Self-Compassion, Social Interest, and Depression

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Abstract

Depression is a serious condition that manifests through physical, emotional, cognitive, and social impairments. Self-compassion is a particular way of relating to oneself that has roots in Buddhist philosophy but is also gaining an empirical understanding. The following literature review and research proposal examines research relating to self-compassion, depression, and the Adlerian concept of social interest to investigate any correlations, and possible causation, between the constructs. Available research indicated that there are a number of possible variables underlying depression, such as severity level, a tendency toward self-criticism and/or a negative cognitive style, that may affect the course of depression and/or the effectiveness of treatment for depression. Available research indicated that self-compassion is a unique construct that may offer distinctive cognitive, emotional, and behavioral protections. These protections may have particular ramifications for people with a tendency toward self-criticism. An analysis of social interest illustrates that it is an established construct from a theoretical standpoint yet a complex construct to measure from an empirical standpoint. This researcher proposes a study that would analyze the strength and directionality of possible correlations between these constructs and their underlying dimensions as measured by the Self-Compassion Scale, Beck Depression Inventory (2nd ed.), and Sullivan Scale of Social Interest.
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Self-Compassion, Social Interest, and Depression

Sharon Salzberg, a well-known Buddhist teacher from the United States, tells the story of an encounter with Tenzin Gyatso, the 14th Dalai Lama (Salzberg, 2011). In 1990, Salzberg attended a Mind and Life conference in Dharmsala, India. Salzberg wanted to ask the Dalai Lama about personal suffering. She posed the question: ‘What do you think about self-hatred?’ (Salzberg, 2011, para. 1). Salzberg reported that silence overtook the room. The Dalai Lama sought various translations from his interpreter. Salzberg wrote that, “finally, looking back at me, the Dalai Lama tilted his head, his eyes narrowed in confusion. ‘Self-hatred?’ he repeated in English, as though trying out the words. ‘What is that?’” (Salzberg, 2011, para. 1).

The Dalai Lama’s surprising unawareness relating to the idea of self-hatred opened the door to a cultural examination for how individuals view themselves (Dalai Lama & Cutler, 1998). The Dalai Lama later noted that “the idea of hating oneself was completely new to me” (Dalai Lama & Cutler, 1998, p. 283). Howard Cutler, an American psychiatrist who has collaborated with the Dalai Lama, suggested that this lack of cultural awareness indicates that self-hatred is not an innate human quality (Dalai Lama & Cutler, 2009). Cutler also hypothesized that, if not an innate human quality, self-hatred could potentially be eliminated.

In subsequent years, the Dalai Lama has discussed the idea of self-hatred in greater detail (Dalai Lama & Cutler, 1998). In order to counteract self-hatred, the Dalai Lama suggested focusing on the innate potential of all living beings and “the positive aspects of one’s existence” (p. 287). The Dalai Lama’s writings have also highlighted one’s relationship to self, observing that “no matter how much we may dislike some of our characteristics, underneath it all we wish ourselves to be happy, and that is a profound kind of love” (Dalai Lama & Cutler, 1998, pp. 286-287). The Dalai Lama noted that people may overlook this relationship with oneself, thinking
that compassion should only be extended outward. Yet he clarified that “love should first be directed at oneself” (Dalai Lama, 2005, p. 25).

The Dalai Lama has strongly emphasized the importance of developing and nurturing compassionate feelings in his teachings (Dalai Lama, 2005; Dalai Lama & Cutler, 1998). This researcher is particularly intrigued with the idea of directing such compassionate feelings toward oneself. This researcher chose self-compassion as the primary variable for this literature review and research proposal because it bridges traditional Buddhist philosophy and current empirical research (Neff, 2003a; Neff, 2003c). The following proposal therefore reviews current research on self-compassion in order to obtain a deeper understanding of the concept and how it plays an important role in mental health.

This literature review and research proposal also attempts to weave together an understanding of self-compassion in relation to two other variables: social interest and depression. This researcher chose social interest as a context variable because of her training in Adlerian psychology. There are also intriguing questions about how self-compassion may facilitate the ability to connect with others. “Loving oneself is crucial. If we do not love ourselves, how can we love others?” (Dalai Lama, 2005, p. 25). Could compassion toward oneself facilitate the ability to care, connect, and empathize with others?

This researcher chose depression as an additional context variable since it is an area of importance in mental health, given the prevalence of major depressive disorder (MDD), the severity of associated role impairment, and the ensuing treatment complexities (Kessler et al., 2003; Kessler, Chiu, Demler, Walters, 2005). This researcher also chose to highlight depression because of the theory of cognitive vulnerability to depression (Abramson, Metalsky, & Alloy,

This literature review explores research relating to self-compassion, social interest, and depression and then identifies potential connections between the variables. This researcher then proposes a study that would measure correlation levels between the three variables and the underlying dimensions that comprise these variables. The goal of the following review and proposal is to highlight self-compassion as a unique and protective mental health variable while also investigating its potential for interaction with social interest and depression.

**Self-Compassion**

Compassion is an emotion and experiential state that differs from analogous emotions such as love and sadness and affective experiences such as empathic distress (Goetz, Keltner, & Simon-Thomas, 2010). Goetz et al. (2010) defined compassion as “the feeling that arises in witnessing another’s suffering and that motivates a subsequent desire to help” (p. 351). Buddhist philosophy and psychology, which views compassion as a core desirable trait, has become an area of great interest for some Western psychologists (Wallace & Shapiro, 2006).

The Buddhist focus on compassion has led researchers in multiple directions. One area of compassion-based research relates to the benefits of self-compassion (Neff, 2003a). Neff (2003a) observed that “in Buddhist psychology, it is believed that it is as essential to feel compassion for oneself as it is for others” (p. 224). Neff acknowledged that both self-compassion and compassion for others require similar qualities. Neff (2003a) defined self-compassion as:

being open to and moved by one’s own suffering, experiencing feelings of caring and kindness toward oneself, taking an understanding, nonjudgmental attitude toward one’s
inadequacies and failures, and recognizing that one’s own experience is part of the common human experience. (p. 224)

Neff has been at the forefront of research that defines and measures self-compassion for scientific purposes. Neff (2003a) created a Self-Compassion Scale and conducted three foundational studies that indicated good construct validity, content validity and convergent validity along with high test-rest reliability.

**Self-Compassion and Self-Esteem**

Neff’s (2003a) studies of the Self-Compassion Scale resulted in important observations regarding the relationship between self-compassion and self-esteem. Research has indicated that self-compassion and self-esteem have a moderate to high level of correlation (Leary, Tate, Adams, Batts Allen & Hancock, 2007; Magnus, Kowalski, & McHugh, 2010; Neff, 2003a; Neff & Vonk, 2009). However, research has also indicated that self-compassion can manifest as a distinct construct that provides unique protections and benefits (Leary et al., 2007; Magnus et al., 2010; Neff, 2003a; Neff & Vonk, 2009). Results from the Leary et al. (2007) and Neff and Vonk (2009) studies indicated that many of the perceived psychological protections of self-esteem may actually be a result of the overlap between self-compassion and self-esteem and be more attributable to the self-compassionate factors. Key findings from Neff and Vonk indicated that self-compassion was more predictive of self-worth over time and was also more stable than self-esteem in the face of external change.

External evaluation was one likely variable differentiating self-compassion and self-esteem (Neff & Vonk, 2009). Cooley (1902/1964) described self-esteem as a highly evaluative process, both in terms of self-evaluation and the perceptions of other people (as cited by Neff & Vonk, 2009). By contrast, results from Neff and Vonk (2009) indicated that self-compassion, as
measured by the Self-Compassion Scale, was negatively correlated with constructs that measured the perceived evaluation of others, including those related to self-worth (p ≤ .001).

It is worth noting that p ≤ .001 is a stricter, and therefore more confident, inferential statistic (Pyrczak, 1995). Pyrczak (1995) explained that the symbol p refers to probability. Smaller p values equate to greater statistical confidence because there is a smaller probability that the obtained result was due to “chance errors associated with random sampling” (Pyrczak, 1995, p. 75). In this case, p ≤ .001 indicates an equal to, or less than, 1 in 1,000 probability that the obtained result was due to chance. By comparison, Pyrczak noted that researchers will more commonly apply a p value of .05 or .01, indicating that there is either a 5 in 100 probability or a 1 in 100 probability that the result was due to chance. Pyrczak also clarified that general statistical agreement states that .05 is the highest possible cutoff for claiming that a result is “statistically significant” (1995, p. 82). On the other hand, Pyrczak cautioned researchers that very strict p values may become problematic if they are too stringent to pick up on a significant result. In keeping with these observations, most of the studies cited in this literature review will utilize p values of either .05 or .01.

In summary, Neff and Vonk (2009) were able to state with high statistical confidence that self-compassion, as measured by the SCS, was negatively correlated with measurements that focused on external evaluation and self-worth as a product of external evaluation. In a related study, Leary et al. (2007) examined participants’ reactions to direct feedback while also analyzing measurements of self-compassion and self-esteem. Leary and colleagues found that higher self-esteem was correlated with “stronger differential reactions to positive versus neutral feedback” (2007, p. 896). In particular, participants with higher self-esteem showed greater “defensive reactions to neutral feedback” (Leary et al., 2007, p. 896). In turn, Leary and
colleagues found that self-compassion appeared to regulate participants’ reactions to both positive feedback and neutral feedback. This finding that self-compassion moderated reactions to positive and neutral feedback supported the theory that self-compassion can be a generally protective and balancing quality against external evaluation.

Magnus et al. (2010) identified motivational distinctions between self-compassion and self-esteem that also related to evaluative differences. In a study of women’s exercise motivation, Magnus et al. (2010) found that “self-compassion explained unique variance beyond self-esteem in predicting lower levels of introjected motivation, ego goal orientation, social physique anxiety, and obligatory exercise” (p < .05) (p. 374). The authors concluded that these variables are more closely related to external evaluation as a motivating factor, providing further support for the hypothesis that self-compassion is not as likely to be affected by external pressures.

Findings from Neff and Vonk (2009) also indicated that self-esteem had a significant positive correlation with narcissism whereas self-compassion did not have any significant correlation with narcissism (p ≤ .001). “The association between self-compassion and narcissism was close to zero once global self-esteem levels were taken into account” (Neff & Vonk, 2009, p. 37). This result was in line with previous findings by Leary et al. (2007) and Neff (2003a). Neff and Vonk (2009) hypothesized that self-compassionate people “do not need to inflate their egos given that they can embrace their weaknesses as well as their strengths” (p. 39). Along a similar vein, Leary et al. (2007) found that participants with higher self-esteem were more likely to attribute positive feedback to their personality and less likely to attribute neutral feedback to their personality. In contrast, participants higher in self-compassion were more likely to report
that both types of feedback were attributable to oneself, therefore accepting “some level of personal responsibility” across conditions (Leary et al., 2007, p. 896).

Although the Leary et al. (2007) study indicated that self-compassion allowed for a broader personal acceptance of feedback, Leary and colleagues found that higher levels of self-compassion were also associated with less negative affect across all subgroups. The authors summarized that, although being generally more accepting of feedback, participants higher in self-compassion “do not seem to ruminate about possible negative implications” (Leary et al., 2007, p. 896). Taken together, these findings from Neff and Vonk (2009) and Leary et al. (2007) highlight some of the ways that both self-esteem and self-compassion may provide protections against external evaluation. Self-esteem may provide certain protections through building oneself up and then defending against potential attacks, whereas self-compassion may provide protection through a form of balanced self-acceptance that encompasses both cognitive and affective reactions (Leary et al., 2007; Neff & Vonk, 2009).

Neff and Vonk (2009) and Leary et al. (2007) indicated that self-compassion may provide unique protections against external evaluations that are different from self-esteem. Leary et al. expanded on the understanding of self-compassion’s cognitive and affective protections by examining participants’ *internal reactions* to real-life and imagined scenarios. In the first study, Leary et al. (2007) measured participants’ emotions, reactions, thoughts and self-appraisals after reporting on negative real-life events. Participants higher in self-compassion, as measured by Neff’s (2003a) Self-Compassion Scale, were found to be more likely to be kind to themselves and less likely to engage in “negative, pessimistic, and self-critical thoughts” (Leary et al., 2007, p. 890). Participants higher in self-compassion were also more likely to keep a situation “in perspective” and recognize that they did not have “bigger problems in life than most people”
Leary et al. (2007) hypothesized that this focus on the *common humanity* element of the Self-Compassion Scale was one of the reasons that self-compassionate participants were less likely to form negative self-concepts and ruminate on self-appraisals.

In a related study, Leary et al. (2007) examined participants’ reactions to *imagined* negative scenarios across performance-based activities. After controlling for both self-esteem and narcissism, Leary et al. (2007) found that self-compassion uniquely and significantly related to less “negative affect” and less “personalizing” of situations along with greater overall “equanimity” ($p < .05$) and ($p < .01$) (p. 893). As another significant finding, these results translated to significantly greater “behavioral equanimity” in at least two of the scenarios (failing a test and forgetting one’s part on stage) (Leary, 2007, p. 893). Taken together, the findings from these two studies highlight self-compassion’s potential for cognitive, affective, and behavioral protections.

Expanding from a discussion of self-compassion as a protective factor, Neff and Vonk (2009) also examined positive emotional states and whether self-compassion made positive contributions to a person’s mental health beyond those offered by self-esteem. The authors found that self-compassion and self-esteem were “statistically equivalent predictors” of happiness, optimism and positive affect (Neff & Vonk, 2009, p. 42). Neff and Vonk found that a “two-tailed t test found no significant differences ($p > .05$) between self-esteem and self-compassion as predictors of outcomes” (p. 42). However, the authors hypothesized that self-esteem and self-compassion may lead to positive emotional states for different reasons.

Magnus et al. (2010) observed that both self-compassion and self-esteem are related to “healthy perspectives of the self” (p. 376). Magnus et al. (2010) suggested that self-compassion and self-esteem not be viewed in terms of “alternatives” as much as being “complementary to
one another” (p. 375). The potential mutual importance of self-compassion and self-esteem was supported by Leary et al. (2007) who found that, in the face of neutral feedback after personal disclosure, “the greatest negative affect was reported by participants who scored low in both self-compassion and self-esteem” (p. 895). In essence, self-esteem and self-compassion appear to offer their own unique protections and benefits that may also work in tandem. It would therefore seem warranted to differentiate these constructs further in research studies in order to further understand self-compassion’s potential for unique protections and how that may interact with other constructs.

Although the research from these studies provided many interesting findings regarding the correlations between self-compassion and self-esteem, it is also important to note that these constructs are “insubstantial” in that they “do not have an obvious basis in the physical world” (Leedy & Ormrod, 2010, p. 22). Their measurement is therefore reliant on the particular instrument utilized in the study. For example, Neff (2003a) measured global self-esteem and “true self-esteem” (based on “one’s authentic self”) utilizing four instruments (p. 236). Neff (2003a) summarized that the results “should not be interpreted to suggest that ‘true self-esteem’ is linked to narcissism, only that proxy measures of ‘true self-esteem’ used in this study are correlated with narcissism” (p. 246). Neff went on to observe that the creation of a more precise measurement instrument for self-esteem may not find a correlation with narcissism. Neff’s observation provided an important general caveat regarding correlational research.

**Self-Regulation and Behavioral Motivation**

The results from Neff and Vonk (2009) indicated that self-compassion contributes to mental health through protective and positive factors. Other studies have set out to determine how self-compassion may or may not affect attempts at behavioral change. Kelly, Zuroff, Foa
and Gilbert (2010) examined whether self-compassion had an effect on self-regulation through a three-week study on smoking reduction. The authors created three experimental groups that compared the degree of smoking reduction for participants engaged in either self-compassion, self-energizing or self-control interventions, as compared to a baseline group engaged in only self-monitoring. Various components of the interventions were adapted to each construct using Gilbert’s (2005/2009) description of compassionate mind training and compassion-focused therapy (as cited by Kelly et al., 2000).

The results of the Kelly et al. (2010) study showed that each of the three interventions reduced the participants’ daily number of cigarettes more quickly than the baseline of self-monitoring alone (p < .05). However, the results indicated that self-compassion may be an intervention that is most effective for people who are high on their level of self-criticism and low on their readiness to change (p < .001). Kelly et al. (2010) hypothesized that self-compassion may have buffered a tendency toward “rumination and self-judgment” among people who are highly self-critical (p. 749). Readiness to change was measured according to the concepts developed by Velicer, Hughes, Fava, Prochaska, and DiClemente (1995) (as cited by Kelly et al., 2010). Kelly et al. and colleagues hypothesized that participants who scored low in readiness to change may have felt “welcoming of the self-compassion condition’s caring, non-pressuring approach” (p. 748). The findings also suggested that helping people engage in vivid compassionate imagery could strengthen the effects of self-compassion training (p < .001) (Kelly et al., 2010). This study provided an interesting example of how self-compassion interventions could be geared towards participants who are potentially more difficult to treat, given their resistance to change and self-critical stance.
In another study that looked at the effects of self-compassion on self-regulation, Adams and Leary (2007) tested whether or not a self-compassionate intervention would affect eating patterns, cognitive responses and emotional reactions to eating, in a sample of female undergraduate college-students. The results from this study included a number of findings that were in line with the Kelly et al. (2010) results. The researchers found that the self-compassion intervention “proved especially helpful in preventing self-criticism and negative affect for highly restrictive eaters” (p. 1139). Self-compassion appeared to neutralize negative cognitive, emotional, and behavioral patterns for highly restrictive eaters (Adams & Leary, 2007). Ultimately, the Adams and Leary (2007) and Kelly et al. (2010) results fit together in terms of identifying self-compassion as a potentially effective antidote to self-critical patterns.

Meditation

When addressing the question of how to increase compassion and self-compassion, research has indicated that meditation may be a promising intervention (Engström and Söderfeldt 2010; Hutcherson, Seppala, & Gross, 2008; Neff, 2003a). Neff (2003a) found that Buddhist practitioners who practiced a mindfulness-based meditation had significantly higher levels of self-compassion when compared to undergraduate students who had not specifically identified as regular meditators (p <.0005). The Buddhist practitioners displayed significantly higher levels of self-kindness, common humanity, and mindfulness and significantly lower levels of self-judgment, isolation, and over-identification (p < .001) (Neff, 2003a). Hutcherson et al. (2008) investigated the effects of loving-kindness meditation (LKM) on participants’ reactions to strangers and also found a trend of enhanced positive views of the self – among many benefits.
Self-Compassion Summary

Compassion is a distinctive emotion and experiential state (Goetz et al., 2010). Research on compassion has drawn on various philosophies, including Buddhist philosophy which has historically emphasized the importance of compassion (Dalai Lama, 2005; Dalai Lama & Cutler, 1998; Goetz et al., 2010; Wallace & Shapiro, 2006). Compassion toward the self is also an important aspect of compassion (Dalai Lama, 2005; Dalai Lama & Cutler, 1998; Neff, 2003a).

In the development of the Self-Compassion Scale, Neff (2003a) demonstrated the validity and reliability of the scale while also introducing a number of key findings. One of the most important findings of the Neff (2003a) studies indicated that self-compassion is a unique construct from self-esteem. This has been further supported by research from Leary et al. (2007) and Magnus et al. (2010). Neff and Vonk (2009) also expanded on this finding and found that self-compassion was more predictive of a person’s self-worth over time and was also a more stable trait when dealing with external change.

The role of external evaluation may be an important area of distinction between self-compassion and self-esteem (Neff & Vonk, 2009). The general stability of self-compassion may be attributed in part to a more balanced reaction to external evaluation (Leary et al., 2007). In a study on feedback, Leary et al. found that self-compassionate participants had more balanced and accepting reactions to both positive and neutral feedback. Greater self-compassion was also associated with lower negative affect across all subgroups of the feedback study. Further research from Leary et al. (2007) indicated that, when faced with a negative situation, the protective benefits from self-compassion extended to cognitive, emotional and behavioral experience. The findings from Leary et al. (2007) supported Neff and Vonk’s (2009) hypothesis
that many of the historically perceived protective attributes of self-esteem may actually be a product of the correlation between self-esteem and self-compassion.

Neff and Vonk (2009) found that self-esteem had a significant positive correlation with narcissism whereas self-compassion had a non-significant correlation with narcissism. This was in line with research from Neff (2003a) and Leary et al. (2007). In a related finding, research from Leary et al. (2007) indicated that participants higher in self-esteem exhibited more defensive reactions to non-positive feedback. By contrast, participants higher in self-compassion exhibited more accepting reactions. This may provide some insight as to how self-esteem and self-compassion provide their own unique protections in the face of external evaluation.

In terms of contribution to positive emotions, Neff and Vonk (2009) found that both self-esteem and self-compassion were “statistically equivalent predictors” of positive emotional states (p. 42). This indicates that self-compassion and self-esteem should be recognized as unique constructs that can provide their own types of protection and benefits (Leary et al., 2007; Magnus et al., 2010; Neff, 2003a; Neff, 2003c; Neff & Vonk, 2009). Cited research has indicated that self-compassion offers a variety of unique cognitive, affective and behavioral benefits that deserve further study.

Research findings have indicated that self-compassion is also an intervention that may be particularly beneficial for people who engage in self-criticism (Adams & Leary, 2007; Kelly et al., 2010). The findings from Kelly et al. (2010) indicated that self-compassion had a significant effect for people who were high on self-criticism, low on their readiness to change and high on their ability to formulate vivid imagery (given that imagery was used as part of the intervention). Adams and Leary (2007) found that the self-compassion intervention was particularly effective
for highly restrictive eaters. Adams and Leary (2007) summarized that the self-compassion intervention appeared to buffer highly restrictive eaters from engaging in negative patterns.

Drawing on the historical link between Buddhist philosophy and compassion, meditation may be a potential route toward the development of compassion and self-compassion (Engström and Söderfeldt 2010; Hutcherson et al., 2008; Neff, 2003a). Neff (2003a) found that Buddhist practitioners with an established mindfulness-based meditation practice had significantly higher levels of self-compassion when compared to undergraduate students. Hutcherson et al. (2008) found that participants engaged in loving-kindness meditation (LKM) trended toward increased positive views of the self. Research into the effects of meditation on the brain may provide important reasoning as to how compassion manifests neurologically and why meditation may be an effective practice.

**Social Interest**

Gemeinschaftsgefühl is a foundational concept in Adlerian psychology (Ansbacher 1978; Ansbacher, 1992; Ansbacher & Ansbacher, 1956; Stein & Edwards, 1998). Heinz Ansbacher (1992) noted that the literal translation of gemeinschaftsgefühl is ‘community feeling’ which alludes to a broad sense of affinity and kinship that extends to a cosmic level (p. 403). Henry Stein and Martha Edwards (1998) also noted that gemeinschaftsgefühl has been translated in various ways with “feeling of community” being a preferred translation for Adler (para. 7).

Ansbacher (1992) noted that social interest, another common translation for gemeinschaftsgefühl, actually refers to the way that a concern for others can lead to “socially useful” behavior (p. 404). Although Adler did not offer an in-depth comparison between the terms community feeling and social interest, he did define “social interest as ‘the action-line of community feeling’” (as cited by Ansbacher, 1992, p. 405). Although the different terms allow
for key distinctions, Ansbacher (1992) noted that Adlerian authors began substituting one term for the other over time. Authors from the United States adopted *social interest* as the primary term, perhaps indicating a preference for “activity” (Ansbacher, 1992, p. 406). Authors in Europe focused more on the *community feeling* aspect of *gemeinschaftsgefühl*. Ansbacher (1992) ultimately made a case for utilizing both terms when distinguishing feeling and action. However, on a logistical level, Ansbacher (1992) also noted that social interest “is the more practical term, certainly in English” (p. 407). Taking all of these elements into consideration, this researcher uses *social interest* as a translation for *gemeinschaftsgefühl* with the recognition that *gemeinschaftsgefühl* is a broader concept that encompasses community feeling and useful action.

Ansbacher (1978) traced the evolution of Adler’s concept of social interest and how it developed over the decades of his career. Ansbacher (1978) discussed how Adler’s theoretical orientation relating to social interest can be generally broken into four main periods. Ansbacher noted that Adler first introduced social interest as a specific and unique concept during the third period of his career, lasting from 1918–1927. The fourth period of Adler’s career (lasting from 1928–1937) hastened the development of social interest as “an aptitude which must be consciously developed, a cognitive function” (Ansbacher, 1978, p. 129). At this time, Adler (1929) did not equate social interest to an instinct so much as an ‘innate potentiality’ (as cited by Ansbacher, 1978, p. 133). This change meant that social interest was seen as a skill that could be consciously developed (Ansbacher, 1978).

It was also during this period that Adler described the roles of empathy and identification in relation to social interest (Ansbacher, 1978). Adler (1929) emphasized that social interest encompassed “…feeling of worth and value…courage and an optimistic view” (as cited by Ansbacher, 1978, p. 135). Ansbacher (1978) also observed that Adler’s theory of social interest
came to encompass an understanding of common sense. Social interest was viewed as a guiding impetus that kept a person oriented toward consideration of others and cooperation with others (Ansbacher, 1978). Social interest became a measurement for whether a person strived “on the socially useful side or on the socially useless side” (Ansbacher, 1978, p. 133). Social interest came to occupy a central role in Adler’s theories, to the point where Adler emphasized the “beneficial relationship of social interest to mental well-being” (Ansbacher, 1978, p. 134). The analysis of Ansbacher indicated that social interest is a fundamental part of Adlerian psychology and, given its evolutionary development, a complex and multi-layered concept.

**Measuring Social Interest**

The measurement of social interest has become an interesting topic in the Adlerian community. Rotter (1962) had urged Adlerians to measure and test social interest at an empirical level (as cited by Bass, Curlette, Kern, & McWilliams, 2002). Adlerian researchers have been active in their attempts to measure social interest and have developed various social interest measurement tools (Bass et al., 2002). However, measuring social interest is not a simple task according to Bass et al. In order to analyze and summarize research conducted on social interest since 1977, Bass and colleagues conducted a meta-analysis of 124 studies that had used one of five different instruments to measure social interest. Bass et al. (2002) discussed the overall difficulties in constructing an operational definition of social interest, noting that it is a “broad construct” (p. 8).

One of the primary findings from the Bass et al. (2002) meta-analysis related to the relationship between instruments. The analysis from Bass et al. (2002) indicated that there are “low pair-wise correlations between the five instruments that purport to measure the construct of social interest” (p. 22). The range of average correlations extended from $r = .080$ to $r = .292$, $p ≤$
.05 (Bass et al., 2002). Pyrczak (1995) explained that this correlation statistic is called the Pearson product-moment correlation coefficient. This statistic is expressed with a number between -1.00 and 1.00. When r = 1.00 that would equate to a “perfect positive relationship” and when r = -1.00 that would equate to a “perfect inverse relationship” (Pyrczak, 1995, p. 55).

Pyrczak clarified that interpreting the strength, or weakness, of the correlation depends on the context of the study. However, it becomes increasingly unlikely that there is a relationship between variables as the correlation approaches zero. In the case of the Bass et al. meta-analysis, one could interpret the correlations between the instruments as being quite low.

Bass et al.’s (2002) finding that there was a low level of correlation between instruments makes it difficult to establish criterion validity for any one instrument. Criterion validity refers to “the extent to which the results of an assessment instrument correlate with another, presumably related measure” (Leedy & Ormrod, 2010, p. 92). Criterion validity for social interest is difficult to demonstrate since there is not one established measure of social interest.

In a review of previous research, Bass et al. (2002) had noted a lack of content validity as a primary challenge to social interest measurement. This observation was upheld by the results of their meta-analysis. Content validity is “the extent to which a measurement instrument is a representative sample of the content area (domain) being measured” (Leedy & Ormrod, 2010, p. 92). Bass et al. (2002) summarized that the low level of correlation between instruments indicated a need to better define what aspect(s) of social interest an instrument was attempting to measure. In this case, content validity would be supported if a measurement tool addressed the various underlying components of social interest “in appropriate proportions” (Leedy & Ormrod, 2010, p. 92). Bass et al. (2002) summarized that defining the empirical dimensions of social
interest could be a step toward developing an operational definition. This could, in turn, assist in establishing a clearer level of content validity.

The Bass et al. (2002) meta-analysis indicated that it may be difficult to establish overall criterion validity and content validity with current social interest measures. However, establishing *construct validity* would appear to be a first step from an empirical standpoint. Construct validity is “one of the three traditional forms of validity that is broader than either content or criterion-related validity” (Whiston, 2009, p. 444). Leedy and Ormrod (2010) summarized that construct validity consists of the measurement of an unobservable construct through underlying observable factors.

Looking more deeply at the idea of construct validity, one could hypothesize that social interest is a difficult concept to measure directly. However, instruments can attempt to measure other factors that would theoretically underlie social interest such as: ‘interest in others,’ empathy, cooperation, optimism, a sense of self-worth and courage (as cited by Ansbacher, 1978, p. 135). Focusing on the social context, researchers could also attempt to measure observable aspects of social relationships as a possible reflection of social interest. For example, Watkins and St. John (1994) compared scores from the Sulliman Scale of Social Interest (Sulliman, 1973) to a scale that measured such items as a person’s number of close friends and how often they see those friends. Whiston (2009) observed that construct validity “involves the gradual accumulation of evidence” (p. 444). The Bass et al. (2002) meta-analysis exemplified this process of empirical growth while also highlighting the difficulty in defining the type and scope of underlying constructs when measuring social interest.

Taking a closer look at the specific instruments, the Bass et al. (2002) meta-analysis indicated that two instruments stood out in terms of the “highest total weighted mean effect size”
Bass et al. (2002) summarized that the Social Interest Index (SII), developed by Greever, Tseng and Friedland (1973), showed a “total weighted mean effect size” at $r = .298$, $p \leq .05$ (p. 23). The Sulliman Scale of Social Interest (SSSI), developed by Sulliman (1973), showed a total effect size of $r = .296$, $p \leq .05$ (Bass et al., 2002). On the other end of the performance continuum, the Social Interest Scale (SIS), developed by Crandall (1981), had the “smallest total mean effect size” with $r = .171$ (as cited by Bass et al., 2002, p. 15-16). Bass et al. noted that comparisons between these three instruments indicated that they were most likely “measuring different aspects of social interest” (p. 20). Overall, the findings of Bass et al. indicated that the SII and SSSI had the greatest total mean effect size in comparison to other social interest measures, but the lack of one operational definition makes the measurement of social interest a tentative proposal.

**Correlational research.** Correlational analysis has provided some indication as to how social interest measurement tools may tap into different constructs. Bass et al. (2002) summarized that “if a researcher were to design a study to correlate a social interest instrument with a psychological variable, a reasonable correlation to expect would be approximately .25” (p. 23). Relating to the discussion of construct validity and content validity, it is interesting to examine which measurement tools correlated most closely to certain constructs.

In regard to the Sulliman Scale of Social Interest (1973), Bass et al. (2002) found that the SSSI had a correlation and total mean effect size above .25 with measurements for the following constructs: empathy, cooperation, narcissism and depression ($p \leq .05$). However, the directionality of these correlations was not completely clear to this researcher. In another independent study, Watkins and St. John (1994) found that SSSI scores had the largest positive correlations with measures of: perspective taking, empathic concern, number of close friends and
an overall happiness rating (p < .01). In addition, the SSSI showed a significant negative correlation with the measure of narcissism (p < .01). However, Watkins and St. John did not find a significant correlation between SSSI scores and two other types of empathy.

In regard to the Social Interest Index (Greever et al., 1973), the Bass et al. (2002) meta-analysis indicated that the SII had a correlation and total mean effect size above .25 with measurements for the following constructs: empathy, spirituality, marital adjustment, narcissism, depression, social desirability and anxiety (p ≤ .05). Again, the directionality of these correlations was not completely clear to this researcher. Conducting an independent study of the SII in relation to spiritual variables, Leak (2006a) found the largest positive correlations to be with measurements for “self-transcendent goal strivings” and “spiritual universalism” and the largest negative correlation to be with “religious ethnocentrism” (p < .01) (p. 65). In a different study, Leak and Leak (2006) compared SII scores to measures of social motivation and reasoning. The authors found that the SII had the largest positive correlation with the highest level of moral reasoning (p < .01). In turn, the SII was negatively correlated with the lowest, and most self-centered, level of moral reasoning (p < .05). However, Leak and Leak (2006) noted that the SII did not pick up on certain expected correlations, such as that between social interest and altruism.

These correlational analyses illustrate the number and scope of constructs that may be associated with social interest. These studies indicated that social interest is perhaps more easily understood as a whole rather than as the sum of individual parts. Highlighting this point, Stein (n.d.) observed that “social interest, or the feeling of community (a better term), cannot be adequately measured with an instrument. It is a complex construct that requires artistic empathy to determine its depth and range” (question 87). Illustrating another perspective, Bass et al.
(2002) advocated for the development of an operational definition of social interest while also acknowledging that it may not be possible to create “one definition” agreed upon by all (p. 23).

This researcher is fascinated with the discussion of whether it is possible to truly measure such a deep and multifaceted construct as social interest. Overall, this researcher believes that continuing attempts to measure social interest are warranted, as long as those efforts do not lose sight of the elegant and subtle aspects of the construct. However, this researcher also agrees that such efforts could be benefited by a more structured discussion within the Adlerian community, as suggested by Bass et al (2002).

**Social Interest Summary**

Gemeinschaftsgefühl is a core concept of Adlerian psychology that is linked to a person’s overall ‘mental wellbeing’ (Ansbacher, 1978, p. 134). Gemeinschaftsgefühl has been primarily translated as both social interest and community feeling, with social interest being the more common translation in English (Ansbacher, 1978; Ansbacher, 1992; Stein & Edwards, 1998). One of the primary roles of social interest is to guide a person’s actions toward socially useful and cooperative behavior that takes the experience of others into account (Ansbacher, 1978). In turn, a person who strives on the useless side of life has exhibited underdeveloped social interest (Ansbacher & Ansbacher, 1956). The definition and understanding of social interest developed and evolved over the course of Adler’s career and has continued to evolve in the decades since his passing (Ansbacher, 1978; Ansbacher, 1992; Bass et al., 2002). The broad scope of social interest, its inherent complexity, and the lack of an operational definition, has made social interest a difficult concept to measure empirically (Bass et al., 2002; Stein, n.d.).
Depression

Clinical depression is a condition that is more than a period of sadness or a “bout of the blues” (Mayo Clinic Staff, 2012, para. 3). The National Institute of Mental Health (NIMH) (2011) described depression as a “common but serious illness” that manifests in several forms (p. 2). According to the DSM-IV-TR, depressive disorders fall under the broader category of mood disorders (American Psychiatric Association, 2000). Mood disorders also include bipolar disorders and other mood disorders (such as substance-induced mood disorder). The subcategory of depressive disorders is then comprised of three possible diagnoses: major depressive disorder, dysthymic disorder and depressive disorder not otherwise specified (American Psychiatric Association, 2000).

Completing the matrix, the DSM-IV-TR lists a multitude of specifying diagnostic characteristics for different mood disorders including: level of severity, patterns over time, remission status and specific features (such as catatonic features, psychotic features or postpartum onset) (American Psychiatric Association, 2000). The range of diagnostic possibilities for mood disorders illustrates the complexity and diversity within the diagnostic category. Given this complexity, this research paper will focus on the specific diagnosis of major depressive disorder (MDD).

The diagnosis of MDD requires at least one major depressive episode that has lasted for at least 2 weeks (American Psychiatric Association, 2000). The foundation of the diagnosis requires either “depressed mood” or “loss of interest or pleasure” (American Psychiatric Association, 2000, p. 356). Additional symptoms may include: changes in weight, changes in sleep patterns, changes in physical action/reaction, feeling fatigued, “feelings of worthlessness or excessive or inappropriate guilt,” trouble concentrating and making decisions, and/or suicidal
MDD is a possible diagnosis if a person does not exhibit any manic episodes in addition to the above symptoms. MDD must also be differentiated from depression caused by a medical condition, the use of a substance, or bereavement. A disruption in functionality across different domains, such as work and social life, would also be required for an MDD diagnosis.

Prevalence and Role Impairment

The National Comorbidity Survey Replication (NCS-R) produced landmark surveys relating to DSM-IV disorders that are cited by the National Institute of Mental Health (NIMH) (Kessler et al., 2003; Kessler et al., 2005; NIMH, n.d.). According to NCS-R, mood disorders were the second most prevalent class of DSM-IV disorders among English-speaking U.S. adults between 2001 and 2003, affecting 9.5% of the population over a 12 month period (Kessler et al., 2005). Of those people diagnosed with a mood disorder, 6.7% were diagnosed with major depressive disorder (MDD) (Kessler et al., 2005). In a previous publication, the NCS-R reported the lifetime prevalence of MDD as 16.2% for U.S. adults (Kessler et al., 2003).

Severity levels for MDD and associated role impairment are major concerns for the mental health field (Kessler et al., 2003; Kessler et al., 2005). Of people diagnosed with MDD, 30.4% reported severe depression (Kessler et al., 2005). Role impairment refers to the level of disruption in a person’s ability to fulfill general daily responsibilities and activities, both in relation to “quality and quantity” (Kessler, 2003, para. 25). Kessler et al. (2003) measured role impairment with scales that gauged “the extent to which depression interfered with functioning in work, household, relationship, and social roles” (para. 24). Kessler et al. summarized that role impairment affected 96.9% of adults with MDD with over one third of respondents reporting
severe to very severe impairment in the realms of relationship and home. The highest percentage
of severe to very severe impairment was in the social domain (43.4%).

Theories of Depression

The National Institute of Mental Health (2011) highlighted interpersonal psychotherapy
(IPT) and cognitive behavioral therapy (CBT) as the primary therapeutic treatments for
depression. In considering treatment for depression, it is also important to consider what theories
underlie therapies such as IPT and CBT. It is also important to consider whether newer theories,
such as the hopelessness theory of depression (Abramson et al., 1989), can provide insight into
treating depression. To provide context for further discussion, this section will focus on a brief
review of the underlying theories behind IPT, CBT, hopelessness depression and cognitive
vulnerability to depression.

Interpersonal psychotherapy. The development of interpersonal psychotherapy (IPT)
can be traced back to research conducted at Yale University in 1969 (Weissman, 2006). Gerald
Klerman, Eugene Paykel, Brigitte Prusoff and Myrna Weissman formed a team that was tasked
with developing a type of therapy to be used in conjunction with antidepressants for a
randomized controlled trial for the treatment of depression (Weissman, 2006).

Klerman had the foundational idea of developing a standardized, testable form of
‘supportive psychotherapy’ (Weissman, 2006, p. 554). The theory behind IPT was based on
Klerman’s observations about the impact of social relationships on depression, although he still
believed that depression was “basically a biological illness” (Weissman, 2006, p. 554). An
underlying hypothesis for IPT was that medication could potentially help with some of the
physiological dynamics of depression while psychotherapy could potentially help with the social
dynamics of depression (Weissman, 2006). “The basic assumption was that there is a
relationship between the onset and recurrence of a depressive episode and the patient’s social and interpersonal relationships at the time” (Weissman, 2006, p. 555). Klerman’s research team was influenced by the writings of Harry Stack Sullivan and Adolf Myers who both emphasized interpersonal relationships in regard to psychology and functioning (as cited by Weissman, 2006). The team was similarly influenced by attachment theory, developed by John Bowlby. In regard to standardization, Klerman had also been inspired by a manual that Aaron Beck developed for his cognitive theory of depression.

Weissman (2006) summarized that research concerning IPT has highlighted its effectiveness with depression in particular. IPT has also been shown to be adaptable to different cultures around the world (Weissman, 2006). “The ease of translating IPT for depression into diverse cultures probably reflects that the problem areas identified in IPT as triggers of depression…are intrinsic, universal elements of the human condition…” (Weissman, 2006, p. 556). Ultimately, when considering the development of IPT, one of the greatest lessons is to assess social dynamics when treating depression.

Cognitive behavioral therapy. Cognitive behavioral therapy (CBT) has integrated the work of multiple psychological movements (Dowd, 2004). Dowd traced the lineage of CBT from the roots of Freud to the behavioral theories of Pavlov, Thorndike and Skinner, to the social learning theory of Bandura and the cognitive theories of Ellis and Beck.

Behaviorism. Dowd (2004) offered an evolutionary perspective for how cognitive therapy and behavioral therapy merged to form cognitive behavioral therapy. Developers of behavioral therapy, such as John Watson, Ivan Pavlov, E.L. Thorndike and B.F. Skinner, focused on the manifestation of human behavior. Behaviorists believed that behavior resulted from
classical conditioning, defined as “learning by association” and operant conditioning, defined as “learning by consequences (reinforcement)” (Dowd, 2004, p. 417).

Dowd (2004) noted that behaviorists were present-focused since they were most interested in the current reinforcements for behavior. Dowd also noted that behaviorists developed many techniques, such as desensitization, that have been practiced for decades. However, the theories behind behaviorism began to fall out of favor as the rise of the cognitive “information-processing model” began to overtake the “machine model” of behaviorism (Dowd, 2004, p. 418).

**Social learning theory.** Albert Bandura’s social learning theory represented a shift from behaviorism to cognitive theories (Dowd, 2004). Dowd highlighted three primary findings of social learning theory. First, social learning theory emphasized that both external and internal factors influence a person. Second, “Bandura’s research showed that a perceived reinforcer was more reinforcing than an actual reinforcer that was not perceived as such” (Dowd, 2004, p. 418). Third, Bandura found that watching another person experience reinforcement could also act as a reinforcement for the observer. These findings added complexity to the behavioral model and supported the rise of the “information-processing model” (Dowd, 2004, p. 418).

**Rational emotive behavior therapy (REBT).** Albert Ellis developed REBT starting in the mid-1950s (Ellis, Shaughnessy, & Mahan, 2002). Ellis credited Alfred Adler with developing the primary cognitive therapy at that time. Ellis also reported drawing upon various philosophers, such as Epicurus, Dewey, Kant and Russell, in the development of REBT theory.

Dowd (2004) noted that it may be difficult to summarize Ellis’ theories since his theories evolved greatly, from rational therapy to rational-emotive therapy to rational-emotive-behavior-therapy. In an interview given at age 88, Ellis summarized the culmination of his theoretical
development. “Therapists should better concentrate not on only cognitive, or only emotive, or only behavioral techniques of therapy. All three processes – cognition, emotion and behavior – interact to create human disturbance” (Ellis et al., 2002, p. 357). This statement indicated how REBT moved from a cognitive model to more of an integrated model over time.

However, Dowd (2004) emphasized that the cognitive concepts, such as rational and irrational beliefs, are a foundation of Ellis’ theories. Ellis particularly noted how beliefs based on “musts, shoulds and oughts” can interfere with functioning (Ellis et al., 2002, p. 357). Ellis also theorized that a person’s belief about an event is what actually affects the outcome rather than the event itself. Acceptance was another important element of Ellis’ theories (Ellis et al., 2002). Ellis advocated for the development of a deep level of acceptance for oneself, others and the unchangeable circumstances of life.

Ellis’ approach mirrored the behaviorists in the sense of being present-focused – he was concerned with a person’s current belief system more than the history for how the beliefs developed (Dowd, 2004). REBT was also designed to be directive and educational, teaching clients how to change (Ellis et al., 2002). Ellis advocated for therapists to help clients “get better” rather than helping them just “feel better” (Ellis et al., 2002, p. 362).

As a student of Adlerian therapy, this researcher appreciated Ellis’ direct acknowledgment of Adler’s theories. “Like Adlerism, REBT strongly encourages clients to adopt more workable and less destructive philosophies of life” (Ellis et al., 2002, p. 358). In Ellis’ focus on belief-systems, it is possible to see the influence of Adler’s theory relating to mistaken beliefs and individual perception (Ansbacher & Ansbacher, 1956). Ellis also noted that he is a constructivist, which seemed parallel to Adler’s belief in the human capacity for creativity (Ansbacher & Ansbacher, 1956; Ellis et al., 2002).
Cognitive Theory. Aaron Beck (1991) wrote about the genesis of his cognitive theory of depression, developed primarily during the 1960s and 1970s. Beck wrote that he had been conducting free associations with patients who had depression. He noticed that the patients had peripheral thoughts that would “arise quickly and automatically, as though by reflex” (Beck, 1991, p. 369). He also noticed that the thoughts would often be followed by an “unpleasant affect” (Beck, 1991, p. 369). When looked at as a whole, the thoughts created a pattern of negative appraisal.

Beck (1991) observed that this pattern of negative appraisal was more internally focused. It was a form of self-talk that could be differentiated from conversations with others. Negative thought patterns appeared to culminate in a number of adverse consequences such as: “low self-esteem, self-blame, self-criticism, negative predictions, negative interpretations of experiences, and unpleasant recollections” (Beck, 1991, p. 369). In addition, Beck noticed what he called cognitive “errors” such as making extreme generalizations, thinking in black / white terms or exaggerating negativity (Beck, 1991, p. 369). Ultimately, Beck noted that these types of cognitive patterns appeared across different diagnostic categories of depression. Beck (1991) also theorized as to the formation of cognitive schemas. Beck (1991) defined a schema as a formation of “absolute beliefs” particularly related to “self-worth, ability, or social desirability” (p. 370). Beck hypothesized that these schemas are developed early-on in a person’s life and may become triggered by environmental situations.

One of the most important developments stemming from Beck’s cognitive theory related to his understanding of hopelessness and subsequent development of a Hopelessness Scale (HS) (Beck, Weissman, Lester & Trexler, 1974). Beck (1991) summarized that negative expectations and cognitive errors geared toward the future result in ‘hopelessness’ which may put people at
greater risk for suicide (p. 369). Supporting this theory, a study of hospitalized patients over a period of five to ten years found that “a score of 10 or more on the Hopelessness Scale correctly identified 91% of the eventual suicides” (Beck, Steer, Kovacs & Garrison, 1985, para. 1). This strong finding lends itself to a further discussion of the meaning of hopelessness and the theory of hopelessness depression (Abramson et al., 1989).

**Hopelessness depression.** Abramson et al. (1989) developed a theory of depression that built on the work of Beck and Ellis. The theory of hopelessness depression hypothesizes that “negative expectations” combined with “expectations of helplessness” lead to a subtype of depression based on hopelessness (Abramson et al., 1989, p. 359). The authors theorized that if a person’s sense of hopelessness is generalized across the life spectrum, depression will be more severe than if the hopelessness is limited to one area of life.

Abramson et al. (1989) traced the “causal chain” of hopelessness depression to “negative life events” that lead to a particular inference about: why it happened, what consequences would occur because of the event or what the event says about oneself (p. 361). The authors described how various mediating factors, such as social factors and the perceived importance of the event, may influence a person’s interpretation. Inferences that are stable across time and global across domains are associated with greater hopelessness. Abramson et al. (1989) emphasized that negative, stable and global conclusions about oneself “should be particularly likely to lead to hopelessness when the person believes that the negative characteristic is not remediable…and that possession of it will preclude the attainment of important outcomes” (p. 361).

Although the theory of hopelessness depression draws firmly from cognitive theory, Abramson et al. (1989) highlighted some distinctions. For example, hopelessness depression theorizes a particular subset of depression with particular “cause, symptoms, course, treatment,
and prevention” (p. 369). The theory of hopelessness depression would also not necessarily assign a term of “unrealistic or distorted” to a person’s inferences even though they were negative in scope (p. 364). The treatment for hopelessness depression may also place greater focus on changing the environment rather than focusing primarily on cognitive change (Abramson et al., 1989).

**Cognitive vulnerability to depression.** Abramson et al. (1989) hypothesized that some people are more likely to perceive life through a negative lens, assigning global and stable attributions to a particular event. The authors called this the “hypothesized depressogenic attributional style” (Abramson et al., 1989, p. 362). They also acknowledged that this theory of “cognitive style” builds on the work of Beck and Ellis (Abramson et al., 1989, p. 362).

Integrating cognitive theory and hopelessness theory of depression has led to the theory of cognitive vulnerability to depression. The theory of cognitive vulnerability posits that “particular negative cognitive styles increase individuals’ likelihood of developing episodes of depression” (Alloy et al., 1999, p. 503). Alloy et al. (1999) found support for this theory in a landmark study that was part of the Temple-Wisconsin Cognitive Vulnerability to Depression Project.

Alloy et al. (1999) conducted a longitudinal study involving undergraduate students. Participants for the study completed cognitive and attribution assessments to determine if they were high-risk (HR) and “most negative” or low-risk (LR) and “most positive” in relation to their cognitive style (Alloy et al., 1999, p. 506). The researchers followed 349 participants over a period of five years, administering self-reports and conducting assessment interviews. Participants also completed a variety of additional assessments such as those relating to Axis II disorders, coping styles, life experiences and parental feedback (Alloy et al., 1999).
The results of the Alloy et al. (1999) study provided support for the theory that a particular cognitive style can contribute to the development of depression. When looking at all participants, Alloy et al. (1999) found that the “HR group showed double the rate of lifetime major depression than the LR group, and triple the rate of HD [hopelessness depression]” (p. 509). Another key finding was that significant differences between high-risk and low-risk participants were only relevant to depression and not to other disorders such as anxiety disorders, addiction disorders and other Axis I disorders (Alloy et al., 1999).

When analyzing the results of participants who did not have a prior history of clinical depression, the high-risk participants were far more likely to develop some form of depression within the first 2 ½ years of the study (Alloy et al., 1999). By comparison, 17% of high-risk participants developed MDD versus 1% of low-risk participants. For minor depressive disorder, 39% of high-risk participants developed minor depression versus 6% of low-risk participants. When looking at the potential subtype of hopelessness depression, 41% of high-risk participants developed hopeless depression versus 5% of low-risk participants. Additionally, these findings were not replicated when analyzing the onset of anxiety disorder – indicating the cognitive vulnerability is most likely specific to depression (Alloy et al., 1999).

In order to study the effect of cognitive style on reoccurring episodes of depression, Alloy et al. (1999) analyzed the participants who had a history of “clinically significant depression” yet were not diagnosed as depressed at the beginning of the study (p. 511). Alloy et al. (1999) found that 27% of high-risk participants had a reoccurrence of major depression versus 6% of low-risk participants. For minor depression, 50% of high-risk participants had a reoccurrence versus 26.5% of low-risk participants. For hopelessness depression, 52% of high-risk participants had a reoccurrence versus 22% of low-risk participants. Ultimately, for
participants with and without a history of depression, cognitive style appeared to play an important role.

Self-concept was also an important factor of consideration for Alloy et al. (1999). The results from Alloy et al. (1999) indicated that high-risk participants showed “…greater endorsement, faster processing, greater accessibility and better recall of content involving themes of incompetence, worthlessness and low motivation” (p. 519). This provided support for the connection between negative cognitive style and a negative concept of self.

**Developmental precursors.** Included as preliminary findings for the Alloy et al. (1999) study on cognitive styles was an analysis of the early lives of high-risk and low-risk participants. This included assessment results for 320 of the participants’ parents. In a separate paper analyzing the same Temple-Wisconsin CVD project study, Abramson et al. (1998d) reported that significantly more mothers of high-risk participants (35%) had a history of a depressive disorder than mothers of low-risk participants (18%) (as cited by Alloy et al., 1999). Abramson et al. (1998d) also reported that the participants’ fathers did not show similar differences, suggesting an area for further research (as cited by Alloy et al., 1999).

In support of the hypothesis that cognitive styles can be learned through modeling, preliminary results from Alloy et al. (1998b) noted that the parents of high-risk participants exhibited “more dysfunctional attitudes than parents” of low-risk participants (as cited by Alloy et al., 1999, p. 523). Alloy et al. (1998b) also found that the parents of high-risk participants gave their children “more depressogenic feedback about causes and consequences of stressful events that happened to their child” (as cited by Alloy et al., 1999, p. 523). In examining reports from both parents and children, Alloy et al. (1998c) reported that parents of high-risk participants were “less accepting of their child” (as cited by Alloy et al., 1999, p. 524). In addition, Alloy et al.
(1998c) reported that high-risk participants felt their parents exerted “more negative control” over them than low-risk participants (as cited by Alloy et al., 1999, p. 524). All of these findings provided support for the theory that a cognitive vulnerability to depression could be impacted by early developmental experiences.

**Attachment theory.** Further exploring the role of developmental antecedents to cognitive style, Permuy, Merino, and Fernandez-Rey (2010) examined attachment style and personality characteristics in relation to cognitive vulnerability and depression. Using a regression analysis, Permuy et al. (2010) found that both the preoccupied (p < .05) and fearful (p < .01) attachment styles significantly contributed to depression symptoms as measured by the Beck Depression Inventory (BDI). It is relevant to note that preoccupied and fearful attachment styles also incorporate a negative view of the self (Permuy et al., 2010). These findings lent support to the hypothesis that early developmental experiences, attachment style and associated personality characteristics can all relate to a person’s vulnerability to depression.

**Treatment for Depression**

Adequacy of treatment for MDD is a great concern for the mental health field (Kessler et al., 2003). Kessler and colleagues reported that approximately half of people with MDD receive treatment. Of those people who are treated, treatment was “adequate” in approximately 42% of cases (Kessler et al., 2003, p. 3095). Kessler (2003) concluded that, in total, just under 22% of people with major depressive disorder were “adequately treated” - leaving a great deal of room for improvement (p. 3095).

Representing a broad spectrum of studies, Hollon and Ponniah (2010) and Cuijpers, van Straten, Andersson and van Oppen (2008) conducted meta-analyses that compared the effects of therapeutic treatments for depression and MDD. The Hollon and Ponniah (2010) meta-analysis
included 101 randomized controlled trials for MDD that included both therapeutic and pharmaceutical interventions. Cuijpers et al. (2008) analyzed 53 randomized trials for mild to moderate depression that only included therapeutic interventions.

Hollon and Ponniah (2010) found three therapeutic interventions (including subtypes) that showed evidence “from at least two settings” of being “superior to a pill or psychological placebo or another bona fide treatment” (p. 892). Those three interventions were interpersonal psychotherapy (IPT), cognitive behavior therapy (CBT) (cognitive therapy in particular), and two types of behavior therapy (BT) (Hollon & Ponniah, 2010, p. 917). Hollon and Ponniah (2010) summarized that these treatments showed evidence of being as effective as medication and also appeared to “enhance the effectiveness of medications when added in combination” (p. 926). The findings from this meta-analyses partly mirrored the recommendations from the National Institute of Mental Health (2011) which highlighted CBT and IPT as primary psychotherapeutic treatments for depression.

The findings from the Cuijpers et al. (2008) meta-analyses offered another complex view for the treatment of depression. Overall, Cuijpers et al. (2008) found “no significant difference” between the effectiveness of the following treatments: “cognitive behavior therapy, psychodynamic therapy, behavioral activation treatment, problem solving therapy, and social skills training” (p. 917). Interpersonal psychotherapy had the largest difference in effect size at \( d = .20, p < .05 \), indicating that it was “somewhat more efficacious” (Cuijpers et al., 2008, p. 917). However, Cohen (1998) noted that an effect size of .20 is generally considered to be small (as cited by Cuijpers et al., 2008). Although Hollon and Ponniah (2010) and Cuijpers et al. (2008) appeared to have differing results, depression severity may have been a moderating factor between the meta-analyses. Hollon and Ponniah (2010) included studies with varying levels of
depression severity whereas Cuijpers et al. (2008) included studies with mild to moderate depression.

Hollon and Ponniah (2010) suggested that people with mild to moderate symptoms may be helped by “generic psychological interventions” that do not include medication (p. 927). The Cuijpers et al. (2008) findings provided general support for this suggestion in that they found no major differences between treatments for mild to moderate depression. The Cuijpers et al. findings potentially interlink with the common factors theory of psychotherapy which hypothesizes that psychotherapeutic change derives from “key ingredients or elements that transcend all approaches” (Duncan, Miller, Wampold & Hubble, 2010, p. 33). For example, a therapeutic alliance would be an example of one ingredient that is present in all therapies (Duncan et al., 2010).

Yet for people with more severe depression, Hollon and Ponniah (2010) suggested focusing on specific therapeutic interventions, specifically CBT, IPT and certain behavioral therapies. Hollon and Ponniah (2010) suggested these therapies be the “first line of treatment” for severe depression (p. 927). It is also important to note that medication may also be necessary for depression treatment, depending on the severity of depression and individual circumstances of the person (NIMH, 2011, p. 16). Overall, the findings from the Hollon and Ponniah (2010) and Cuijpers et al. (2008) meta-analyses exemplify how the results from depression research may differ based on underlying factors and the complexity of the disorder.

Marshall, Zuroff, McBride and Bagby (2008) conducted a study that examined how a different kind of underlying factor may affect treatment for depression. Marshall et al. (2008) assigned participants with MDD to one of three therapeutic interventions: IPT, CBT or a
pharmacological treatment. The study measured whether participants who were high in self-criticism or high in dependence achieved different results between experimental groups.

Focusing on individuals with self-criticism, the only treatment option that approached significant effectiveness was the pharmacological treatment (Marshall et al., 2008). The authors did not find a significant relationship between treatment outcomes for CBT and high self-criticism. However, individuals high in self-criticism did show a significantly poorer treatment outcome from IPT. Marshall et al. (2008) hypothesized that self-critical individuals can be more achievement-oriented and “less preoccupied with interpersonal issues” which could mean that IPT would “have less of an impact on the severity of depressive symptoms” (p. 240).

Marshall et al. (2008) summarized that treatment for depression should take into account potential sub-types of depression. Marshall et al. (2008) observed that, at least theoretically, CBT “may seem more relevant to self-critical individuals who are more preoccupied with issues related to individual achievement and performance” (p. 241). However, the findings from Marshall et al. (2008) did not offer significant support for this logical connection between self-criticism and CBT, indicating that self-criticism may be an important underlying variable when assessing depression and that further research is warranted.

**Depression Summary**

The broader category of mood disorders, and the subset of depressive disorders, comprise a diverse range of diagnostic symptoms (American Psychiatric Association, 2000). Major depressive disorder is a specific diagnosis that includes impairment in physiological, cognitive, emotional and/or social realms. The disruption in functioning across life domains that is associated with depression is a major concern for the mental health field (Kessler et al., 2005). MDD has an estimated lifetime prevalence of 16.2% for U.S. adults (Kessler et al., 2003).
There are a variety of theories relating to the associated treatments of depression. IPT is a form of therapy that focuses on treating the social underpinnings of depression (Weissman, 2006). CBT is a form of therapy that focuses on the cognitive and behavioral aspects of depression, integrating theories such as behaviorism, social learning theory, REBT and cognitive theory (Dowd, 2004). It is also important to consider physiology in relation to depression, including the potential benefit of medication (NIMH, 2011).

Hopelessness is a concept that has been highlighted in the cognitive theories and has gained recognition for its connection to suicide (Beck, Brown & Steer, 1989; Beck et al., 1985; Beck et al., 1974). The theory of hopelessness depression is a newer theory that extrapolates a subset of depression based on hopelessness (Abramson et al., 1989). Hopelessness theory draws upon cognitive theories while also building its own definition of hopelessness based on the combination of negative expectations and a perception of helplessness (Abramson et al., 1989).

Cognitive theory and hopelessness theory have also given rise to a theory of cognitive vulnerability to depression (Abramson et al., 1999; Alloy et al., 1999). A longitudinal study of undergraduate students found that high-risk and low-risk participants (in regard to negative cognitive style) showed definite differences in the development of depression (Alloy et al., 1999). Alloy and colleagues found that high-risk participants showed double the rate of major depression and triple the rate of hopelessness depression. High-risk participants were more likely to develop depression even if there was no prior history of depression. High-risk participants were also more likely to have a reoccurrence of depression if a history of depression was present. These findings were specific to depression and not other Axis I diagnoses (Alloy et al., 1999).

In relation to developmental factors, a maternal history of depression and negative familial interactions were found to be more common among high-risk participants (as cited by
Alloy et al., 1999). Adding to a developmental understanding, Permuy et al. (2010) found that attachment style may also be linked with a vulnerability to depression. These findings all point to the need to research variables associated with depression in order to better understand, and potentially tailor, particular interventions.

IPT and CBT are recognized as effective therapeutic treatments by the National Institute of Mental Health (2011). However, research has not yielded consistent results when it comes to depression treatment (Dowd, 2004). Treatment effectiveness is a significant concern for the mental health field, considering that approximately 22% of people with MDD are “adequately treated” (Kessler, 2003, p. 3095). This takes into account the fact that only about half of people with MDD receive treatment in the first place (Kessler, 2003). Understanding the range and scope of potential symptom modifiers, such as severity and/or traits such as self-criticism, may need to be considered when assessing treatment options (Hollon & Ponniah, 2010; Marshall et al., 2008).

**Connecting Self-Compassion, Depression, and Social Interest**

**Self-Compassion and Depression**

Research reviewed in this paper suggests that self-criticism and negative cognitive style may be important moderating variables for depression and may also link depression with self-compassion. The results from Alloy et al. (1999) indicated that high-risk participants (with the “most negative” cognitive style) were more likely to develop some form of depression, including major depression, when compared to low-risk participants (p. 506). The results from Alloy and colleagues indicated that high-risk participants had a more negative self-concept. Additionally, results from Gilbert, Baldwin, Irons, Baccus and Palmer (2006) illustrated a positive correlation between “trait self-criticism” and depressive symptoms (r = .63, p < .05). Permuy et al. (2010)
found that attachment styles associated with a negative view of the self significantly contributed to depressive symptoms. Available research indicated that self-criticism, negative self-concept and negative cognitive style may be significant variables in relation to depression and may also contribute to a potential sub-type of depression (Alloy et al., 1999; Gilbert et al., 2006; Marshall et al., 2008; Permuy et al., 2010).

Adding self-compassion to the discussion, Neff (2003a) found that self-compassion, as measured by the SCS, showed a significant negative correlation with self-criticism ($r = -.65$, $p < .01$) (Neff, 2003a). Findings from Neff (2003a) also indicated that self-compassion scores had a significant negative correlation with depressive symptoms as measured by the original Beck Depression Inventory ($r = -.51$, $p < .01$). In regard to self-compassion interventions, Kelly et al. (2010) found that the self-compassion intervention was most effective for participants with high scores of self-criticism and less effective for participants with low scores of self-criticism. Adams and Leary (2007) found that the self-compassion intervention was most effective for participants who identified as highly restrictive eaters, buffering them against self-criticism and negative patterns. Connecting the results from this research indicates that self-compassion interventions may be an effective intervention (or part of an effective intervention) for people who are highly self-critical and either exhibit depressive symptoms or are at risk for depressive symptoms due to cognitive style.

Shedding further light on this hypothesis, Gilbert et al. (2006) conducted a study that measured depressive symptoms in relation to self-criticism and also self-reassurance. For this study, self-reassurance was described as “ease and clarity of generating warm and supportive images of the self” (p. 183). The self-reassurance intervention did not specifically measure self-compassion as defined by Neff (2003a). However, Gilbert et al. (2006) did incorporate a
discussion of self-compassion and described how “generating warm, compassionate images and using these in self-evaluative situations, might be one way to try to stimulate the warmth-soothing system and make it available for self-evaluation” (p. 186). The Gilbert et al. study is intriguing in the way it integrated theories of self-compassion with attachment theory.

A main finding of the Gilbert et al. (2006) study related to participants’ abilities to generate feelings of warmth, self-acceptance, and encouragement. Gilbert et al. (2006) found that people with a trait toward self-criticism had a more difficult time dismissing self-criticism and also had a difficult time accessing “feelings of inner support and reassurance/warmth” (p. 193). In turn, people who had greater levels of self-reassurance could more easily “dismiss a self-critical image” while also generating feelings of self-warmth and reassurance (Gilbert, 2006, p. 196).

When correlating these various factors to depressive symptoms, Gilbert et al. (2006) found that measurements of depressive symptoms had a significant negative correlation with “trait self-reassurance” and a significant positive correlation with “trait self-criticism” (p < .05) (p. 191). Gilbert et al. (2006) summarized that “it may be the inability to generate warmth, as much as the inability to counteract self-criticism that is central to some depressions and perhaps some emotional difficulties” (p. 197). Gilbert (2006) hypothesized that “warmth, compassion and forgiveness” could be important enhancements to cognitive therapies (p. 197). On a theoretical level, the term warmth is also used by the Dalai Lama as an important human experience, particularly in regard to relationships (Dalai Lama & Cutler, 1998).

Gilbert et al. (2006) added to the research in this literature review by integrating warmth and compassion with cognitive and attachment theories. Gilbert et al. (2006) also identified self-criticism as a potential block when compassionately engaging in self-reassurance. This idea of
combining cognitive and affective interventions is also in line with research by Leary et al. (2007) which found that self-compassion appears to stretch across cognitive and emotional experiences with the potential for affecting behavioral outcomes.

**Self-Compassion and Social Interest**

Research findings, such as that provided by Bass et al. (2002), indicated that until an operational definition of social interest (with underlying constructs) is more clearly defined, connecting self-compassion to social interest may be a theoretical pursuit more than an empirical one. However, the two concepts appear to share similarities in relation to their complexity and broad purview. There is also room to believe that self-compassion and social interest share certain underlying constructs.

Leary et al. (2007) noted the cognitive, affective, and behavioral components of self-compassion. Stein and Edwards (1998) observed that gemeinschaftsgefühl, Adler’s original term for social interest, is also a “multi-level concept” that extends to the cognitive, affective and behavioral realms (paras. 7-8). Both concepts are ultimately intricate and deep in scope, providing multiple points of connection between relationship to self and relationship to others.

As far as identifying shared underlying constructs between self-compassion and social interest, compassion itself could be a shared dimension. Self-compassion is compassion directed toward oneself (Neff, 2003a). In relation to Adlerian psychology, Ansbacher (1978) wrote that “Adler in fact probably never held a theory without ‘room in it for love’ and compassion” (p. 120).

The idea of *common humanity* may also be a shared dimension. Neff (2003a) included common humanity as one of the subscales on the Self-Compassion Scale. The Dalai Lama also described a feeling of common humanity when discussing social connection, observing that “you
can relate to other fellow human beings...because you are still a human being, within the human community. You share that bond” (Dalai Lama & Cutler, 1998, p. 31). By comparison, Adler wrote that social interest is “a goal which would have to signify the ideal community of all mankind” (Ansbacher & Ansbacher, 1956, p. 142). A shared appreciation for compassion and common humanity appears to create overlap between self-compassion and social interest.

Social connection may be another point of intersection between the constructs. Neff (2003a) found that the Self-Compassion Scale had a significant and positive correlation with a measurement of social connectedness (r = .41, p < .01). Although Neff did not measure social interest directly, social connectedness could be reasonably thought of as being related to social interest.

A lack of competitive focus may be another shared dimension between social interest and self-compassion. Adler wrote that all people strive for superiority (Ansbacher & Ansbacher, 1956). However, Adler also noted that a person with strong inferiority feelings may attempt to move “from an increased inferiority feeling towards superiority over the other, the opponent” (Ansbacher & Ansbacher, 1956, p. 255). In this way, Adler described a form of striving for superiority that is based on competition. In contrast, Adler summarized that “all human judgments of value and success are founded...upon cooperation” (Ansbacher & Ansbacher, 1956, p. 255). In this passage, Adler summarized a key distinction between cooperation with others and competitively striving to be better than others.

Adler’s description of competition versus cooperation paralleled certain descriptions of self-compassion versus self-esteem. Although self-compassion and self-esteem are significantly correlated, it is an emphasis on external evaluation that appears to be one of the key differentiating factors between the two constructs (Leary et al., 2007; Neff & Vonk, 2009). Neff
and Vonk (2009) observed that “self-esteem is often predicated on the feeling of being special, on standing out in a crowd” (p. 27). In comparison, Neff and Vonk (2009) observed that “self-compassion is predicated on the acknowledgment of shared and universal aspects of life experiences and therefore tends to highlight similarities rather than differences with others” (p. 27). In a related comment, the Dalai Lama observed that a deep sense of self-worth can stem from a feeling of common humanity and that “bond can be a source of consolation in the event that you lose everything else” (Dalai Lama & Cutler, 1998, p. 31). This discussion highlights self-compassion’s unique relationship with self-worth, one that is based on a more inclusive frame of reference, mirroring the Adlerian ideal of social interest.

When studying meditation, Hutcherson et al. (2008) conducted a study that showed how meditation can moderate feelings of compassion as well as social connection. The Hutcherson study investigated the effects of loving-kindness meditation (LKM) on participants’ reactions to strangers. LKM is a practice that involves directing “compassion and wishes for well-being toward real or imagined others” (Hutcherson et al., 2008, p. 720). The results showed that, for participants in the LKM condition, “even just a few minutes of loving-kindness meditation increased feelings of social connection and positivity toward novel individuals on both explicit and implicit levels” (p.720). Findings indicated that LKM meditation could be a way for some people to increase both self-compassionate feelings as well as socially compassionate feelings (Hutcherson et al., 2008). Although the Hutcherson et al. study did not measure social interest directly, it alluded to potential social benefits of compassion-based meditation.

Social Interest and Depression

Herrington, Matheny, Curlette, McCarthy and Penick (2008) conducted a study of university women that analyzed the correlation between measures of depression and social
interest. Herrington et al. measured social interest with the Belonging/Social Interest Scale (BSI) of the Basic Adlerian Scale for Interpersonal Success (BASIS-A), developed by Wheeler et al. (1993) (as cited by Herrington et al., 2008). For context, Bass et al. (2002) found that the BSI had the third highest total mean effect size, and the highest weighted mean effect size for independent data, among the five social interest measures.

The findings from Herrington et al. (2008) differentiated between variables when studying women who have depression. The results indicated that the BSI had a significant negative correlation with depression symptoms as measured by the original Beck Depression Inventory (p < .01) (Herrington et al., 2008). However, scores related to coping resources, confidence and social support all had larger negative correlations with the BDI scores than social interest (p < .01). This study provided evidence for some, but not strong, connection between depression and social interest as measured by the BSI. The aforementioned caveats regarding social interest measurement would also apply (Bass et al., 2002).

The Kessler (2003) report on MDD was also interesting from an Adlerian standpoint in that it measured impairment in areas that paralleled Adler’s description of the “three ties in which human beings are bound…the three problems of life” including: occupation, society and love (Ansbacher & Ansbacher, 1956, p. 131). Kessler (2003) reported that the “social role domain” was the area of greatest impairment for U.S. adults with MDD. In regard to severity, 43.4% of respondents reported severe to very severe impairment in social roles. In regard to the other categories, 34.3% of respondents reported severe to very severe impairment in relationship roles, 34.2% in home roles and 28.1% in work roles. MDD appears to have a great effect on various realms of social relationships.
The finding that role impairment was greatest for the social domain was reminiscent of Adler’s core philosophy that “it is always the lack of social interest…which causes an insufficient preparation for all the problems of life” (Ansbacher & Ansbacher, 1956, p. 156). Adler went on to describe a “hesitating attitude” which he linked to the description of “melancholic” (Ansbacher & Ansbacher, 1956, p. 170). Adler wrote that the “melancholic” is “so oppressed by his own worries that his gaze is turned backward or inward” (Ansbacher & Ansbacher, 1956, p. 170). These statements potentially provide an Adlerian perspective on why depression, and the theory of negative cognitive style, may impact social functioning.

Methodology

Participants and Recruitment

The following proposal provides an overview of a study that could be developed into a complete dissertation project. The proposed participants for this study will be 30 undergraduate students from a large Midwestern university located in an urban area. Participants will be recruited from the psychology program and will ideally represent a range of freshman students through senior students. The researchers will recruit participants through announcements made in pre-approved psychology courses with participating faculty. Advertisements will also be placed in the school newspaper (both hard copy and online) as well as on fliers throughout the psychology building.

Informed Consent

The U.S. Department of Health and Human Services (DHHS) is the educational and regulatory agency that oversees human subject research through the Office for Human Research Protections (OHRP) (DHHS, n.d.). DHHS (2005) recognized The Nuremberg Code of the late 1940s as the first protective code for human subjects, emphasizing the crucial importance of
voluntary consent. The regulations regarding human subject research in the United States have evolved over the decades and are currently catalogued by DHHS (2009) under Title 45 Part 46 of the Code of Federal Regulations. Title 45 Part 46 outlines the requirements of various aspects of research protection including such topics as institutional review boards, protection for vulnerable subjects and informed consent procedures.

DHHS (2009) outlined that informed consent procedures must be given in clear language that would be understood by the participant. Researchers must protect the participants’ right to voluntary participation by not placing pressure on participants or rushing the process of informed consent. Participants should have “sufficient opportunity to consider whether or not to participate” (DHHS, 2009, p. 7). Researchers can also not ask participants to forego legal rights or release the researchers from “liability for negligence” (DHHS, 2009, p. 7). Informed consent procedures must be documented and overseen by the applicable IRB.

DHHS (2009) described how researchers need to provide adequate and clear information so that participants can make an informed decision, including explanatory statements that outline the research: “purposes…duration…procedures…risks or discomforts…benefits…alternative procedures…confidentiality of records…compensation” (p. 7). In addition, researchers must provide contact information for any questions related to the research and the participants’ legal rights. Researchers must also include a clear statement that “participation is voluntary” and that there will be “no penalty or loss of benefits” for withdrawal from the research study (DHHS, 2009, p. 8). Taking these factors of participant protection and informed consent into consideration, this researcher will include informed consent procedures at three stages of the study: the recruitment process, interview / information stage and actual study.
In regard to the potential risks of research, Leedy and Ormrod (2010) clarified that the risks should “not be appreciably greater than the normal risks of day-to-day living” (p. 101). From an ethical standpoint, it is also important to make sure that the risk to a participant is not greater than the reward of the research (Grant & Sugarman, 2004). This applies to both physical and psychological realms. Researchers can provide necessary protection to participants by conducting a risk assessment for the study, implementing thorough informed consent procedures and protecting participant confidentiality (Leedy & Ormrod, 2010).

Risk assessment is a complex process. DHHS (2009) defined minimal risk as “the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests” (p. 4). This proposed study would appear to fall under this definition since it would utilize common psychological tests. However, the Society for Science & the Public (2012), a nonprofit organization devoted to promoting scientific understanding, published a risk assessment guide for researchers and overseers of research. They noted that any “research activity” that activates “emotional stress would be considered more than minimal risk” (p. 3). The Society for Science and the Public (2012) clarified that questionnaires relating to weighted emotional experiences such as abuse or “psychological well-being (e.g. depression, anxiety, suicide)” would be considered beyond minimal risk.

This proposed study would measure depressive symptoms utilizing the Beck Depression Inventory (2nd ed.) (BDI-II) (Beck, Steer & Brown, 1996). The BDI-II also contains a question relating to suicide. The informed consent for this study would therefore err on the more cautious side of the analysis and include risk assessment language that would discuss the general risk of
research along with the fact that this particular research could be considered “more than minimal risk” (The Society for Science and the Public, 2012, p. 3). Debriefing and referral procedures would also need to be implemented to assist in limiting the risk to participants (Leedy & Ormrod, 2010; Society for Science & the Public, 2012).

**Informed consent procedures.** Starting at recruitment, the announcement script and advertisement fliers will ‘invite’ students to participate rather than recommending participation or offering an opportunity to participate (University of Minnesota IRB, 2004/2009, p. 24). The recruitment language will contain a brief and clear synopsis of the purpose and set-up of the study. The script/flier will explain that the study involves completing three different psychological questionnaires. As mentioned, language relating to the general and specific risks of psychological questionnaires will be included. The language will also highlight that all participation is voluntary and that participants can withdraw at any time without penalty. Contact information for the university’s IRB will be provided for further information relating to participants’ rights. Contact information for the study will also be provided.

Participants will be informed that the entire process, including a de-briefing afterwards, will include two meetings on different days. First, there will be a brief interview of about 30 minutes followed by the later study that could last up to 90 minutes. The language will note that participants will receive one extra credit point if the participant is enrolled in a participating psychology class. To uphold the tenet of voluntary participation, the language will also state that participants will receive the extra credit even if they choose to withdraw from the study. The language will also request that all participants be 18 years of age or older due to parental permission requirements for children under 18 years (University of Minnesota IRB, 2004/2009).
The students who respond to the study announcement or advertisement will be instructed to call or email the research office. The researchers will mail potential participants a hard-copy packet which will include: an introductory letter, informed consent document and demographic survey. The letter will ask participants to first review the informed consent document before proceeding.

The demographic survey will ask for details such as participants’ age and ethnicity. Since this study could be viewed as an initial pilot study, the researchers would ask for this information for the purpose of ad hoc analysis. This will help researchers determine any potentially key variables for future research.

The informed consent document will review and expand on the basic information listed in the recruiting language. The mailed informed consent document will carefully outline risk assessment to help participants determine whether this is an appropriate study for them. As an additional precaution, the informed consent document will list a number of higher-risk experiences (i.e., psychotic episode, significant loss, DUI, self-harm activities, taking psychotropic medications, current use of substances) and then tactfully ask participants that, if they have recently experienced any of the above, to consider suspending participation at this time given the potential discomfort caused by psychological research. The informed consent document would provide a statement that the researchers are available to answer any questions about the risks and benefits of the study. Contact information for the research office and overseeing IRB would be provided.

Informed consent is a process that requires the participant to truly understand the scope of the study and what is being asked of him or her. The University of Minnesota IRB (2004/2009) suggested assessing a participant’s level of understanding using open-ended
questions. The researchers will therefore schedule a brief meeting with participants who have had at least a week to complete the survey and review the informed consent documents.

The conversations will be conducted by a trained PhD graduate student who will not be involved in the later study. This PhD student will review all of the documents with participants. The graduate student will ask scripted questions that are open-ended such as, “describe in your own words the purpose of the study” (University of Minnesota, 2004/2009, p. 23). The interviewer will also remind potential participants that all participation is strictly voluntary and that they can withdraw from the study at any point with no questions asked. For participants who choose not to participate at this time, the researcher will read from a de-briefing script that will include community mental health referrals.

As an additional screening measure, the researcher will ask if participants are fluent and competent reading and writing in English. The BDI-II is written for “adults and adolescents aged 13 years and older” (Beck, Steer & Brown, 1996). In turn, the SSSI was originally tested for students in ninth to twelfth grade (Sulliman, 1973). The interviewers would therefore ask participants: “Do you believe you are at a mastery level in English equivalent to a 13 year old (about 8th grade)?” Future studies would hope to expand on the participant base by offering assessment tools in other languages.

The third level of informed consent will take place at the actual study. The assigned proctor will review the informed consent document with participants before the study and ask for participants to sign the document, highlighting that participants can withdraw at any time without penalty. Community mental health referral information would also be available as a take-away packet.
Incentives

The question of whether or not to offer an incentive for research participation is a complicated one according to Grant and Sugarman (2004). Of particular importance is the idea that an incentive can act as a motivating force and influence a person’s choice in a given situation. Grant and Sugarman (2004) observed that incentives in research are not automatically problematic if certain principles are taken into account: “beneficence, respect for persons, and justice” (p. 726). Beneficence refers to whether the study “involves a reasonable level of risk in relation to the prospect of benefit” (Grant & Sugarman, 2004, p. 726). “Respect for persons” refers to the importance of individual autonomy to make decisions without ‘undue influence’ (Grant & Sugarman, 2004, pp. 724-725). Justice requires the protection of research participants while also calling for diverse representation in research, as appropriate.

Grant and Sugarman (2004) offered two primary questions for the provision of incentives: Does the incentive create “coercive inducement to participate” and does the incentive “compromise the dignity of the subject?” (p. 719). Grant and Sugarman additionally encouraged researchers to think about power dynamics when offering incentives. They provided the example of a professor who offers extra credit for participating in his or her research. Grant and Sugarman observed that the students’ sense of voluntary participation in the research may be undermined by adding the power differential of professor/student and the incentive of an increased grade.

However, in looking beyond these logistical considerations, Bluvshtein observed that the variable of social interest may alter the equation for this particular study. Social interest is in part defined by “motivating, activating, guiding behavior” that is also “socially useful” (Ansbacher, 1992, p. 404). If this researcher does not offer an incentive then all volunteers could ultimately be motivated by the principle of discovery, and one could argue, social interest. This form of
voluntary selection could lead to a form of sampling bias that could distort the results when analyzing levels of social interest (Leedy & Ormrod, 2010).

For comparison, this researcher reviewed a spectrum of studies that measured social interest. Leak (1982) utilized two methods of finding participants across two studies involving undergraduate psychology students. The first study randomly selected participants who had agreed to participate. The second study offered students one point of extra credit. Leak (2006a) also offered undergraduate participants an incentive in the form of extra credit. Leak and Leak (2006) offered extra credit across two studies involving college students. Mozdzierz et al. (2007) analyzed psychological assessments for hospitalized patients in a multifaceted substance abuse program and did not indicate that an additional incentive was offered. Herrington et al. (2005) did not mention a particular incentive when describing “458 university women volunteers” from around the United States (p. 347). This sampling of studies indicates the potential for diversity relating to incentives and recruitment.

Upon reviewing this sample of studies, this researcher concluded that offering a small extra credit incentive would be in line with past research and would help control for the potential for sampling bias related to social interest. In order to address the power and incentive dynamic described by Grant and Sugarman (2004), this researcher would repeatedly outline how participants can withdraw from the study without penalty. To encourage purely voluntary participation, participants would be told that they could receive an extra credit point whether or not they completed the study. This researcher would also work with participating faculty to provide examples for how students could receive extra credit outside of participating in this particular study.
Study Procedures

The study will be held in a large classroom at the university. One licensed psychologist and four graduate students will be involved in conducting the study. The graduate student with the most experience in test instruction will be assigned the role of proctor. Another graduate student will conduct the debriefing procedure. Upon arrival, the remaining two graduate students will check the students in. Each student will be assigned a number to be used in place of his or her name to ensure confidentiality. After check-in, the proctor will review the informed consent document which would have already been discussed in detail at the prior interview. Participants who agreed to participate would then sign the document.

The three graduate students who are not the proctor will have a list of 1/3 of the participants. Each third of the participants will be taking the assessment tools in a different order. Each graduate student will need to distribute the assessment tools to his or her assigned students in a particular order. One third of the students will complete the BDI-II, followed by the Sulliman Scale of Social Interest, followed by the Self-Compassion Scale. One third of the students will complete the Sulliman Scale of Social Interest, followed by the Self-Compassion Scale, followed by the BDI-II. One third of the students will complete the Self-Compassion Scale followed by the BDI-II, followed by the Sulliman Scale of Social Interest. This process is designed to help control for any underlying effects of completing the instruments in one sequential order. The proctor will instruct the participants to complete the instruments in the order they are received.

Once the tests are distributed the proctor will introduce each of the assessment tools to the students and lead them through the instruction process. The proctor would instruct students to answer each question on every assessment. The Self Compassion Scale by Neff (2003a) is self-
The Sulliman Scale of Social Interest (Sulliman, 1973) also includes a brief explanatory paragraph. These two assessments should only require a brief overview. The BDI-II (Beck, 1996) also offers instructions on the first page but may require more explanation. Beck, Steer and Brown (1996) provided instructions for self-administration of the BDI-II.

The proctor would instruct students to refer to the instructions on the front of the questionnaires if they have a question. The proctor would also let participants know that s/he will be available in that room for any questions. In order to avoid possible test anxiety, students would then be told that they could choose to stay in the classroom or go to the nearby school library to answer their questionnaires. Students would be instructed to return to the main classroom once they had completed their questionnaires.

After all participants had handed in their completed instruments, the proctor would start the debriefing procedure that explained the purpose of the study in detail. The proctor would remind participants that they could review the final summary of the study once completed. The participants would be given a packet including their informed consent document, contact information for the primary researcher, contact information for the IRB at the university and community referrals for psychological services. The proctor would ask students whether there were any remaining questions and whether they had any feedback regarding the study and processes. This information would then be taken into account for future studies of this type. The proctor would thank all students for their participation.

The Self-Compassion Scale

Kristin Neff at the University of Texas at Austin published the Self-Compassion Scale in 2003. Neff (2003a) created the Self-Compassion Scale by identifying various qualities associated
with self-compassion along with the contrasting state of thinking or feeling. The Self-
Compassion Scale is therefore based on six subscales: “self-kindness versus self-judgment,
common humanity versus isolation, and mindfulness versus over-identification” (Neff, 2003a, p.
234). Neff (2003a) discussed how these subscales are distinctive concepts that can yield their
own score yet can also be combined to form a global self-compassion score.

The long form of the Self-Compassion Scale is comprised of 26 questions answered on a
scale of 1 to 5. A 1 equates to “almost never” while a 5 equates to “almost always” (Neff,
2003b). It is important to remember that three categories measure positive outlooks: self-
kindness, common humanity and mindfulness. In turn, three categories measure negative
outlooks: self-judgment, isolation and over-identification. In order to calculate a total self-
compassion score, the questions for the three negative categories need to be reverse-coded so
that a 5 becomes a 1, a 4 becomes a 2 and so on. After reverse-coding, it is possible to calculate a
total self-compassion score. Neff (2003b) observed that it is “easier to interpret the scores if the
total mean is used” (p. 1). The total mean would be calculated by adding the scores from all of
the questions and dividing by 26.

When looking at the total mean score, Neff (2003b) stated that a score of 3.0 would
constitute an average score. Scores of 1.0 – 2.5 would indicate a low level of self-compassion; a
mean score of 2.5-3.5 would indicate a moderate level of self-compassion; a mean score of 3.5-
5.0 would indicate a high level of self-compassion (Neff, 2003b). Yet the ability to additionally
analyze subscale scores provides a primary benefit to using the long form of the Self-
Compassion Scale (Neff, 2003a).

**Underlying concepts and definitions.** To explain self-compassion, Neff (2003a)
discussed the broader context of compassion. Neff (2003a) defined compassion as “being open to
and moved by the suffering of others, so that one desires to ease their suffering” (p. 224). Yet in order to be open to and moved to action by someone else’s suffering, Neff observed that various related qualities are necessary. Some of these qualities would include: “patience, kindness and non-judgmental understanding” (Neff, 2003a, p. 224). Self-compassion, in turn, is the practice of applying these same compassionate qualities toward oneself (Neff, 2003a). This philosophy is outlined in the two SCS sub-scales of “self-kindness versus self-judgment” (Neff, 2003a, p. 234).

Neff (2003a) also defined self-compassion by looking at what it is not. For example, Neff (2003a/2003c) cited authors, such as Goldstein and Kornfield (1987), who had distinguished self-compassion from self-pity. One of the key differences between the constructs is that self-pity can increase feelings of self-absorption whereas self-compassion increases “feelings of interconnectedness” (Neff, 2003a, p. 224). This understanding would support Neff’s (2003a) theory that someone who feels self-compassion would have a greater sense of “common humanity” rather than “isolation” (Neff, 2003a, p. 234).

Neff (2003a) also theorized that self-compassion would help a person “put one’s personal experiences into greater perspective” and foster “greater clarity” (p. 224). In contrast, self-pity would enmesh a person with their problems to the point of losing a broader perspective. The idea of maintaining a broader perspective through self-compassion is represented by the SCS subscales of “mindfulness versus over-identification” (p. 234). Neff (2003a) defined the concept of mindfulness as “a nonjudgmental, receptive mind state in which individuals observe their thoughts and feelings as they arise without trying to change them or push them away” (p. 224). Neff’s (2003a) analysis of self-compassion and its underlying qualities allowed for the creation of the SCS which can be interpreted in terms of sub-categories as well as an overall score.
**Development of the Self-Compassion Scale.** Neff (2003a) developed, edited, and streamlined the first drafts of the scale with focus groups, questionnaires and two pilot tests of undergraduate students. The first study of the Self-Compassion Scale involved a larger group of undergraduate students (Neff, 2003a). Neff (2003a) tested for content validity, convergent validity, and discriminant validity by comparing the Self-Compassion Scale scores to other scales relating to kindness, social desirability, self-criticism, connectedness, emotional intelligence, perfectionism, anxiety, depression and life satisfaction.

This study underlined the importance of measuring a sub-category (such as self-kindness) and its opposite (self-judgment). In an interesting development, Neff (2003a) found that the different sub-categories were “not mutually exclusive” explaining that “a person may tend not to judge himself, but that doesn’t necessarily mean that he typically takes proactive steps to be kind to himself either” (p. 234). At the same time, Neff (2003a) found support that a global view of self-compassion could be formed from the connections between subscales.

This first study helped Neff (2003a) to establish initial construct validity and convergent validity. In addition, the Self-Compassion Scale showed a “significant positive correlation with life satisfaction” and a “significant negative correlation with anxiety and depression” (Neff, 2003a, p. 235). This indicated initial support for the hypothesis that self-compassion helps to bolster mental health and resilience.

Neff’s (2003a) second study focused on comparing the Self-Compassion Scale to measures of self-esteem, narcissism and emotional patterns. Neff (2003a) included depression and anxiety measurements to re-test the first study’s results relating to mental health. The results indicated that the SCS was measuring self-compassion as a distinct concept. The results also supported Neff’s (2003a) previous findings that self-compassion was negatively correlated with
depression and anxiety. High test-retest reliability was additionally established at .93 (Neff, 2003a).

Neff’s (2003a) third study was engineered as a comparison between practicing Buddhists and undergraduate college students. Neff (2003a) theorized that practicing Buddhists would be well-versed in self-compassion practices given the Buddhist understanding of the concept. Neff (2003a) also included measures of self-esteem to compare and contrast with the Self-Compassion Scale. Neff (2003a) found that “Buddhists had significantly higher total self-compassion scores than the undergraduates” with \( p < .0005 \) (p. 243). The Buddhist practitioners also had significantly higher scores on the ‘positive’ subscales and significantly lower scores on the ‘negative’ subscales with \( p < .001 \) (Neff, 2003a, p. 243). In addition, Neff (2003a) found a “significant correlation between self-compassion scores and number of years of practice within the Buddhist sample (r = .35, \( p < .05 \))” (p. 243). The self-esteem comparisons between the groups yielded results with slight significance. Ultimately, the results from three separate studies indicated that the Self-Compassion Scale maintained construct validity, content validity and convergent validity along with “good test-retest reliability” (Neff, 2003a, p. 239).

**Beck Depression Inventory – Second Edition**

The Beck Depression Inventory – Second Edition (BDI-II) is a depression assessment tool designed for people 13 years old and above (Beck et al., 1996). Beck et al. (1996) emphasized that the BDI-II is not “an instrument for specifying a clinical diagnosis” so much as an “indicator of the presence and degree of depressive symptoms” (p. 6). Beck et al. (1996) observed that the BDI-II should be administered by professionals with psychological training and should also be supported by other diagnostic processes.
Beck et al. (1996) estimated that the BDI-II takes “between 5 and 10 minutes to complete” although people with more severe depression can require more time (p. 7). The BDI-II consists of 21 questions that are linked to the DSM-IV criteria for depression (Beck et al., 1996). Each question is rated on a scale of increasing severity, from 0 to 3. The scale for each question differs according to the category. Also, the response options to the sleep and appetite questions were modified as part of the revision to the BDI-II (Beck et al., 1996).

Beck et al. (1996) provided a range of cut-off scores that were based on “maximizing sensitivity” which refers to accurately identifying people who have depression (p. 11). This suggested range of scores erred on the lower end of the scale, potentially accruing more affirmative responses for people who do not actually have clinical depression (Beck et al., 1996, p. 11). Beck et al. acknowledged that the cut-off range can be changed based on the purpose of the administrator. For example, a researcher may want to increase the cut-off range in order to reduce “false positives” and stay true to the depressive symptoms (Beck et al., 1996, p. 11). The professional discretion allowed by the BDI-II is one example of why it should be administered and interpreted by people who have “clinical training and experience” (Beck et al., 1996, p. 6).

The symptomatic timeframe of the BDI-II is the past 2 weeks which is in line with the DSM-IV-TR criteria for a major depressive episode (American Psychiatric Association, 2000). The question / categories for the BDI-II address a number of different symptom areas for depression (Beck, 1996). The BDI-II included new categories that can indicate “severe depression or depression warranting hospitalization” (Beck et al., 1996, p. 1). These new categories replaced four previous categories relating to weight, body image, somatic symptoms, and work difficulties (Beck et al., 1996).
**Development of the BDI-II.** The BDI-II is a revised version of the BDI-IA developed in 1979 by Beck, Rush, Shaw & Emery (as cited by Beck et al., 1996). The BDI-IA was, in turn, a revised measure of the original Beck Depression Inventory published by Beck et al. (1961). Beck et al. (1996) observed that the original Beck Depression Inventory was not based on diagnostic criteria so much as symptoms outlined by the “verbal descriptions by patients” (p. 2). The revisions to the BDI-IA primarily consisted of rewording certain phrases and limiting response options to four possibilities.

Beck et al. (1996) noted that “the BDI-II constitutes a substantial revision of the original BDI” (p. 1). These revisions represent an effort to bring the BDI-II more in line with the diagnostic symptoms of depression required by the DSM-IV. The primary changes to the BDI-II included the removal of four previous categories and the inclusion of four new categories along with a significant rewording of existing response options (Beck et al., 1996).

It is important to note that the BDI has been “one of the most widely accepted” depression screening tools throughout the years (as cited by Beck et al., 1996, p. 1). In a survey of mental health clinics and centers with a psychologist on staff, Piotrowski and Keller (1989) found that the BDI was ranked 12th as far as frequency of use when looking at 30 of the most popular psychological assessments.

Beck et al. (1996) tested the BDI-II in a study of 500 outpatients and 120 college students. The results indicated that the BDI-II has a higher internal consistency than the original BDI. A sub-set study established test re-test reliability at .93 with p < .001 (Beck et al., 1996, p. 25). Another sub-set study indicated that the correlation between the BDI-II and the BDI-IA was .93 (p < .001). The Beck et al. (1996) study found that the BDI-II was also positively correlated to other established depression scales (p < .001).
Sulliman Scale of Social Interest

The Sulliman (1973) Scale of Social Interest (SSSI) is a self-report scale developed as a measurement tool for social interest. Sulliman acknowledged that social interest can be viewed as a broad term. After reviewing theoretical interpretations, Sulliman summarized three concluding points: there is not one exact definition of social interest that is universally accepted, any definition that attempts to limit social interest “will be met with opposition by those demanding expansion of its boundaries” and casting a wide net in regard to the possible scope of social interest is “the most logical way in which to set up a criterion for the assessment of social interest” (Sulliman, 1973, p. 13). In line with these observations, Sulliman designed the SSSI to be interpreted as a total score rather than emphasizing individual items.

Sulliman (1973) chose to utilize a true-false measurement scale for a number of reasons. The scale was originally developed for use with high-school students and the author hypothesized that a true-false scale is more easily understood in that age group. Second, Sulliman anticipated that a true-false scale would yield the same basic agreement/disagreement result as a continuum. Third, Sulliman noted that having a sufficient number of items (20 or more) would control for reliability.

Sulliman (1973) started with 100 statements that were thought to represent different aspects of social interest. The initial test involved 173 students. The original items were analyzed according to how the item score correlated to the total score of the instrument. A higher score offered greater “discrimination” in regard to the total score (Sulliman, 1973, p. 24). Tests of discrimination and internal consistency were used to choose items for the final questionnaire. The author noted that three areas of broader interest appeared: ‘self, others, and the environment’ (Sulliman, 1973, p. 60).
Tests of validation and reliability were then enacted with a larger group of 452 students (Sulliman, 1973). Reliability tests showed an internal consistency of .91, test-retest reliability as .93 and a split-half reliability as .90. Validity was calculated comparing scale scores to the ratings of teachers. Factor analysis allowed for subscale scores according to two broader categories: ‘concern for and trust in others’ and ‘confidence in oneself and optimism in one’s view of the world’ (Sulliman, 1973, p. 71). The first subscale had a correlation of .87 with the total score while the second subscale had a correlational score of .90 with the total score. The mean score for the final version of the scale was 36.06 with a standard deviation of 9.2 (Sulliman, 1973).

Although the SSSI was originally tested with high-school students, it has been tested with other populations. When comparing five social interest instruments, Bass et al. (2002) found that the SSSI had the second highest total mean effect size at $r = .296, p \leq .05$. Mozdzierz et al. (1986/1988) found generally favorable results for the SSSI in a study of male veterans who were in treatment for substance use. However, the authors also acknowledged that there are certain inconsistencies with existing social interest measures. Watkins and St. John (1994) concurred with the generally positive recommendation for the SSSI. However, they offered a similar caveat regarding the difficulty of measuring social interest.

**Limitations and Potential Bias**

The research sample is one of the primary limitations for this proposed study. The generalizability of the results may be limited based on the recruitment population and sample size. The population would be recruited from undergraduate psychology majors. This recruitment population could create its own sampling bias. It would also be difficult to generalize results to other geographic areas since all students would be from a Midwestern university. The
smaller sample size would also limit generalizability to the broader population. This researcher recognizes that recruitment, informed consent and study procedures will be more streamlined if the initial sample is from the same university and if the sample size is smaller. However, future studies could look at ways to expand the population pool and sample size.

The process of measuring social interest provides at least two limitations to this study. First, Bluvshtein observed that a sample of people who volunteer with the intention of contributing to societal knowledge may already be self-selecting in regard to social interest. This would affect the generalizability of the study’s results. This proposal attempts to address this concern by offering one extra credit point to participants (while also taking precautions to uphold ethical considerations relating to incentives). However, even with this small incentive, it is possible that social interest would continue to be a self-selecting variable. Second, Bass et al. (2002) analyzed the challenges of measuring social interest using current instruments. Ultimately, there remain many uncertainties to address when connecting concrete measurements of social interest to its theoretical understanding.

Study procedures may also create research limitations. In order to limit test anxiety, the participants will be given the choice of completing the questionnaires in the study room or in the library. However, completing the questionnaires in a different location will diversify the environment for participants and could foreseeably alter their response based on different sights and sounds. The researchers will provide the instruments to participants in a different order to limit any potential effect from completing the instruments in one order. However, it is possible that completing the instruments all together may still have some effect on individual results.

The utilized instruments could also be a limitation to this study. Although this researcher chose these instruments based on careful consideration of validity, reliability and usage, they are
still measuring psycho-social constructs that are somewhat intangible (Leedy & Ormrod, 2010). It is possible that utilizing a different instrument, such as the Social Interest Index (Greever et al., 1973) or the PHQ-9 (Kroenke, Spitzer & Williams, 2001), could alter the results. Bluvshtein also observed that the name of the instrument could potentially affect participants’ responses. If participants know that they are completing the Beck Depression Inventory (2nd ed.), would the word *depression* affect their response mode? In turn, would the term *social interest*, in the Sulliman Scale of Social Interest, also affect response modes? It is possible that the names of the instruments could be leading to participants in a conscious or unconscious way.

**Potential bias.** This researcher began to study Buddhist philosophy and psychology in her late teenage years. While not specifically identifying as a Buddhist, this researcher acknowledges the profound influence of Buddhist thinking and practices in her life. Compassion is a construct that has deep relevance to Buddhist philosophy (Dalai Lama, 2005; Dalai Lama & Cutler, 1998; Wallace & Shapiro, 2006). The Buddhist emphasis on compassion led this researcher toward an investigation of empirical evidence relating to compassion and self-compassion in particular. The study of Buddhism has created some potential bias in this researcher toward the benefits of compassion and self-compassion.

It is also important to note that this researcher identifies as an Adlerian. Adlerian psychology considers social interest to be a foundational component of mental health (Ansbacher, 1978). This researcher acknowledges that the study of social interest at Adler Graduate School has had a personally beneficial impact on her life. Therefore, this researcher would also note potential bias relating to the positive benefits of social interest.
Hypothesizing Results

The purpose of this study is to examine the relationships between the three variables of self-compassion, depression, and social interest utilizing the Self-Compassion Scale (Neff, 2003a), the Beck Depression Inventory (2nd ed.) (Beck et al., 1996) and the Sulliman Scale of Social Interest (Sulliman, 1973). The study would therefore apply correlational statistics or “the statistical process by which we discover whether two or more variables are in some way associated with one another” (Leedy & Ormrod, 2010, p. 273). According to Leedy and Ormrod (2010), this correlational research analyzes both the direction of the relationship (positive or negative) and the strength of the correlation (between 0 and 1).

It is worth noting that there has already been a foundation of research in this area. For example, Neff (2003a) found that the Self-Compassion Scale had a “significant negative correlation with the Beck Depression Inventory” (p. 233). However, given the many changes from the BDI to the BDI-II (Beck et al., 1996), it would seem that an in-depth analysis with the updated scale would be warranted.

The anticipated findings for this proposed study highlight the fact that self-compassion and social interest are both broader concepts that are comprised of underlying dimensions. In turn, depression is also a multi-faceted diagnosis that incorporates various dimensions and diagnostic criteria. Although that complexity makes each of these concepts fascinating to study from a theoretical perspective, it may also could make them more difficult to research and understand from a holistic perspective. One of the purposes of this research project would be to look at the correlations, both positive and negative, between the three instruments’ overall scores, subscales and individual items. For example, Neff’s (2003a) Self-Compassion Scale has sub-scales that include: “self-kindness versus self-judgment, common humanity versus isolation,
and mindfulness versus over-identification” (Neff, 2003a, p. 234). A major question for this research would be to analyze how these subscales correlate to the overall BDI-II and SSSI scores along with the individual items.

Looking at self-compassion through a different lens, one could also theorize that self-compassion includes both cognitive and affective elements. As an example, the Self-Compassion Scale (Neff, 2003a) includes items such as: “when I’m feeling down I tend to obsess and fixate on everything that’s wrong.” This speaks to a cognitive and ruminative process. However, the Self-Compassion Scale also includes the statement: “I try to be loving towards myself when I’m feeling emotional pain.” This item speaks to an affective experience, soothing a difficult emotional experience through loving feelings. One of the definitions of love is “a feeling of warm personal attachment or deep affection” (Dictionary.com, 2012). This researcher would therefore pay close attention to the affective items of the Self-Compassion Scale to see how those questions related to items on the BDI-II and the SSSI.

Social interest is also a broad concept that can incorporate many underlying components (Ansbacher, 1978; Ansbacher, 1992; Bass et al., 2002). As a measurement tool, the Sulliman Scale of Social Interest (1973) hypothesized two subscales along with the overall score: ‘concern for and trust in others’ and ‘confidence in oneself and optimism in one’s view of the world’ (Sulliman, 1973, p. 66). It is interesting to note that social interest, as measured by Sulliman, incorporates a positive self-concept. This could create an interesting comparison when looking at the self-concept statements included in both the BDI-II and Self-Compassion Scale. The Self-Compassion Scale offers different kinds of positive self-concept statements, such as “I’m tolerant of my own flaws and inadequacies” (Neff, 2003a).
Looking at a broader world-view, it could be important to analyze how social interest items that measure concern for others relate to the Self-Compassion Scale item that states: “When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world” (Neff, 2003a). This statement is interesting because it connects self-criticism to a broader community feeling and sense of social engagement. In turn, how would the isolation subscale for the Self-Compassion Scale relate to social interest scores and measures?

Depression is a diagnosis with various underlying diagnostic possibilities, as evidenced by the BDI-II, that incorporates physiological, cognitive, emotional, and mood-based symptoms of depression (Beck, 1996; Beck et al., 1996). This researcher would look at whether these underlying symptoms would correlate, positively or negatively, to sub-scales such as self-kindness and self-judgment from the Self-Compassion Scale (Neff, 2003a)? What items might have the greatest correlation? Looking ahead to future research, would it be possible to counteract specific depressive symptoms by implementing specific self-compassionate and/or social therapeutic elements that have a strong negative correlation with that depressive symptom?

Analyzing individual items. Moving the lens to a micro view, it is possible to hypothesize as to which specific items on the scales would correlate to one another. For example, it seems reasonable to conclude that the self-judgment questions on the Self-Compassion Scale (Neff, 2003a) would show a positive and strong correlation with the BDI-II (Beck et al., 1996) questions pertaining to self-criticalness, self-dislike, past failure and worthlessness. These items could also potentially correlate to SSSI items such as, “It seems like everything I do turns out wrong” and “no one really cares about me” (Sulliman, 1973).

It could also be hypothesized that questions of over-identification on the Self-Compassion Scale (speaking to rumination, inadequacy, and a lack of proportional emotion)
could be positively correlated to *pessimism* on the BDI-II and negatively correlated to items on the SSSI that speak to an optimistic world view.

This researcher would also hypothesize that questions of *isolation* on the Self-Compassion Scale would be positively correlated to the question pertaining to *suicidal thoughts or wishes* on the BDI-II. These items may also positively correlate to SSSI items such as “I often feel like I am completely alone in the world” (Sulliman, 1973).

While some of the more negatively phrased items across the three measurement tools appear to offer clearer overlap, it would also be important to look at the more positive, protective items. For example, would the *common humanity* subscale of the Self-Compassion Scale positively correlate to SSSI items such as, “people are all of equal worth, regardless of what country they live in” (Sulliman, 1973)?

**Discussion**

The Dalai Lama (1998) offered an interesting perspective on depression and general suffering that appeared parallel to Adlerian theory as well as cognitive and interpersonal theories of depression. In language reminiscent of Adlerian psychology, the Dalai Lama equated depression to a sense of “discouragement” that can be “an obstacle to taking the steps necessary to accomplish one’s goal” (Dalai Lama & Cutler, 1998, p. 287). In regard to cognitive theory, The Dalai Lama and Cutler (1998) observed that “all too often we perpetuate our pain, keep it alive, by replaying our hurts over and over again in our minds, magnifying our injustices in the process” (p. 150). Mirroring elements of interpersonal theories of depression, there is also a strong belief in Buddhism that “human affection, warmth, friendship, and so on are conditions absolutely necessary for happiness” (Dalai Lama & Cutler, 1998, p. 119). In turn, the Dalai Lama observed that compassion is a foundational concept when relating to one another, also
highlighting the importance of directing those feelings toward oneself (Dalai Lama, 2005; Dalai Lama & Cutler, 1998).

The tendency toward self-criticism is an important variable to examine from a philosophical and empirical standpoint. From a theoretical standpoint, the Dalai Lama offered an interesting perspective on self-criticism. During an interview, Christopher Germer reported that the Dalai Lama emphasized that “even when people are harsh with themselves, they are expecting something good to come out of it…we believe in a mistaken way that this will lead us to being happier and free from suffering” (Fain, 2012, para. 7). From an empirical standpoint, Neff (2003a) found that a measurement of self-criticism showed a significant negative correlation with self-compassion as measured by the SCS (Neff, 2003a). It therefore appears to fit, theoretically and empirically, that self-compassion interventions may be particularly useful for people who are more self-critical (Adams & Leary, 2007; Kelly et al., 2010).

Self-criticism may also be a moderating variable for the course and treatment of depression (Marshall et al., 2008). In a study analyzing the treatment of depression, Marshall and colleagues found that CBT alone did not have a significantly positive effect on self-critical participants with MDD. This was a surprising result given the recognition of CBT as a primary treatment for depression (NIMH, 2011). Marshall et al. (2008) theorized that “self-criticism moderates the relationship between treatment modality and treatment outcome” (p. 240). This is a significant hypothesis given that research has found a positive result for self-compassionate interventions in regard to self-criticism (Adams & Leary, 2007; Kelly et al., 2010). One broader question from this research proposal would be if, and how, self-compassion interventions could be specifically tailored to people with depression and a tendency toward high self-criticism. This
could even be taken a step further to examine the particular effectiveness of self-compassion in relation to hopelessness depression (Abramson et al., 1989).

Gilbert et al. (2006) had also hypothesized that cognitive therapies may benefit from the addition of “warmth, compassion and forgiveness” (p. 197). Along a similar vein, research from Leary et al. (2007) indicated that self-compassion has cognitive, affective and behavioral benefits. Another question from this research proposal relates to whether self-compassion interventions may provide a potential bridge between cognitive therapies and other therapies given that it includes cognitive elements while also incorporating many factors of warmth as described by Gilbert et al. (2006).

This literature review and research proposal highlights how self-concept factors into the theories behind self-compassion, social interest, and depression (as well as therapeutic interventions such as CBT). One of the most important findings is that self-compassion appears to be a unique construct from self-esteem (Leary et al., 2007; Magnus et al., 2010; Neff, 2003a; Neff & Vonk, 2009). In turn, one of the intriguing elements of self-compassion is that it appears to relate to a more stable form of self-acceptance that may be less affected by external evaluation (Leary et al., 2007; Neff & Vonk, 2009). Another broader question as to this proposal would be if, and how, self-compassion could be utilized to help people with a particularly negative self-concept.

Connecting questions of the self to questions of society, could changing a person’s self-concept affect how he or she interacts in the social world? Was the Dalai Lama correct when he wrote that “Loving oneself is crucial. If we do not love ourselves, how can we love others?” (Dalai Lama, 2005, p. 25). Could altering a person’s negative self-concept, and lifting any sense
of self-hatred - as described by Salzberg (2011) and the Dalai Lama and Cutler (1998) - positively affect that person’s interactions with others?

Questions relating to social relationships are particularly important to Adlerian psychology given that it has historically placed great emphasis on the social dynamics of life (Ansbacher, 1978; Ansbacher, 1992; Ansbacher & Ansbacher, 1956; Stein & Edwards, 1998). Given this social emphasis, helping clients increase social interest is considered to be a major goal of Adlerian therapy (Ansbacher & Ansbacher, 1956; Carlson, Watts & Maniaci, 2006). However, the social element is also important from a broader mental health perspective, particularly when considering the social impairment that is common to depression (Kessler et al., 2003; Kessler et al., 2005). This researcher would be particularly intrigued to study in more detail if, and how, self-compassionate feelings may affect a person’s relationships with others.

This literature review and research proposal appears to have generated more questions than answers. However, Buddhist understanding of compassion as it relates to self and others struck a chord for this researcher, particularly given her Adlerian training. Throughout this time of research and study, this researcher has frequently been surprised by the varied benefits that self-compassion appears to offer from both a theoretical and empirical standpoint. Although the connections between self-compassion, social interest, and depression are complex and multilayered, there appears to be a solid foundation for further inquiry. It would be the hope of this researcher that even this modest initial study could help to build on the work and contributions of previous researchers and further the understanding of these complex personal and social dynamics.
References


