2	3	4	5

Appendix E

NPI-16

Please read each pair of statements and then choose the one that is closer to your own feelings and beliefs. Indicate your answer by circling the letter "A" or "B" to the left of each item. Please do not skip any items.

1. A. When people compliment me I sometimes get embarrassed.
B. I know that I am good because everybody keeps telling me so.
2. A. I prefer to blend in with the crowd.
B. I like to be the center of attention.
3. A. I am no better or nor worse than most people.
B. I think I am a special person.
4. A. I like having authority over people.
B. I don't mind following orders.
5. A. I find it easy to manipulate people.
B. I don't like it when I find myself manipulating people.
6. A. I insist upon getting the respect that is due to me.
B. I usually get the respect that I deserve.
7. A. I try not to be a show off.
B. I am apt to show off if I get the chance.
8. A. I always know what I am doing.
B. Sometimes I am not sure of what I am doing.
9. A. Sometimes I tell good stories.
B. Everybody likes to hear my stories.
10. A. I expect a great deal from other people.
B. I like to do things for other people.
11. A. I really like to be the center of attention.
B. It makes me uncomfortable to be the center of attention.
12. A. Being an authority doesn't mean that much to me.
B. People always seem to recognize my authority.
13. A. I am going to be a great person.
B. I hope I am going to be successful.

14. A. People sometimes believe what I tell them.
B. I can make anybody believe anything I want them to.
15. A. I am more capable than other people.
B. There is a lot that I can learn from other people.
16. A. I am much like everybody else.
B. I am an extraordinary person.

Appendix F

BPI- Identity Diffusion and Primitive Defenses Subscales

Please read each statement and choose whether the statement is true or false for you. If you are unsure, choose your answer based on the majority of the time. Please do not skip any items.

- | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------|------|-------|
| 1. I frequently experiences panic spells. | True | False |
| 2. Sometimes I feel that people and things around me are not real. | True | False |
| 3. My feelings towards other people quickly change into opposite extremes (for example: from love and admiration to hate and disappointment). | True | False |
| 4. I often feel a sense of worthlessness or hopelessness. | True | False |
| 5. Sometimes I act and feel in a way that does not fit me. | True | False |
| 6. I have had the feeling of being directed or controlled from outside, like a puppet on a string. | True | False |
| 7. I have felt the presence of another person, when he or she was not really there. | True | False |
| 8. Sometimes my body or parts of my body seem strange or somehow changed to me. | True | False |
| 9. Sometimes I feel that other people are out to get me. | True | False |
| 10. Sometimes I feel like I am someone special. | True | False |
| 11. Sometimes it is difficult for me to tell, whether something really happened, or whether it occurred only in my imagination. | True | False |
| 12. Sometimes I feel a sense of not being real. | True | False |
| 13. Sometimes I have the feeling that my body is dissolving or that a part is dissolving or that a part of my body is missing. | True | False |
| 14. I often have the feeling that others laugh or talk about me. | True | False |
| 15. People often appear to me to be hostile. | True | False |
| 16. I often don't know what I really want. | True | False |

17. Sometimes I feel I am living in a dream, or see my life before me as if it were a movie.

True False

18. I often experience pangs of hunger which cause me to devour everything in sight.

True False

Appendix G

Global Assessment of Functioning

100 91	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
90 81	Absent or minimal symptoms, good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns.
80 71	If symptoms are present, they are transitory and expectable reactions to psychosocial stressors; no more than slight impairment in social, occupational, or school functioning.
70 61	Some mild symptoms OR some difficulty in social, occupational, or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships.
60 51	Moderate symptoms OR moderate difficulty in social, occupational, or school functioning.
50 41	Serious symptoms OR any serious impairment in social, occupational, or school functioning.
40 31	Some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood.
30 21	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment OR inability to function in almost all areas.
20 11	Some danger of hurting self or others OR occasionally fails to maintain minimal personal hygiene OR gross impairment in communication.
10 1	Persistent danger of severely hurting self or others OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
0	Inadequate information.

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Appendix H

Personal History Form

1. **Age:** _____ 2. **Sex:** Male Female
2. **Race:** Caucasian African American American Indian
 Asian/Pacific Islander Hispanic/Latino Other: _____
4. **Marital Status:** Single In a Relationship Married
 Widowed Divorced Separated
5. **Living:** In Own Home With Family or Friends
 Group Home Nursing Home
6. **Highest Grade in school complete?**
- | | | | | | | | | |
|------------------|---|----|----|----|---|---|---|---|
| Grade School: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| High School: | 9 | 10 | 11 | 12 | | | | |
| College: | 1 | 2 | 3 | 4 | | | | |
| Graduate School: | 1 | 2 | 3 | 4 | 5 | 6 | | |
7. **Employment Status:** Full Time Part Time
 Unemployed Retired
8. **Functional Status:** Independent Requires Assistance With Daily Living Activities Dependant

Do not fill out. Examiner Section.

Client ID #: _____
Axis I: _____

Axis II: _____
Axis V: _____