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Self-Compassion Among College Counseling Center Clients: An Examination of Clinical Norms and Group Differences

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There has been growing interest in the mental health benefits of self-compassion. This study was designed to establish norms on the Self-Compassion Scale–Short Form, a popular measure of self-compassion for individuals seeking counseling, and to examine group differences in self-compassion based on gender, race/ethnicity, sexual orientation, previous counseling, and psychiatric medication use. Data for this study were collected through the Center for Collegiate Mental Health, a practice-research network of more than 240 college and university counseling centers.

Keywords: self-compassion, clinical norms, college counseling

The last decade has seen growing interest in the mental health benefits of self-compassion, a form of self-to-self relating that involves treating oneself with the same kindness, understanding, and support that one would give to a good friend (Neff, 2011). Self-compassion responds to personal experiences of suffering with care and concern, including experiences of perceived inadequacy, failure, and painful life situations. Neff (2003a) defined self-compassion as being composed of three interacting components: self-kindness versus self-judgment, a sense of common humanity versus isolation, and mindfulness versus overidentification when confronting painful, self-relevant thoughts and emotions. These components combine and mutually interact to create a self-compassionate frame of mind.

Self-kindness refers to the tendency to be caring and understanding with oneself rather than being harshly critical or judgmental. Instead of taking a brusque or cold approach in times of suffering, self-kindness offers soothing and comfort to the self. Common humanity involves recognizing that all humans are imperfect, fail, and make mistakes. It connects one's own flawed condition to the shared human condition so that greater perspective is taken toward personal shortcomings and difficulties. Mindfulness, the third component of

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self-compassion, involves being aware of one's present moment experience in a clear and balanced manner rather than exaggerating or overidentifying with the negative aspects of oneself or one's life. Compassion can be extended toward the self when suffering occurs through no fault of one's own—when the external circumstances of life are simply difficult to bear. Self-compassion is equally relevant, however, when suffering stems from one's own mistakes, failures, or inadequacies.

Self-compassion has received increased research attention lately, with more than 200 journal articles and dissertations examining the topic since 2003, when the first two articles defining and measuring self-compassion were published (Neff, 2003a, 2003b). One of the most consistent findings in the research literature is that self-compassion is inversely related to psychopathology (Barnard & Curry, 2011). In fact, a recent meta-analysis (MacBeth & Gumley, 2012) found large effect sizes between self-compassion and depression ($r = -.52$), anxiety ($r = -.51$), and stress ($r = -.54$) across 20 studies. Of course, a key feature of self-compassion is the lack of self-criticism, and self-criticism is known to be an important predictor of anxiety and depression (Blatt, 1995). However, self-compassion still offers protection against anxiety and depression when controlling for self-criticism and negative affect (Neff, Kirkpatrick, & Rude, 2007).

Self-compassion appears to facilitate resilience by moderating people's reactions to negative events. In a series of studies, for instance, Leary, Tate, Adams, Allen, and Hancock (2007) asked undergraduates to recall unpleasant events, imagine hypothetical situations about failure and humiliation, or perform an embarrassing task. Results indicated that individuals who were higher in self-compassion demonstrated less extreme reactions, less negative emotions, more accepting thoughts, and a greater tendency to put their problems into perspective while at the same time acknowledging their own responsibility. Self-compassionate people are less likely to ruminate on their negative thoughts and emotions or to suppress them (Neff et al., 2007). Moreover, self-compassion is directly associated with psychological strengths such as happiness, optimism, wisdom, personal initiative, and emotional intelligence (Heffernan, Griffin, McNulty, & Fitzpatrick, 2010; Hollis-Walker & Colosimo, 2011). Unsurprisingly, people who lack self-compassion are more likely to come from dysfunctional families and display insecure attachment patterns (Neff & McGeehee, 2010; Wei, Liao, Ku, & Shaffer, 2011). It appears that self-compassion can be enhanced through training, however. Neff and Germer (2013) developed an 8-week intervention (mindful self-compassion) for nonclinical populations that has been shown to yield large gains in self-compassion.

Although research on the relevance of self-compassion to mental health is expanding, there are still many unanswered questions. In particular, research on self-compassion has most often focused on the psychological functioning of nonclinical populations, even though the construct has a high degree of clinical relevance (Germer & Neff, 2013). Thus far, there has been no comprehensive research aimed at establishing normative values for individuals who

are receiving mental health services. Moreover, although a small number of studies have examined self-compassion in clinical populations (e.g., Krieger, Altenstein, Baettig, Doerig, & Holtforth, 2013; Kuyken et al., 2010; Van Dam, Sheppard, Forsyth, & Earleywine, 2011; Vettese, Dyer, Li, & Wekerle, 2011; Werner et al., 2012), these studies have been conducted with community samples, and to our knowledge, no research has been conducted with clinical populations in college.

Mental health in college settings has been an area of growing interest. National surveys of college counseling directors suggest that the prevalence and severity of mental health problems may be increasing in the college student population (Gallagher, 2008). It may be that college students seeking services for mental health problems also lack self-compassion, but at this point their normative levels of self-compassion are unknown. Moreover, it is not clear if particular mental health variables such as previous use of counseling or psychiatric medication use affect self-compassion levels. It may be that having a history of counseling or medication use signals more serious mental health challenges, which are related to a lack of self-compassion. If so, it would suggest that counseling efforts aimed at students who have a counseling or medication history should place more explicit emphasis on developing students' level of self-compassion.

There is also increasing interest in understanding how variables such as race/ethnicity, sexual orientation, and gender affect mental health. Previous college mental health studies have revealed that members of cultural minority groups experience greater psychological distress compared with the overall general population (Hayes, Chun-Kennedy, Edens, & Locke, 2011). For example, students who have identified as gay or lesbian have experienced greater rates of depression and suicide (Hayes et al., 2011). Furthermore, racial/ethnic minorities tend to have greater rates of depression and anxiety (Hayes et al., 2011). It may be that minority status also lowers self-compassion, especially since minorities may be less likely to feel a sense of common humanity when facing their suffering. So far, there has been no research exploring whether self-compassion levels differ by race/ethnicity or sexual orientation. If differences do exist, this would have important implications for potential interventions designed to increase college students' self-compassion.

Similarly, women, who tend to be more self-critical than men and display a ruminative coping style (Leadbeater, Kuperminc, Blatt, & Hertzog, 1999; Nolen-Hoeksema, Larson, & Grayson, 1999), often suffer more mental health challenges than men. There has been some prior research investigating sex differences in self-compassion, although findings have been inconsistent. For example, whereas several studies have found that undergraduate women tend to have lower self-compassion than men (Neff, Hseih, & Dejitthirat, 2005; Neff & McGehee, 2010; Yarnell & Neff, 2012), others have not found significant sex differences (Iskender, 2009; Neff et al., 2007; Neff, Pisitsungkagarn, & Hseih, 2008). However, there has been no research aimed at determining whether gender plays a role in the self-compassion levels of college students seeking treatment for mental health issues. It may be that the self-compassion differences are more

clear-cut for this population, given that self-criticism and rumination play a key role in mental health. If women were found to display less self-compassion than men, it would suggest that counseling centers may want to focus more explicitly on raising the self-compassion levels of women seeking treatment.

Many college counseling centers have advocated for a more strengths-based approach in college counseling to complement the traditional focus on diagnosis and psychopathology; however, there has not been a resiliency-based measure that has established clinical norms or group differences for college students seeking treatment. The need of strengths-based measures was explicitly recognized among member-centers of the Center for Collegiate Mental Health (CCMH), a nationwide practice-research network composed of more than 250 university and college counseling centers. Thus, the CCMH advisory board decided in 2012 to investigate the Self-Compassion Scale–Short Form (SCS-SF), which is a well-known and empirically sound measure of self-compassion that could provide clinically useful and relevant information. However, no research has been conducted to confirm whether the SCS-SF is reliable in a college counseling population, nor have scale norms been established for this population.

The purpose of our study, therefore, was to establish reliability and normative values on the SCS-SF for individuals who are receiving mental health services at college counseling centers in hope of increasing the utility of the scale within this setting. Furthermore, we sought information regarding differences in self-compassion according to counseling history or medication use to provide a more nuanced understanding of self-compassion in clinical settings. Finally, our study explored whether race/ethnicity, sexual orientation, and gender are linked to self-compassion in students seeking mental health services.

Method

Participants

Participants were college or university counseling center clients who contributed data to the CCMH. Students were receiving individual counseling from one of 10 university counseling centers located in six different states. A total of 1,609 clients participated in the study. Of the students who identified their gender, 1,035 were women (69%), 461 (30.7%) were men, and four (0.3%) identified as other. Of the students who identified their race/ethnicity, 194 were African American/Black (13%), 127 were Asian American (9%), 880 were European American/White (59%), 194 were Hispanic/Latino/a (13%), 65 were multiracial (4%), and 30 identified as other (2%). The majority of the sample identified as heterosexual (n = 1,288), followed by bisexual (n = 42), gay (n = 33), questioning (n = 30), and lesbian (n = 26). Of the students who reported their academic status, 20% (n = 304) were 1st-year students, 19% (n = 280) were sophomores, 24% (n = 361) were juniors, 21% (n = 312) were seniors, 15% (n = 223) were graduate students, and 1% (n = 12) identified their academic status as other. The age of participants ranged from 18 to 63 years with an average of 22.74 years (SD = 5.63). Nearly 85%

of students were 25 years of age or younger. A total of 738 students reported they had never received any form of mental health counseling, 544 indicated that they had been in counseling previously, and 317 did not report their previous counseling history. Furthermore, 938 students reported they had never taken psychiatric medication, 341 reported they were currently taking and/or had previously taken medication for mental health concerns, and 330 did not respond to the question about medication use.

Measures

Standardized Data Set. The Standardized Data Set (SDS) contains demographic and mental health history questions typically asked of students at intake who are seeking treatment at a university counseling center. We collected demographic information, including race/ethnicity, gender, and class standing, using this form (CCMH, 2012). In addition, we collected information about counseling history and medication use using the SDS. With regard to counseling history, students responded to the following prompt: "Attended counseling for mental health concerns." For medication use, students responded to the following prompt: "Taken a prescribed medication for mental health concerns." For each of those questions, students could respond with "never," "prior to college," "after starting college," or "both." Students who endorsed an option other than "never" were considered to have a history of mental health treatment.

SCS-SF. The SCS-SF (Raes, Pommier, Neff, & Van Gucht, 2011) was constructed as a 12-item short-form version of the original 26-item Self-Compassion Scale (Neff, 2003a, 2003b). The SCS-SF has six subscales that measure the main components of self-compassion: Self-Kindness versus Self-Judgment, Common Humanity versus Isolation, and Mindfulness versus Overidentification. Item responses are indicated using a 5-point scale ranging from 1 *(almost never)* to 5 *(almost always)*. Confirmatory factor analysis for the scale supported the same six-factor structure as found in the long form, including a single higher order factor of self-compassion that could explain the intercorrelations among the six subscales (nonnormed fit index = .96, comparative fit index = .97; Raes et al., 2011). Given the brevity of the SCS-SF, it is recommended that only the total score be examined because subscale scores tend to be less reliable. Total scores are calculated by taking the grand mean of all 12 items after reverse scoring negative items from the Self-Judgment, Isolation, and Overidentification subscales. The SCS-SF has demonstrated adequate internal consistency (α = .86), and the retest reliability measured over a span of 5 months was .71. It was also found to have a near perfect correlation of r = .98 with the long form (Raes et al., 2011).

Procedure

Data for our study were gathered by CCMH during the 2012–2013 academic year. As a practice-research network, CCMH encourages collaboration between researchers and clinicians such that clinicians are involved in all stages of the study, aiming to keep the focus of the research clinically relevant. All schools

contributing data to CCMH received institutional review board approval prior to participating in the study.

Of the 132 colleges and universities that contributed data to CCMH during the 2012–2013 academic year, 10 university and college counseling centers also agreed to administer the SCS-SF as part of a pilot study intended to explore the utility of adding a strengths-based instrument. Participating centers were recruited on a voluntary basis via e-mail to member-centers of the CCMH. Centers then had students complete the SCS-SF at intake along with the SDS. For students who gave consent, all data were de-identified and uploaded to CCMH.

Results

Given the results of item–total correlations, all 12 items of the SCS-SF were found to contribute positively to the internal consistency estimate for the total self-compassion score. Cronbach's alpha was found to be .85, demonstrating good internal consistency reliability.

In terms of the normative self-compassion levels of students seeking counseling, the mean for this sample was 2.80 and the standard deviation was 0.74. We conducted a two-way analysis of variance (ANOVA) to determine if SCS-SF scores differed according to counseling history or use of psychiatric medications (see Table 1). Findings indicated that there was a significant main effect for counseling, $F(1, 1249) = 15.51$, $p < .01$, partial $\eta^2 = .01$, such that students who had been in counseling previously ($M = 2.67$, $SD = 0.71$) had lower SCS-SF scores than those seeking counseling for the first time ($M = 2.94$, $SD = 0.75$). There was no main effect for medication use, $F(1, 1249) = 0.29$, $p = .59$, nor was there a significant interaction effect, $F(1, 1249) = 0.05$, $p = .83$, suggesting that medication use does not affect self-compassion.

We then examined whether self-compassion scores differed according to students' race/ethnicity, sexual orientation, or gender (see Table 2). First, we conducted an ANOVA to determine if differences in self-compassion existed based on race/ethnicity. Results indicated that there were no statistically significant differences in SCS-SF scores based on a client's race/ethnicity, $F(4, 1430) = 0.82$, $p = .51$. Similarly, an ANOVA found no statistically significant differences in self-compassion based on sexual orientation, $F(5, 1414) = 1.61$, p

TABLE 1

Self-Compassion Levels Based on Previous Counseling Experience and Psychiatric Medication Use

	Tests of Between-Subject Effects				
Source	**Type III *SS***	***MS***	***F***	***p***	**Partial η^2**
Previous therapy	1,195.92	1,195.92	15.51	.00	.01
Previous medications	22.26	22.26	0.29	.59	.00
Previous Therapy × Previous Medications	3.46	3.46	0.05	.83	.00

Note. $df = 1$, $R^2 = .03$, adjusted $R^2 = .03$.

= .15. Finally, we conducted an independent sample *t* test to determine if there were differences in the self-compassion levels of men and women. Students who identified as having another gender were excluded from the comparison given the small sample size. Results indicated that there were significant differences in SCS-SF scores as a function of gender, $t = -2.60$, $df = 901.67$, $p < .01$, Cohen's $d = -0.15$, with men reporting greater self-compassion than women.

Discussion

The aim of our study was to establish clinical norms for a brief, popular measure of self-compassion for college students as well as to examine differences in self-compassion based on students' previous mental health utilization, use of psychiatric medication, and important cultural variables. The clinical value of these norms is contingent upon the psychometric properties of the instrument used to establish them. Toward that end, then, the SCS-SF proved to be reliable for use with a clinical college population, evidencing strong internal consistency ($\alpha = .85$). The reliability observed in our study was almost identical to the reliability found for the original SCS-SF ($\alpha = .86$; Raes et al., 2011), which was derived using a nonclinical population. The fact that the SCS-SF is reliable with clients is encouraging because it suggests that the total score can be used as an indicator of self-compassion for college students seeking counseling. Given the large body of literature demonstrating the importance of self-compassion for psychological health (Barnard & Curry, 2011; MacBeth & Gumley, 2012), it is advantageous to have a relatively brief measure of the construct that is reliable for this population. Further work will need to be done to establish the validity of the SCS-SF with college students, however.

TABLE 2

Self-Compassion Levels as a Function of Students' Gender, Race/Ethnicity, and Sexual Orientation

Demographic	*n*	*M*	*SD*	Range
Women	1,012	2.77_a	0.74	1.0–5.0
Men	458	2.88_b	0.71	1.0–5.0
Other	4	2.75	0.61	2.2–3.6
White	868	2.79	0.74	1.0–5.0
Hispanic/Latino/a	190	2.86	0.74	1.1–4.7
African American/Black	187	2.85	0.78	1.1–5.0
Asian/Asian American	125	2.74	0.68	1.3–4.3
Multiracial	65	2.79	0.71	1.3–4.8
Other	30	2.83	0.61	1.7–4.3
Heterosexual	1,268	2.81	0.75	1.0–5.0
Bisexual	42	2.56	0.67	1.1–4.3
Gay	33	2.91	0.66	1.4–4.5
Questioning	29	2.72	0.67	1.5–4.1
Lesbian	24	2.82	0.78	1.7–5.0
Other	24	2.56	0.76	1.1–3.8

Note. Item responses are indicated using a 5-point scale ranging from 1 (*almost never*) to 5 (*almost always*). Means in the same column that do not share the same subscripts differ at $p < .01$.

When comparing norms of the clinical student population in our current study (M = 2.80, SD = 0.74) to those found with general student populations (e.g., Neff, 2003a; Raes et al., 2011), it appears that students seeking counseling tend to have lower self-compassion. It is also worth noting that the self-compassion levels of college students with a previous counseling history (M = 2.67, SD = 0.71) are similar to those found among depressed clients who are not college students. For example, one study found that depressed outpatients had a mean self-compassion score of 2.75 (Krieger et al., 2013), whereas another reported that individuals with recurrent depression had a mean self-compassion score of 2.56 (Kuyken et al., 2010). It is interesting, however, that past research with individuals suffering from anxiety suggests that they may have lower self-compassion than students in our study. For example, Van Dam et al. (2011) found that individuals with a self-reported anxiety disorder had a mean self-compassion score of 2.20, and Werner et al. (2012) also found that individuals with social anxiety disorder had a mean self-compassion score of 2.20. Although we can only speculate as to why self-compassion might be lower among anxious individuals than depressed persons, it could be that anxiety is perpetuated by a lack of self-compassion in a way that depression is not. For example, anxious clients may fear making mistakes because they lack the self-compassion to forgive themselves when they do so. Whereas fear of making a mistake may not cause depression, it does perpetuate anxiety.

Finally, our study examined potential differences in self-compassion based on race/ethnicity, sexual orientation, and gender. Results suggest that self-compassion does not vary according to race/ethnicity or sexual orientation. Thus, cultural minority status among college students does not appear to affect self-compassion, positively or negatively. Whereas the pathways by which self-compassion is developed await future research, results suggest that self-compassion is not a particular struggle for minority students, and this strength can potentially be capitalized on in the course of psychological treatment.

There were small but statistically significant differences in self-compassion between men and women, however, such that men were more self-compassionate than women. These results are in line with other studies with college populations (Neff, 2003a; Neff et al., 2005; Yarnell & Neff, 2012), suggesting that gender differences in self-compassion, though small, hold true for clients as well as the larger campus student body. Messages that young women receive from society about appearance and body image may contribute to a self-critical stance that interferes with self-compassion. Thus, interventions that enhance self-compassion may be particularly important for female college students, both within counseling centers (e.g., self-compassion groups for women) and in outreach efforts across campus (Neff & Germer, 2013).

Implications for College Counseling

With regard to differences found in our study based on students' mental health history, it is important for clinicians to draw attention to the finding that clients who have received counseling previously had significantly lower

self-compassion than clients seeking counseling for the first time. Considering this, counseling center staff may need to be particularly sensitive to the possibility that clients who have prior therapy experience may be self-critical, feel isolated, and overidentify with their problems, given that these are the three counterparts to self-compassion (Neff, 2003a). The importance of this finding is underscored by the fact that nearly half of all college students seeking counseling report prior experience in therapy (CCMH, 2014). It should be noted that, whereas self-compassion varied as a function of prior counseling history, self-compassion was no different among students who were and were not taking psychiatric medication. These findings highlight the fact that self-compassion is an overall important area to examine in clinical populations and could be a contributing factor in why students are seeking counseling. Furthermore, it provides support for the idea that it could be clinically beneficial to focus on self-compassion in sessions and use the SCS-SF repeatedly over the course of therapy to track if and how self-compassion is increasing (e.g., Neff & Germer, 2013).

With regard to previous use of counseling, our study's findings are consistent with a recent study by Boswell, McAleavey, Castonguay, Hayes, and Locke (2012). They found that depression remediated more slowly among students who had been in counseling previously than first-time users of counseling, perhaps because of the chronic and entrenched nature of the concerns of students who had been in therapy previously. It could be that a lack of self-compassion contributes to the chronic nature of students' mental health concerns. Alternatively, it is possible that the previous counseling students received may have been ineffective, both generally and in terms of enhancing self-compassion. Future research should examine this issue directly, especially given that a more nuanced understanding of how compassionately clients treat themselves could help counselors design more effective interventions. Overall, it might be reasonable to expect that building and fostering self-compassion in students who have long-standing mental health issues will take longer than for students who are seeking counseling for the first time.

Finally, despite the lack of significant differences based on race/ethnicity and sexual orientation, these factors may still matter when considering how to raise the self-compassion of clients. If a lack of self-compassion is due to feelings of racial discrimination, for example, or to feelings of isolation due to not having the same sexual orientation as most students, the ways that students are helped to develop greater self-compassion may need to be very different than approaches used with White heterosexual students. Similarly, understanding the reasons why women have less self-compassion than men will also be important in developing treatment modalities. For example, the self-worth of women has been found to be more contingent on perceived appearance than that of men (Harter, 1999), and it may be that issues like body image need to be targeted when attempting to enhance women's self-compassion. Regardless, it will be important for clinicians to examine the potential factors that contribute to a lack of self-compassion in each student individually and then to tailor sessions based on his or her specific needs.

Limitations and Future Research

There are several limitations to our study that should be kept in mind while interpreting the results. First, students' presenting concerns and diagnoses were unknown. As such, we were unable to determine what led them to seek counseling and how those factors may be associated with students' self-compassion. Moreover, this study examined the SCS-SF only at one time point: the start of treatment. Therefore, it is unknown if or how self-compassion changes over the course of therapy. Finally, this study was able to determine that the SCS-SF is a reliable instrument for clinicians to use in college and university counseling centers. However, it is not yet known how the SCS-SF relates to other mental health instruments deemed reliable and valid measures for college student mental health. For example, how does the SCS-SF correlate with other instruments such as the Counseling Center Assessment of Psychological Symptoms–62 (Locke et al., 2011), an instrument widely used in college counseling centers? Examining how the SCS-SF is related to other instruments already established for use in college counseling centers will help to provide additional evidence of the psychometric properties of the SCS-SF as a college counseling center tool.

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