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The Effects of a Compassion Focused Intervention on a Non-Clinical Student Population

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Running head: EFFECTS OF A COMPASSION FOCUSED INTERVENTION

The Effects of a Compassion Focused Intervention on a Non-Clinical Student Population

A Thesis

Presented To

Eastern Washington University

Cheney, Washington

In Partial Fulfillment of the Requirements

for the Degree

Master of Science

By

Adrian Kunemund

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MASTER'S THESIS

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ABSTRACT

Previous research has suggested that Compassion Focused Therapy (CFT) is beneficial for individuals suffering from a variety of mental health concerns including depression, shame, and self-criticism. The present study assessed the effects of a 10-week university Introduction to CFT course that includes a group orientation to CFT including exposure to CFT intervention exercises. It was hypothesized that those receiving the CFT course would show reductions in shame, self-criticism, and fears of compassion, and increases in gratitude, positive affect, and self-compassion relative to controls. While some differences were observed between the CFT and control groups, none of the hypothesized group X time interactions achieved statistical significance. These results suggest that a course-style CFT intervention is not sufficient for producing measureable clinical change in participants.

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Recent research illustrates that younger generations are experiencing higher levels of psychological distress and symptomatology than seen in previous birth cohorts (Twenge, 2000). Specifically, high school and college-aged individuals are reporting higher rates of depression and are suffering from significant levels of stress and feelings of shame and self-blame (Reynolds, Stewart, & MacDonald, 2006; Turner & Husman, 2008; Twenge, 2000). These feelings of shame and self-blame are of great concern because of previous research illustrating the significant effect these feelings can have on the development and maintenance of mental distress. Within the college population, these feelings have been linked to the competitive culture and perceived academic failures experienced by students (Andrews, Qian, & Valentine, 2002; Canda & Szentagota, 2013; Turner & Husman, 2008).

Given the observed increase in mental distress and feelings of shame/self-blame in young people, it is important to explore therapeutic interventions and techniques that may help college students cope with the increasingly competitive culture they face and the high expectations that occur within it. The current project sought to address this issue through examining the efficacy of a classroom Introduction to Compassion Focused Therapy (CFT) course as an intervention. CFT may be helpful in addressing these concerns because it specifically focuses on assisting individuals in dealing with threatening emotions such as shame, frustration, and self-blame. As part of the course, students were educated on the CFT model and practiced many of the components present in CFT therapy programs. Thus, the course was evaluated as an intervention. In this thesis, I explored the issue of emotional distress in young people and reasons why a CFT course was considered as a potential method to help this population work with this distress.

Mental Distress, Self-blame, and Shame Among Students

Mental distress and psychopathology are prevalent and growing issues in the United States. Kessler et al. (2005) note that 26.2 percent of Americans ages 18 and

older, or about one in four adults, are estimated to suffer from a diagnosable mental disorder in any given year. Past research indicates that rates of psychopathological symptoms and characteristics are increasing in younger generations (Twenge et al., 2010). For example, increasing rates of depression have been noted over the past fifty years in terms of incidence, prevalence, and earlier age of onset, with these differences being particularly pronounced among more recent birth cohorts (Twenge et al., 2010). Compton et al. (2006) compared the United States adult population from 1991-1992 to the adult population in 2001-2002 and found a significant increase in the prevalence of depression. In 1991-1992, 3.33% of the adult population suffered from major depression; this number more than doubled to 7.06% in 2001-2002. This increased prevalence of depression was reported for both sexes, and among both African Americans and Caucasians. Additionally, Goodwin (2003) observed an increased prevalence of panic attacks among adults from 1980 to 1995. Another study found significant increases in anxiety and neuroticism among birth cohorts for adults and children, with typically healthy children in the 1980s reporting more anxiety than child psychiatric patients in the 1950s (Twenge, 2000).

This increase in mental distress has also been found in college students. One study comparing MMPI scores of American college students from 1938 to students in 2007 shows that students in 2007 scored significantly higher on all clinical scales, including depression and schizophrenic scales, with "five to eight times" as many college students having scores above 70 out of 100 on any given scale (Twenge et al., 2010). The same research indicates that five times as many students "now score above common cutoffs for psychopathology, including up to 40%" on the Hypomania scale (Twenge et al., 2010, p.145).

An important factor contributing to mental distress is shame. Shame is defined as negative feelings we have about the whole self, not just a specific behavior (Lewis, 1971; Gilbert, 2009). Gilbert (2009; 2010) divides shame into two experiences: internal shame

and external shame. Internal shame occurs when a person's "attention and reasoning" are "focused inwardly on one's experience of self as subject" (Gilbert, 2010, p.85). Externalized shame occurs when a person's "attention and reasoning" is focused "on what is going on in the minds of others about the self as subject" (Gilbert, 2010, p.85). A growing body of literature indicates that shame plays a significant role in a wide variety of psychological disturbances, particularly in depression and those problems in which anxiety plays a prominent role. Shame has been positively correlated with the onset and maintenance of depression (Andrews, Qian, & Valentine, 2002) and Cheung, Gilbert, and Irons (2004) found a positive relationship between shame and depression when controlling for rumination. Vidal and Petrak (2007) discovered that higher levels of traumatic stress in sexual assault survivors was associated with higher levels of shame. This supports Lee, Scragg, and Turner's (2001) model of shame-based PTSD, which suggests that shame may prolong and increase the severity of PTSD symptomatology. Additionally, it has been observed that individuals with Social Anxiety Disorder report higher levels of shame-proneness and shame cognitions than individuals without social anxiety disorder (Michail & Birchwood, 2013). This research suggests that shame plays a significant role in mental distress and is an important factor to consider when addressing the issue of increasing mental health issues.

One theory as to why this shift towards increasing psychopathological issues has occurred in more recent birth cohorts cites changing cultural and societal values, pressures, and goals (Twenge et al., 2010). More recent generations are the product of an increasingly consumerist and individualistic culture with increased focus on extrinsic achievements, such as money, among students and young adults (Pryor, Hurtado, Saenz, Santos, & Korn, 2007; Reynolds et al., 2006). For example, the Cooperative Institutional Research Program (CIRP) Freshman Survey (Pryor et al., 2007, p.56) indicates that between 1966 to 1987, the "importance of being well off financially" had increased among college freshman from 42.2% to 74.1% and has remained at about 73% since.

Additionally, students are expecting to achieve greater success in school and in their professional lives than previous generations expected to achieve (Twenge, Campbell, & Freeman, 2012; Reynolds et al., 2006). Reynolds et al.'s (2006) explanation for this observed effect was that the ambitions of these students were unrealistic and therefore they were setting themselves up for failure.

These perceived failures, especially academic failures, can result in shame and self-criticism. For example, one study found that adolescents who do poorly on standardized tests reported feelings of shame and experiences of marginalization (Reynolds et al., 2013). In college students, previous research has observed that those who experience test anxiety and "beliefs about one's inability to control learning" experience significant shame upon receiving an undesired test grade and feedback (Turner & Husman, 2008, p.141). Additionally, research suggests that students who experience perceived academic failure often attribute such failure and/or the inability to learn to fundamental aspects of the self (Turner & Husman, 2008). This often leads to self-criticism and increased shame about the self and possibly even greater negative academic outcomes. "When students strive for future goals for which their educational attainment is instrumentally connected, appraisals of academic failure and subsequent feelings of shame may lead them to abandon their personal, future goals" (Turner & Husman, 2008, p. 142). This research illustrates that shame can impact academic achievement and can also result in academic disappointments. This connection is important to note due to the fact that shame may impact the severity and perseverance of mental distress.

In summary, research has demonstrated that perceived failures, test anxiety, and beliefs about low self-efficacy can lead to feelings of self-blame and shame in the student population and these feelings can be linked with negative emotional and academic outcomes. Compassion Focused Therapy (CFT) was specifically developed to help people cope with shame and self-criticism in healthy ways, as well as to help them with

challenging emotions and life difficulties in productive, non-shaming ways. Therefore, I reasoned that students may benefit from learning about the CFT model and how to apply it in their lives. Helping reduce students' shame/self-blame may ease other anxieties and help them better regulate their emotions and achieve more success in school.

Self-Compassion

A main component of CFT is self-compassion (Gilbert, 2009; 2010). Self-esteem and self-compassion are often confused as the same concept, however there are some key differences (Neff, 2014). Self-esteem relies upon being successful, special, or better than others (Neff, 2014). Difficulty can arise when people are unable to achieve the success they have imagined and internalize this inability as a fundamental flaw within themselves (Turner & Husman, 2008). As mentioned previously, this can be particularly problematic for high school and college-aged individuals experiencing perceived academic failures that are unrealistic in nature (Turner & Husman, 2008). Self-compassion has been shown to have the same benefits as self-esteem with more realistic applications in the sense that self-esteem is unrealistic because high self-esteem relies on being better than others, which is not always going to be the case (Neff, 2014). However, self-compassion allows individuals to acknowledge that they may not always be the best and take responsibility for what they are good at (Neff, 2014).

As defined by Neff (2003), self-compassion has three core components: self-kindness, feelings of common humanity, and mindfulness. Self-kindness is the ability to be kind and understanding with ourselves in ways that are not judgmental or self-critical. Feelings of common humanity refer to an understanding that imperfections and mistakes are experienced by everyone, and are not an individual or isolated experience. The third component of self-compassion, mindfulness, involves being aware of the present and of one's flaws without ruminating on them.

Past research indicates that increased self-compassion is associated with psychological well-being, and inversely, less self-compassion is associated with mental

distress (Krieger, Altenstein, Baettig, & Doerig, 2013; Neff, 2003; Neff, Rude, & Kirkpatrick, 2007) . The relationship between self-compassion and wellness factors has been found in several correlational studies. Positive associations have been noted between self-compassion and positive affect (Neff, Rude, & Kirkpatrick, 2007), satisfaction with life (Neff, 2003), emotional intelligence (Heffernan, Griffin, McNulty, & Fitzpatrick, 2010; Neff, 2003), and social connectedness (Neff, 2003). Furthermore, a negative relationship between self-compassion and symptoms of depression and anxiety has also been found. Neff (2003) examined this association when creating the Self-Compassion Scale to measure the three components of self-compassion. In this study, a significant negative correlation was found between self-compassion and symptoms of both depression and anxiety. Additionally, this association has been noted among individuals with major depressive disorder (Krieger, Altenstein, Baettig, & Doerig, 2013), schizophrenia spectrum disorders (Braehler et al., 2012), and social anxiety disorder (Werner et al., 2012). Cross-culturally, studies examining college students in Iran (Ghorbani, Watson, Chen, & Norballa, 2012), Thailand (Neff, Pisitsungkagarn, & Hsieh, 2008), Taiwan (Neff, Pisitsungkagarn, & Hsieh, 2008), and China (Wong & Mak, 2013) have reported a similar negative relationship between psychopathology symptoms and self-compassion. In summary, self-compassion may be a useful tool for preventing and managing mental distress.

Compassion Focused Therapy

Compassion Focused Therapy (CFT) is a multimodal therapy model designed to help those who suffer from mental health issues associated with shame and self-criticism (Gilbert, 2010). The theory behind CFT developed out of evolutionary psychology, affective neuroscience, and psychological science models (Gilbert, 2010). In conceptualizing psychological disturbances, CFT places emphasis on attachment, emotion regulation, social mentalities, and compassion.

The Roots of CFT

Compassion-Focused Therapy (CFT) is rooted in the observation that there are many factors that shape human development that are neither chosen nor designed by the experiencing individuals (Gilbert, 2010). CFT places a special emphasis on the ways in which our mental experience is dually shaped by the processes of evolution and our early attachment relationships (Gilbert, 2009; 2010). According to Darwin's theory of evolution and natural selection, our genetic makeup and fundamental physical and mental processes are a result of gradual adaptations over time. This includes emotions like joy, kindness, love, anger, and fear, which are seen as evolving to serve specific functions that contributed to our ancestors' survival (Gilbert, 2009; 2010). This evolutionary perspective also provides a context for understanding the development of human abilities to empathize, nurture, and give/receive compassion. For example, mammals, as a result of producing relatively few offspring whom are essentially helpless at birth, evolved to nurture in order to ensure the survival of their genes (Gilbert, 2009).

The genetic shaping of our emotions and temperaments is important in that these characteristics then influence the environments in which we find ourselves, as described in the reciprocal gene-environment model of human development (Barlow & Durand, 2011). For example, in social situations, certain responses or behaviors of one individual can elicit certain types of reactions from others, shaping how these others interact with the individual in turn. If the individual behaves in a manner that others disapprove of, his or her social environment can rapidly become hostile or isolating. In turn, how the individual interprets the responses to them from others can shape how they continue to behave, think, feel in the future, potentially creating feedback loops that can serve to reinforce and entrench particular styles of interaction.

This consideration of evolutionary development highlights a major goal of CFT, which is helping individuals accept that some aspects of their experience is beyond their control and therefore not their fault (Gilbert, 2009; 2010). This knowledge is beneficial when working with clients who experience shame and self-blame, particularly those who

engage in self-shaming and self-attacking in response to their own emotions. Ultimately understanding that there are some aspects of their experience that they did not choose to have and do not directly control allows them to move beyond shaming themselves for those characteristics and focus on the aspects they can change and work with (Gilbert 2009; 2010)

Attachment and the Social Shaping of the Self

Along with our genetic make-up, our early environments and attachment style shapes us in many ways, and are particularly involved in shaping our ability to regulate emotions. Attachment styles develop through a person's early relationships with their caregivers. These relationships play a significant role in shaping our developing minds. Healthy attachments help individuals to regulate and balance their emotions. However, if one's early relationships shape maladaptive attachment styles, it can produce the opposite effect, leading to emotion dysregulation and the inability to self-soothe (Bowlby, 1969, 1973).

According to attachment theory there are four attachment styles (Bowlby, 1969, 1973), and each profoundly impacts individuals in terms of how we experience the world (as dangerous or filled with resources to draw upon), other people (as malevolent or helpful) and ourselves (as worthy of love and care, or as fundamentally flawed and unlikeable).

One of these attachment styles is called "secure" attachment (Bowlby, 1969, 1973). A secure attachment develops when a caregiver acknowledges and meets their child's needs consistently over time. This assists children to develop healthy emotion regulation skills. When a parent does not properly respond to their child's needs repeatedly over time it can lead to what is called insecure attachment (Bowlby, 1969, 1973).

There are three types of insecure attachment styles (Bowlby, 1969, 1973).

Avoidant attachment develops when a child is consistently ignored or rejected by their caregiver when distressed. "As an adult, this child is likely to have difficulty accessing and expressing his/her emotions and will run the risk of being isolated and emotionally disengaged from both him/herself and others" (Teyber & McClure, 2011, p. 11). The second type of insecure attachment is anxious ambivalent. An anxious ambivalent attachment is the result of a parent responding to their child's distress inconsistently or being intrusive and unsupportive of the child's independence. As an adult, this child may be needy and have significant levels of worry and anxiety, particularly in relation to being accepted or rejected by others. The third type of insecure attachment is disorganized. Individuals with disorganized attachment have often experienced trauma or abuse at the hands of their caregivers. Often this can result in difficulty maintaining future relationships and put these individuals at higher risk of developing a serious psychosis. Each of these insecure attachment styles can be associated with difficulty in feeling safe and soothed through social contact, contributing to difficulties regulating emotions. In contrast, healthy, secure attachments assist individuals in learning to regulate and balance their emotions. (Bowlby, 1969, 1973)

In CFT, it is important to recognize that both evolution and social/environmental aspects shape us in ways that are beyond our control (Gilbert, 2009; 2010). This knowledge helps individuals recognize that some of the aforementioned unhelpful aspects of themselves are not their fault, including difficulties regulating emotions due to early attachment experiences and/or experiencing certain types of emotions when threats are perceived. Recognizing this can often be the first step towards change, allowing people to focus on what they do have control over in the here and now, and preventing them from getting caught up in shame and self criticism (Gilbert, 2009; 2010).

Model of Emotions

Neurophysiological research has also contributed to the development of CFT and its objectives (Gilbert, 2009). CFT presents a model of emotions that groups our affective

experience into three evolved emotion regulation systems in the brain, each of which is associated with neurotransmitter activity and characteristic patterns of responses. Innately and through conditioning experiences, the brain comes to activate specific systems in particular situations. When the emotion system is activated, it sets certain emotional and physiological responses into motion that are seen as having evolved to guide a person and ensure their survival and/or security. (Gilbert, 2009)

The three emotion systems described in CFT are the threat and self-protection focused system; the drive, seeking, and acquisition focused system; and the contentment, soothing and affiliative-focused system (Gilbert, 2009; 2010). The threat system is focused on identifying and helping us respond to perceived threats, and is associated with emotions such as anxiety, anger, and disgust. Physiologically, this system is associated with the release of stress hormones and activating physiological responses, such as rapid heartbeat or breathing. For example, if we perceive crowds as a threat, we may experience sweaty palms and a racing heartbeat when in a crowded room (Gilbert, 2009; 2010).

The drive system evolved to help us detect and respond to opportunity and to pursue goals necessary for survival and social pursuits; it focuses our attention on resources, such as money or mating opportunities, prompts us to obtain them, and rewards us for doing so. Emotions commonly associated with this system are excitement, desire, and pleasure. Dopamine is a primary neurotransmitter involved with the activation of this system, which can cause one to feel energized or elated. For example, if we need or want money we may then get a job and we feel good once we begin to receive our paycheck (Gilbert, 2009).

The third system, the safeness (soothing and affiliation-focused) system helps bring us to peace and calmness and is activated when one is not facing a threat or in need of resources, but is feeling satisfied (Gilbert, 2009). This system is associated with feelings such as contentment, connectedness, and safeness, and helps balance activation

in the drive and threat systems. Endorphins are associated with this system; these chemicals help one feel soothed and calm. This safeness system is also associated with affiliation and attachment, being cared for, connected, and attended to by others. Also linked to the affiliative and attachment processes is the hormone oxytocin (Gilbert, 2009). This hormone, like endorphins, is related to feeling safe and the reduction of feelings of stress, and is released during nurturing interactions with others (Feldman, 2012).

A CFT perspective suggests a healthy/balanced person is able to access the appropriate systems at the appropriate times, striking a balance among them and implicitly choosing the best one for their current circumstance (Gilbert, 2009; 2010). However, problems can arise for people when the emotion systems become imbalanced and/or the individual cannot easily shift among the systems (Gilbert, 2010). What can be especially problematic is when a person has difficulty accessing feelings of safeness (Gilbert, 2009; 2010). For example, if a person has experienced abusive or neglectful relationships with caregivers or significant others with a corresponding lack of experiences that helped them to feel safe, that person can become habitually stuck in an ongoing threat response and it can be difficult for them to access the safeness system, even when they are in situations in which no threat is present. In such a case, they may have difficulties ever feeling safe.

Relatedly, it can also be problematic when an individual perceives or incorrectly infers threats (particularly social threats) when no threat is present. When this occurs, CFT posits that people begin to develop “safety-strategies” (Gilbert, 2010). Safety-strategies are conceptualized as maladaptive threat-driven coping mechanisms that serve to reduce immediate threat activation but often lead to undesirable unintended consequences that are ultimately problematic for the individual. Safety strategies often involve strategies such as avoidance or angry acting-out which can lead to feelings such as shame, as well as negative social consequences and other undesirable outcomes. This heightened and unhealthy over-activation of the threat system and associated thoughts,

physiological responses, and maladaptive coping mechanisms that result can negatively impact mental health and increase psychological distress (Gilbert, 2010).

In summary, this model of emotions describes how our brains organize and respond to emotions we experience in response to situations that we register as safe or threatening based on the interaction between our genetic makeup and life experiences. This model allows for the development and implementation of interventions to promote adaptive emotional regulation and assist individuals in balancing their emotions.

Social Mentalities

In addition to the emotion regulation systems discussed above, CFT posits that individuals typically develop patterns for specific social situations and relationships (Gilbert, 2009). In CFT, these patterns are referred to as “social mentalities” (Gilbert, 2009; 2010). For example, the drive system, which evolved to motivate us to obtain resources, is associated with competitive or rank-based social mentalities, which organize our thought processes and behaviors in socially competitive situations. As such, social mentalities are seen as providing a link between people's cognitions/thought process and behaviors they engage in order to obtain and maintain social relationships. Social mentalities are created out of a person's innate motivation to develop specific social relationships, like seeking out a caregiver. These mentalities influence a person's emotions, thoughts, and behaviors in ways that lead them to develop relationships that fill a need, such as emotional support (Gilbert, 2009).

Social mentalities are also conceptualized as helping us to recognize when a relationship has developed, guide our feelings and interactions in appropriate ways that benefit the relationship and maintain it, and tend to produce certain corresponding emotions (positive or negative) depending on how the relationship is developing (Gilbert, 2009). They not only organize a person's own thoughts, feelings, and behaviors in regards to a relationship, but also help one maintain awareness of the desired other's thoughts,

feelings, and behavior. For example, social mentalities help us recognize when a friend is upset and needing reassurance (Gilbert, 2009).

Gilbert (2009) suggests that over time, our brains develop several types of social mentalities as a result of the interaction between our evolved predispositions (for example, to obtain resources and form social connections) and our individual life experiences. Examples of such mentalities include care seeking, care-giving, cooperation/establishment of groups, social rank/competition, and sexuality, with each mentality being associated with different motivations and patterns of attention, cognition, and using different emotional systems to help obtain and preserve the needed relationship. For example, a care-seeking mentality is seen as guiding one to people who are helpful and who potentially can fulfill a need of being protected or attended to in a way that will ease suffering or distress and increase safeness feelings. Evolutionarily speaking, this offers several advantages in terms of protection and coping, however if one seeks such relationships and the efforts are futile, it can increase feelings of distress or can lead to seeking out a person who offers protection but not affection, which can ultimately lead to more distress.

Another example of a social mentality is the social rank/competition mentality. This mentality focuses one's awareness of one's standing in society, among peers, etc., and involves considering how much power and control one has within his or her community. Gilbert suggests that this awareness evolved out of a need to organize people and resources and that it motivates people in all areas of life - work, school, friendships, and other areas. In summary, these social mentalities highlight how we have evolved specific mental capacities to increase our survival and health via social relationships. This occurs by developing patterns of thinking and behavior that are beneficial towards our goals, in particular social situations (Gilbert, 2009).

As with the emotion systems, people have learned, consciously and subconsciously, to alternate among these mentalities according to their current needs.

However, when this ability has not been learned, it can lead to difficulties. For example, if one is playing out a rank-based/competitive social mentality at a casual social event, behaving in a competitive manner can create difficulties in the ability to engage in normative social interactions in that context. In increasing one's awareness of social mentalities and how they play out in one's minds, CFT seeks to increase the fluidity with which a person can draw upon and successfully apply these mentalities in their lives.

Compassion: Mind & Self

Compassion Focused Therapy addresses the issue of maladaptive emotional responses and the resulting unbalanced emotion system and unhelpful behaviors and thoughts that occur. Such a situation is exemplified when an individual is unable to access the safeness system after living in a constant threat state. Often the threat system can be stimulated unnecessarily or in situations in which it is no longer adaptive. For example, a hyper-vigilant individual with posttraumatic stress disorder may perceive danger even in normal social situations. The aim of CFT is to establish a healthy and flexible relationship between the three systems by reducing the over-activation of the threat system and increasing access to the safeness system; for example, by increasing the individual's ability to self-soothe (Gilbert, 2009; 2010).

The primary method of accomplishing this is to work with the threat and soothing systems to establish more adaptive emotional responses. This is achieved through the development of specific capacities (Gilbert, 2009). Empathy is one of these capacities and is the ability to be compassionate and understanding towards the self and others. This ability allows individuals to non-judgmentally increase their understanding of others' difficulties and their own.

Another one of the capacities that leads to more helpful emotional responses is mindfulness. Mindfulness is the ability to have non-judgmental awareness of the present. This helps individuals recognize their automatic thoughts and change them to be more compassionate (Gilbert, 2009).

Compassion is another capacity that allows for more adaptive functioning. Compassion involves two specific components: the sensitivity to suffering in self or others and the felt motivation to help alleviate and address it (Gilbert 2009; 2010).

Another skill to promote adaptive emotional responses is distress tolerance. Distress tolerance is the ability to experience painful emotions as they occur. In CFT being able to experience these emotions without criticizing oneself is key.

Adaptive coping strategies are also promoted in CFT. They involve healthy ways of managing and processing painful thoughts and feelings. For example, an adaptive coping strategy for shaming self-dialogue may be to become mindfully aware of it and redirect one's attention to the cultivation of self-compassionate dialogue.

Finally, the capacity to regulate physical arousal responses occurs through the use of adaptive coping strategies and compassionate relaxation techniques that allow individuals to alter the state of their body from stressed to soothed. As a whole, CFT refers to the cultivation of these capacities as the development of the "compassionate self." This development occurs through a process of guided discovery as well as skill development and exercises (Gilbert, 2009).

Three exercises that are used to help develop the compassionate self in CFT and the CFT class are soothing-rhythm breathing, guided compassionate imagery, and compassionate letter writing. Soothing-rhythm breathing allows an individual to gradually transition from the emotional state of feeling threatened and stressed to a state of calmness. It begins by having an individual shift to a comfortable posture with their spine straight and feet on the floor if they are sitting. They focus on their breathing, and mindfully and purposefully slow down the breath. This exercise helps individuals reduce the physiological arousal, such as increased heart rate or muscle tension that can serve to fuel threat emotions like anger and fear. Reducing this arousal prepares the individual to work with challenging emotions and to improve decision-making (Gilbert, 2009)

CFT also utilizes compassionate imagery to help develop the compassionate self (Gilbert, 2009; 2010), and to assist the individual in stimulating the safeness system. Compassionate-self imagery uses method-acting techniques to help individuals connect with how they would feel, think, and behave as if they had already succeeded in cultivating qualities such as compassion, kindness, wisdom, confidence, and distress tolerance. The goal is to help clients begin to think of themselves already possessing compassionate qualities, and to practice how they might act, think, and feel as this “compassionate self” (Kolts, 2011, p.148).

Safe-place imagery is another imagery exercise used in CFT. This imagery focuses on imagining a place where one feels safe, supported, and cared for. The purpose of this exercise is to create a time and space where no feelings of threat or drive are present, and in which the safeness system is activated. These exercises are used to help the individuals soothe and relax their bodies in preparation for the cultivation of qualities such as self-compassion, empathy, and distress tolerance.

The CFT exercise of compassionate writing involves writing a compassionate letter to oneself. This letter should be written from the compassionate self to the current or future struggling self. It should be encouraging, accepting, and kind. This letter helps organize all the things learned during a CFT intervention and can be used as a reference and tool in the future. Overall, these exercises are designed to provide individuals with skills needed to develop the attributes that compose the compassionate mind, which will help them cope effectively with challenging emotions and situations (Gilbert, 2009).

Furthermore, developing this compassionate mind and the associated attributes allows individuals to then apply compassion to themselves, which a primary goal of CFT. This emphasis on self-compassion in CFT evolved out of the observation that many individuals who struggle with emotions engage in extensive self-criticism and shame-based self-attacking (Gilbert, 2010). Coping with this shame and self-blame is a key focus of CFT. The goal is to help the individual cease the loop of self-shaming

rumination, so that they can access feelings of safeness and work with difficulties in a productive manner. Ultimately achieving a more balanced and well-regulated emotion system (Gilbert, 2009).

Previous Research on CFT

Several studies have supported the benefits of utilizing CFT as a way to manage mental distress. One study utilized a CFT group treatment for individuals in the community with histories of enduring mental health concerns (Judge, Cleghorn, McEwan, & Gilbert, 2012). Participants reported high levels of shame and self-criticism at the start of group. Over 12-14 weekly group sessions, participants took part in a typical CFT counseling group. This includes completing exercises like guided compassionate-self imagery and soothing rhythm breathing. Participants demonstrated significant decreases in depression, anxiety, and levels of shame as measured by pre- and post-test questionnaires.

Another study examined individuals with schizophrenia-spectrum disorder after adding CFT to their usual group treatment (Braehler et al., 2012). Participants had sixteen weekly sessions in which they participated in CFT interventions such as mindfulness and compassionate imagery. Afterwards, participants showed significant improvements in psychosis. The same participants also completed narrative interviews in which increased compassion among participants was noted at the end of treatment compared to the group with no CFT. This increase of compassion was correlated with diminished fears about relapsing, decreased depression, and reductions in negative beliefs about their mental health.

In further support of the efficacy of CFT, a study investigating individuals with personality disorders administered a sixteen-week group therapy CFT program (Lucre & Corten, 2012). During the program clients were educated on the CFT model and participated in compassionate mind training, including self-soothing and compassion-focused imagery. Results showed reductions in shame, self-hatred, depression, and stress.

The same study also found reductions in negative social comparisons, results also reflected in the Judge et al. (2012) study.

This research illustrates the effectiveness of CFT to reduce mental distress, including shame and self-criticism. This suggests that CFT may be beneficial for students who self-criticize, strive in a stressful and competitive environment rife with peer comparison, and who are vulnerable to feelings of shame.

The Current Study

This study aimed to contribute to past CFT research by exploring a potentially viable form of administration that would allow CFT to be effectively applied in mass group settings to benefit non-clinical populations. Students participating in a university Introduction to CFT course received an orientation to the CFT model and exposure to CFT interventions/exercises over a 10-week period. Through the assessment of a variety of pre-test/post-test measures CFT treatment, students were compared to a control group of students in a Introductory Statistics course. I hypothesized that CFT students would show a decrease in shame, self-criticism, and fears of compassion and an increase in self-compassion, gratitude, and positive affect relative to controls after exposure to the CFT model and several CFT skills and interventions.

Method

Participants

Participants were 48 psychology students at a university in the inland northwest of the United States. Participants in the CFT group were drawn from a university course in Compassion Focused Therapy, which had an overall enrollment of 43 students. Control participants were drawn from an Introductory Statistics course taught by the same instructor, which also had an overall enrollment of 43 students. Participants were invited to participate and were rewarded with extra-credit applying to the relevant course in which they were enrolled. Ultimately, 24 students in the Compassion Focused Therapy

class and 24 students in the Introductory Statistics class chose to participate in both (pre-test and posttest) facets of the study.

Design

This study utilized a 2 (group) \times 2 (time) mixed factorial design. Dependent variables analyzed were self-compassion, positive affect, gratitude, shame, self-criticism, and fears of compassion. Pre-test/post-test measures were analyzed for each group using a General Linear Model (GLM) analysis conducted in SPSS version 21.

Measures

Self-Compassion. Self-Compassion was measured using the Self-Compassion Scale (SCS) (Neff, 2003). The SCS is considered a valid and reliable scale designed to measure an individual's level of self-compassion (Neff, 2003). The measure consists of 26 statement items ("I'm disapproving and judgmental about my own flaws and inadequacies") that are rated on a scale of 1 (almost never) to 5 (almost always). The items comprise six subscales: Self-Kindness, Common Humanity, Mindfulness, Self-Judgment, Isolation, and Over-identification. Self-Kindness assesses one's kind and understanding attitude toward the self as opposed to the Self-Judgment subscale, which addresses being critical of the self. The Common Humanity subscale measures the extent to which individuals consider their experiences as relatable to the general human experience, as opposed to alienating or negatively unique experiences, which are measured by the Isolation scale. The Mindfulness scale assesses an individual's ability to consider negative or distressing thoughts and feelings in balance with other emotions instead of over-identifying and focusing on them. The Self-Judgment, Isolation, and Over-Identification subscales are reverse coded and then an average of all the subscales is calculated to determine an individual's level of self-compassion. Reported internal consistency reliability for each of the subscales was good, with Cronbach's alphas between .75 and .81 (Neff, 2003). Good construct validity was demonstrated by finding significant positive Pearson correlation coefficients between the SCS and scales

measuring similar constructs to self-compassion (Neff, 2003). Additionally, a significant negative correlation was found between the SCS and a Self-Criticism subscale (a construct opposite to self-compassion) (Neff, 2003). Good test-retest reliability was also observed with a correlation of .93 for overall scores (Neff, 2003). The current study, reported good internal consistency with a Cronbach's alpha of .94 ($M = 3.01$ $SD = .73$).

Self-Criticism. Self-criticism was measured using the Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS). This scale was developed by Gilbert, Clark, Hempel, Miles and Irons (2004) to measure self-criticism and an individual's ability to reassure themselves ("when things go wrong for them"). The scale consists of 22 items measuring two components. One component is self-criticalness, which consists of two subscales: the inadequate self and the hated self. The inadequate self subscale focuses on thoughts and feelings of personal inadequacy. The hated self subscale measures one's desire to engage in self-harm or self-condemnation. The other component is the self-reassure subscale. The statement "when things go wrong for me" is given followed by a list of response statements such as "I remember and dwell on my failings" and "I am gentle and supportive with myself" to which the individual responds using a 5-point Likert scale of 0 (not at all like me) to 4 (extremely like me). Gilbert et al. (2004) reported good reliability with Cronbach's alpha coefficients of .90 for inadequate self and .86 for hated and reassured self and demonstrated validity when compared with measures assessing related constructs. (Gilbert et al., 2004) The current study reported good internal consistency reliability for the hated self subscale with a Cronbach's alpha of .85 ($M = 3.44$, $SD = 4.83$) and for the reassured-self subscale with a Cronbach's alpha of .85 ($M = 21.66$, $SD = 5.93$).

Positive Affect. The Positive and Negative Affect Scale - Expanded Form (PANAS-X) was developed by Watson and Clark (1999) as a means to measure general positive and negative affect, as well as 11 specific affects. These 11 specific affects/scales are categorized into three groups. The Basic Negative Emotion Scales

consists of the specific affects of Fear, Sadness, Guilt, and Hostility. The Basic Positive Emotion Scales are Joviality, Self-Assurance and Attentiveness. The Other Affective States are Shyness, Fatigue, Surprise, and Serenity. The measure consists of 60 items made up of words and phrases that represent an emotion and/or feeling such as "afraid" or "joyful". The individual indicates the extent to which they have felt that way 'during the past few weeks using a 5-point Likert scale, from 1 (very slightly or not at all) to 5 (extremely). It has demonstrated good psychometric properties with high internal consistency reliabilities ranging from Cronbach's alpha .83 to .90 and good construct validity (Watson & Clark, 1999). The current study reported good internal consistency reliability for the positive affect subscale with a Cronbach's alpha of .90 ($M = 32.22$, $SD = 9.48$).

Shame. The Experiences of Shame Scale (Andrews, Qian, & Valentine, 2002) was used measure the construct of shame. This is a 25-item questionnaire that features questions regarding shame such as, " Have you felt ashamed of your manner with others?" Responses are made using a 5 point scale, ranging from 1 (not at all) to 5 (very much). High internal consistency was reported with a Cronbach's alpha coefficient of .92. The measure also has demonstrated good test-retest reliability with a correlation of .83 (Andrews, Qian, & Valentine, 2002). The current study reported good internal consistency with a Cronbach's alpha of .96 ($M = 52.18$, $SD = 17.08$).

Gratitude. The Gratitude, Resentment, and Appreciation scale revised (GRAT-R) was used to measure gratitude (Watkins, Woodward, Stone, & Kolts, 2003). This is a 44-item measure that features statements regarding gratitude such as, "I feel grateful for the education I have received." Responses are made using a 9 point scale, from 1 (I strongly disagree) to 9 (I strongly agree with the statement). This measure has good internal consistency with a Cronbach's coefficient of .92 (Watkins et al., 2003). The current study reported good internal consistency with a Cronbach's alpha of .93 ($M = 312.18$, $SD = 39.24$).

Fear of Compassion. The Fear of Compassion Scale (FOC) is used to measure fears of compassion (Gilbert, McEwan, Matos, & Rivis, 2011). The scale consists of three subscales measure fear of compassion for others, from others, and for self. All three subscales combine consist of 41 statement items with a Likert response scale, from 0 (don't agree at all) to 4 (completely agree). The fear of compassion from others subscale measures an individual's insecurities regarding the safeness and support of others. It consists of 13 items (e.g. "If people are kind I feel they are getting too close") with a Cronbach's alpha of .87 (Gilbert et al., 2011). The fear of compassion subscale for others evaluates an individual's ability to be caring towards others. It is comprised of 13 items (e.g. "People will take advantage of you if you are too forgiving and compassionate") with a Cronbach's alpha of .78 (Gilbert et al., 2011). The fear of compassion for self subscale measures one's ability to be self-compassionate. It has 13 items (e.g. "I find it easier to be critical towards myself rather than compassionate") with a Cronbach's alpha of .85 (Gilbert et al., 2011). The current study reported good internal consistency for the compassion for others subscale with a Cronbach's alpha of .89 ($M = 15.05$, $SD = 8.43$), for the compassion from others subscale with a Cronbach's alpha of .91 ($M = 13.07$, $SD = 9.08$), and for the compassion for self subscale with a Cronbach's alpha of .94 ($M = 10.28$, $SD = 10.97$). The current study also reported good internal consistency for the fear of compassion total scale with a Cronbach's alpha of .96 ($M = 35.67$, $SD = 23.61$).

Procedure

Participants in both classes first completed the packet of measures as a pre-test assessment in the first week of class. Pre and Post questionnaire packets were later linked through the use of unique subject identifier codes. Participants created their codes for this study by combining the first three letters of their mother's maiden name, the digit number of blood related siblings they have, and the digit number of the day their birthday is on.

Participants in the treatment condition learned about the theoretical basis and clinical practice of CFT, and learned about and took part in several CFT interventions

over a period of 10 weeks as part of the CFT course. Participants learned and repeatedly participated in soothing-rhythm breathing exercises led by a clinical psychologist (the professor). They also participated in guided compassionate-self imagery. This imagery exercise involved participants visualizing themselves as compassionate and is based on the method outlined by Gilbert (2009). Participants in the CFT group were also guided in a safe-place imagery exercise adopted from Gilbert (2009). Participants in the treatment condition also wrote reflective papers bi-weekly focused on how they were relating the material to their lives, and wrote a compassionate letter to themselves at the end of the quarter, an exercise obtained from Gilbert (2010). Throughout this time, participants receiving the treatment were oriented to and educated in the CFT model twice weekly as a class. Participants in the control condition did not partake in any of these interventions and attended an Introduction Statistics class that was unrelated to CFT, but was taught by the same professor. At the end of the quarter, during the ninth week (the week prior to final exams), participants in both conditions completed the same packet of measures as a post-test assessment to track possible changes in levels of shame, gratitude, positive affect, and compassion.

Results

In order to test the hypotheses that the CFT condition would demonstrate changes on the dependent measures relative to participants in the control condition, a series of mixed-model 2×2 (time \times condition) ANOVA analyses were performed via SPSS General Linear Model (GLM) procedures, using the full measure of self-compassion, the hated-self and self-reassure subscales of the self-criticism measure, the full measure for shame, the full measure and all three subscales of the fears of compassion measure, the full measure of gratitude, and the positive affect subscale as dependent variables. It was predicted that individuals in the treatment group (the CFT class) would have significantly higher levels of increases in self-compassion, gratitude, and positive affect relative to control subjects. It was also predicted that participants in the CFT group would have

significantly decreased levels of fears of compassion and shame after receiving the treatment relative to controls.

Regarding self-compassion there was no significant main effect of time $F(1,42) = 2.52, p = .120, \eta^2 = .06$. There was also no significant main effect of group $F(1, 42) = 0.46, p = .502, \eta^2 = .01$. There was no significant interaction between time and group, $F(1,42) = 0.37, p = .548, \eta^2 = .01$. This suggests that exposure to the CFT treatment did not significantly impact participants' levels of self-compassion.

With regard to Fear of Compassion, three subscales were analyzed to assess fear of compassion for others, fear of compassion from others, and a fear of compassion for the self, and then a total fear of compassion score was produced. It was predicted that individuals in the CFT group would have decreased levels of fear of compassion after treatment compared to prior to treatment and to the control group. The analysis of the total score revealed a significant main effect of group $F(1,39) = 0.76, p = .019, \eta^2 = .13$, with individuals in the CFT group ($M = 26.50, SD = 25.53$) having significantly lower fears of compassion compared to the control group ($M = 46.53, SD = 23.60$), (See Table 1 for all means and standard deviations). There was no significant main effect of time for the total score, $F(1,39) = 0.76, p = .388, \eta^2 = .02$. There was no significant interaction for the total score, $F(1,39) = 1.40, p = .245, \eta^2 = .04$. Regarding the fear of compassion for others subscale, there was a significant main effect of group $F(1,39) = 13.89, p = .001, \eta^2 = .26$, with CFT group having significantly less fear ($M = 9.05, SD = 7.05$) than the control group ($M = 18.16, SD = 8.41$), (See Table 1). There was no significant main effect of time, $F(1,39) = 1.10, p = .166, \eta^2 = .05$, as well as no significant interaction $F(1,39) = 0.84, p = .365, \eta^2 = .05$. The same analysis was conducted for fear of compassion from others subscale yielding no significant main effect of group, $F(1,39) = 3.79, p = .059, \eta^2 = .09$. No significant main effect of time was found $F(1,39) = 0.08, p = .774, \eta^2 = .00$. And there was no significant time \times group interaction, $F(1,39) = 0.57, p = .457, \eta^2 = .01$. Similarly, no significant effects were observed on the last subscale, fear of

compassion for self, for group, $F(1,39) = 1.51, p = .227, \eta^2 = .04$, time $F(1,39) = 0.23, p = .638, \eta^2 = .01$, and the time \times group interaction, $F(1,39) = 1.20, p = .280, \eta^2 = .03$. The results suggest that within the treatment group fears of compassion were not significantly changed. However, compared to the control group, the CFT group reported significantly lower fears of compassion overall, which was particularly evident in the compassion for others subscale. However, contradictory to my hypotheses, no significant differences were observed between groups in changes in compassion over the time of the intervention.

It was predicted that levels of gratitude would increase over time for the CFT group and remain the same for the control group. Analysis revealed no significant effects of group, $F(1,41) = 1.13, p = .294, \eta^2 = .03$, time, $F(1,41) = 2.35, p = .133, \eta^2 = .05$, and for the group \times time interaction, $F(1,41) = 0.06, p = .815, \eta^2 = .00$. These results suggest that exposure to CFT treatment did not significantly affect participants' gratitude relative to controls.

It was predicted that positive affect would increase for individuals in the CFT group and remain consistent for the control group. Analysis of positive affect revealed a significant main effect of group, $F(1,43) = 13.34, p = .001, \eta^2 = .24$, with the control group having significantly higher positive affect compared to the treatment group (see Table 1 for all means and standard deviations). There was no significant main effect of time, $F(1,43) = 0.07, p = .787, \eta^2 = .00$. There was also no significant group \times time interaction, $F(1,43) = .13, p = .725, \eta^2 = .00$. These results suggest that while the CFT group reported higher positive affect over both time periods than controls, no difference between groups was observed in changes of positive affect over the intervention period.

In the GLM analysis examining shame, a marginally significant group \times time interaction was observed for shame $F(1,27) = 3.24, p = .083, \eta^2 = .11$, with levels of shame decreasing for the CFT treatment group over time (See Figure 1). There was no significant main effect of group, $F(1,27) = 0.47, p = .498, \eta^2 = .02$ and no significant

main effect of time, $F(1,27) = 0.07, p = .792, \eta^2 = .00$. This suggests that levels of shame were decreased and with exposure to treatment, however the marginal level of significance reached by this hypothesized interaction prevents substantive interpretative statements from being made.

A repeated measures ANOVA was conducted on the forms of self-criticizing/attacking and self-reassuring scale. Analysis revealed no significant interaction for the hated self subscale, $F(1,44) = 0.09, p = .764, \eta^2 = .00$. There was also no significant main effect for time for this scale, $F(1,44) = 0.50, p = .486, \eta^2 = .01$. And no significant main effect for group, $F(1,44) = 0.11, p = .745, \eta^2 = .00$. Analysis of the reassured self scale revealed no significant interaction, $F(1,44) = .00, p = .975, \eta^2 = .00$. There was no significant main effect of time found, $F(1,44) = 0.35, p = .558, \eta^2 = .01$. There was no significant main effect of group found, $F(1,44) = 1.96, p = .168, \eta^2 = .04$. Results for the overall score and for the inadequate self could not be produced. The results suggest that the CFT treatment did not significantly impact self-criticism.

Discussion

The purpose of the current study was to evaluate the potential effectiveness of a CFT introduction course as an intervention to improve mental well-being and decrease mental distress in college students. It was hypothesized that individuals exposed to the CFT course, which included exposure to the CFT model as well as active experience with CFT interventions and reflective writing assignments designed to apply the concepts to their lives, would show improvements in levels of self-compassion, positive affect, and gratitude relative to controls. It was also predicted that levels of shame and fears of compassion would decrease in CFT participants relative to those in the control condition.

Contrary to the hypotheses, no significant group \times time interactions were observed for any of the dependent variables. The sole significant effects were main effects of group on the total Fear of Compassion (FOC) scale, the FOC Compassion for Others subscale, and the PANAS positive affect scale. Individuals in the CFT course

reported having fewer overall fears of compassion, fewer fears of expressing compassion to others did individuals in the control group. This is possibly due to the different natures of the course and the individuals taking them. The CFT course is a voluntary elective course not required by a department, as opposed to the statistics course, which is a required class for several majors. This potentially creates an imbalance between the motivations and attitudes of participants. For example, if students are voluntarily taking the class out of an interest and excitement regarding compassion this may have impacted their scores regarding compassion. These students in the CFT class may have maintained a greater desire to be compassionate and a level of investment towards the class and participation. In addition, these students were mostly psychology students indicating a prior knowledge of related concepts, such as mental well-being and empathy, maybe even compassion. This previously existing knowledge of psychological functioning and the benefits of compassion could have contributed to an overall greater understanding and acceptance of these concepts being measured. It is also possible that this previous knowledge could have created less fear regarding compassion because students understood the concept and its benefits. Furthermore, students may already have been utilizing techniques and ideas learned in previous psychology classes that enhance their general level of compassion and reduce anxiety associated with compassion. However, students in the statistics course may have been more apprehensive and reserved about the class and potentially even about participating in the current research. Having been required to take this course without having more of an invested self-motivated interest could have reflected on their fears of compassion scores. Statistics is also known for being a challenging class for many students. Additionally, as many of these students were not psychology students, they may been less formally familiar with the concept of compassion. A lack of understanding regarding this concept may have translated into a fear or sense of apprehension regarding being compassionate in general and towards others. In summary, these differences between classrooms and participants could

potentially have impacted scores between groups, with the CFT class having less fear towards compassion in general compare to the statistics class. Thus, future research may benefit from using a more neutral course as their control group and utilizing random assignment if possible. Setting the experiment up in this way may prevent potentially confounding imbalances between groups.

Contrary to the hypothesis, there was a significant main effect of group for positive affect with the control group having more positive affect than the CFT group. Some of the words rated on the positive affect scale included "alert," "attentive," and "active." Students may have reported feeling this way more in the statistics course because it was earlier in the morning compared to the CFT classes and one of their first classes of the day.

The only result that was consistent with the current hypotheses was a marginally-significant group \times time interaction for shame, in which individuals in the CFT group tended to demonstrate greater reductions in shame over time than those observed in control participants. This pattern was predicted, in that CFT is specifically designed to address issues of shame and self-criticism. However, the marginal nature of this effect combined with the non-significant effects observed for all of the other hypothesized comparisons, limits the interpretation of this finding.

With regard to the other non-significant effects, results indicated that levels of self-compassion, gratitude, and positive affect changed in the predicted direction for the CFT group, but not to a significant degree. One reason for this may be the low level of engagement between group members. In this study, we were testing to see if larger groups engaging in a more didactic experience would be able to benefit given the material presented in the CFT course. However, the results suggests that learning the concepts of CFT and engaging in experiential exercises was not a powerful enough treatment to produce the desired effects of a therapeutic group intervention to a significant degree. This may be due to the instructional nature and the classroom setting

of the course, which resulted in an absence of therapeutic interactions between group members. This supports the idea that cohesion and supportive interactions among group members may be a crucial factor contributing to the effectiveness of group interventions. In addition, the lack of inter-member group participation resulted in a lack of feedback from peers. In fact, the primary form of feedback received was a grade assigned by the professor. This type of feedback may have been an issue for some participants who have a tendency to self-criticize or perceive grades as negative evaluations of the self, and limited the ability of the participants to focus on the more therapeutic aspects of the course.

Furthermore, the large group size may have exacerbated the lack of interaction among members. Studies have shown that smaller counseling groups, ranging from 3-6 people are more effective than larger groups (Wheelan, 2009; Kivlighan, London, & Miles, 2012). Kivlighan et al. (2012) noted that larger groups of about 10 to 12 members were associated with more in-group conflict and less engagement. It is speculated that smaller groups are associated with the members having more active roles and individuation (Kivlighan et al., 2012). For this study, the CFT class had 43 students, clearly limiting possibilities for building cohesion and processing among the group. While it was thought that the reflective writing exercises might potentially substitute for the processing of issues in the group context, the study results do not support this. Ultimately, the findings of this study support the long-held idea that interpersonal relationships among group members are a necessary factor in promoting therapeutic change in group settings. Future studies examining large group interventions may benefit from creating a more interactive environment in which group members can share and process their thoughts and feelings with one another.

Another factor that may have influenced the effectiveness of the class as an intervention is that participants were being graded on their work in the class. Most individuals join a therapy group because of a desire to bring about positive change in

their lives. However, this group was participating as part of their education and to receive a graded course credit. There are two ways in which this may have impacted the ability of participants to benefit from the material. The first is that, as class members, participants in the CFT condition may have been lacking the internal motivation to change that many people in therapy maintain. The motivation for these participants may have been solely to learn and do well in the class. Thus, they may not have been focused on integrating the material into their own lives, preventing them from receiving all the benefits of the treatment. Second, participating in a class for a grade may have added undue pressure on the participants to understand the material, and prevented learning and application of the material on a deeper level. In fact, they were learning the material in the very environment that is associated with stress and self-criticism – the classroom (Andrews, Qian, & Valentine, 2002; Candea & Szentagota, 2013; Turner & Husman, 2008). This may have hindered the participants' ability to personalize and effectively integrate the skills into their lives in a meaningful way because they may have been more concerned about getting a good grade. They also may have experienced more stress associated with the intervention than expected due to the grading procedures. Future studies could use a more therapeutic setting in which participants are explicitly encouraged to apply the techniques regularly in their own lives – one that does not confound the intervention type (using a larger-scale, more didactic intervention) with the dimension of grading and evaluation for course participation that is not anchored to therapeutic change.

Another possible reason for the lack of significant change within the CFT group and among the student participants in general may be that they had higher baseline scores for the well-being factors and lower baseline scores for the mental distress factors compared to a clinical population. These baseline scores among a non-clinical population could make it more difficult to create significant change because what is attempting to be increased is already present at a healthy level in the participants' lives. Additionally, the CFT group members reported higher levels of self-compassion, gratitude, and lower fears

of compassion pre-treatment than individuals in the control group. This could suggest a difference in well-being or insight into well-being factors, such as compassion, between students pursuing the field of psychology and students in other majors. This implies that for future studies, it may be more beneficial to expose the treatment to individuals who have limited prior knowledge to the concepts behind mental health.

Limitations

The current study included a number of limitations. One limitation was that participants were graded on their class work that was also simultaneously the “treatment.” This added an outside source of pressure and stress directly associated with the intervention, and an incentive to focus on learning/memorizing the material rather than applying it functionally in their lives, potentially interfering with its effectiveness. In fact, if students were not doing well in the course it, could have potentially increased the self-criticism and shame that the treatment was trying to decrease. Future investigations may benefit from creating a less stressful (i.e. ungraded) environment that allows participants to focus on learning and participating in the group rather than have to worry about being evaluated or graded by the professor.

Another possible limitation to the study was the lack of processing and personalization of the treatment. While there was in-class reflection on intervention participation, it was brief and only a few participants in the group vocalized their experiences. This may have prevented further integration and consolidation of the theory into their personal lives. In addition to these limitations, group size may also have been a deterring factor. Group members were unable to learn and give feedback to one another on a personal and emotional level. Ultimately both of these issues could have diminished the amount of change occurring.

Additionally, the Experiences of Shame Scale seemed to be confusing to several of the participants. The way the response scale was formatted for the first question seemed to confuse participants into thinking that they were not supposed to answer

because it was an example of how to use the scale to answer. Leaving this first item of the questionnaire blank discounted several of the questionnaires so that they were not able to be included in the data set. In the future, it may be beneficial to reformat the answering scale for the first question so that the answer spaces are blank.

Furthermore, several participants who completed the pre-test did not complete the post-test and therefore were not included in the data set. This was most likely because the pre-tests were collected during the first day/week of classes. Often students will change their schedules during the first work by adding and dropping classes online. This may be what caused the loss of so many participants. Another reason could be that students did not need any more extra credit, which was the incentive to complete the study. In the future experimenters may want to offer increased incentive to complete the post-test data or ask participants to let the experimenter know if they are dropping out the class and/or group.

In addition to addressing these limitations in future studies, it could be beneficial to select participants randomly so that the results can be more generalizable. Also, utilizing flyers and advertising to gather participants may allow for more people to participate in the study due to internal motivation to change.

Another limitation was a mistake made with the Forms of Self-Criticizing/Reassuring scale. In the copying process, one of the items was partially cut off so that participants could not read the entire statement. Several of the participants left the item blank, which made it impossible to generate the overall score and the score for the inadequate self subscale.

Finally, variations were unable to be noted among demographics. Demographic data were not collected in order to preserve the anonymity of the participants, at the request of the sponsoring university's institutional review board. The lack of demographic data precludes examination of whether or not certain specific participant characteristics such as age or gender may have impacted the results of the study. Future

research would do well to examine the potential impact such personal variables might have on the ability to benefit from compassion interventions.

Conclusion

In summary, this study examined the efficacy of an Introduction to Compassion Focused Therapy course as a possible large group intervention. It was hypothesized that participation in this course and the associated experiential exercises would reduce mental distress and increase feelings related to well-being, such as self-compassion and positive affect. Although some differences were observed between the CFT group and the control group, analysis of pre-test and post-test measures did not support the hypothesis that the CFT group would show greater improvement than the control group over time. These results suggest that although there were changes made within the CFT group in the predicted directions, the classroom CFT intervention was not enough to generate significant levels of change among participants.

This study guides future research on large CFT group interventions for non-clinical populations because it demonstrates that being educated to the model in a didactic style group is not an effective form of administration on its own. Future research studying administration methods for large CFT groups may want to consider having the group be more process oriented and lead by a group facilitator instead of a professor/educator. Ultimately, having a more therapeutic environment and inter-member connection may be most beneficial.

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Table 1. Means and Standard Deviations by Condition

Measure (Pre & Post-Tests)	CFT		Control	
	Mean	SD	Mean	SD
Self-compassion Total Pre	3.06	0.94	2.97	0.47
Self-compassion Total Post	3.23	0.91	3.04	0.49
Fear of Compassion (FOC) Total Pre	31.77	25.10	45.74	24.64
Fear of Compassion (FOC) Total Post	26.50	21.53	46.53	23.60
FOC from Others Pre	10.68	9.56	14.95	8.87
FOC from Others Post	9.50	9.24	15.47	8.81
FOC for Others Pre	11.27	7.82	18.63	7.48
FOC for Others Post	9.05	7.05	18.16	8.41
FOC for Self Pre	9.82	11.23	12.16	11.89
FOC for Self Post	7.95	7.82	12.89	9.55
Gratitude Pre	317.87	37.7	306.05	41.85
Gratitude Post	324.48	44.83	310.90	38.93
Positive Affect Pre	28.75	10.77	36.19	5.78
Positive Affect Post	28.88	7.39	35.24	7.33
Shame Pre	50.46	19.94	51.37	19.35
Shame Post	46.29	17.60	54.47	17.42
Self-Criticising Hated Self Pre	3.70	5.57	3.17	4.07
Self-Criticising Hated Self Post	3.26	4.22	3.00	3.02
Self-Criticising Reassured Self Pre	20.39	7.29	22.61	3.94
Self-Criticising Reassured Self Post	20.78	7.01	23.04	4.74

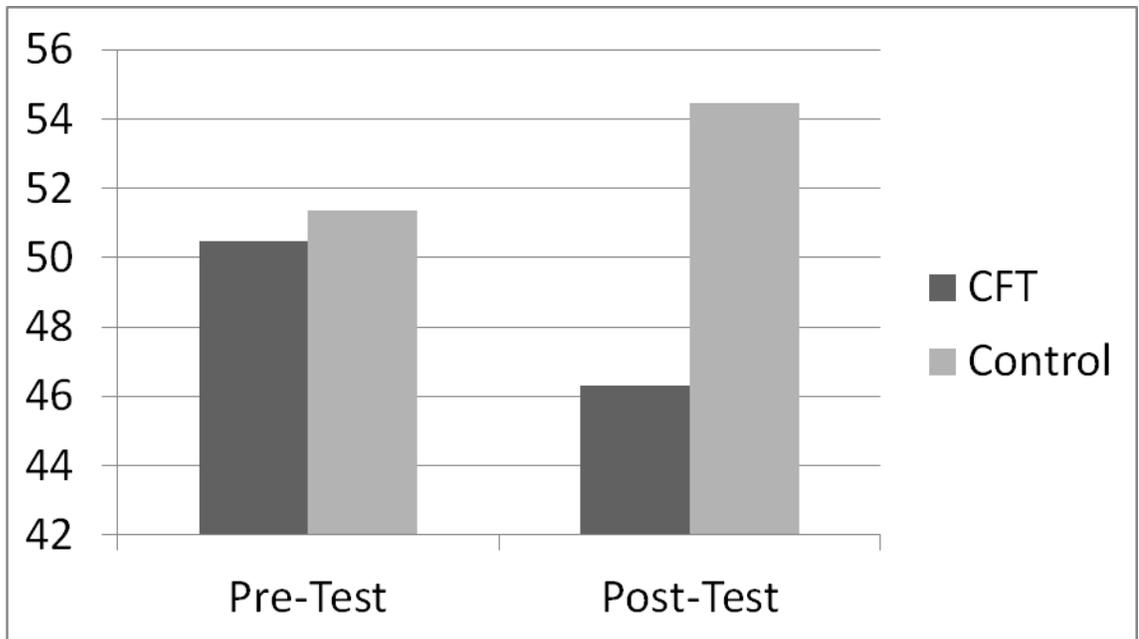


Figure 1. *Interaction of Shame*

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