Prevention in Counseling Psychology: Theory, Research, Practice and Training is a publication of the Prevention Section of the Society for Counseling Psychology. The publication is dedicated to the dissemination of information on prevention theory, research, practice and training in counseling psychology, stimulating prevention scholarship, promoting collaboration between counseling psychologists engaged in prevention, and encourages student scholars. The publication focuses on prevention in specific domains (e.g., college campuses) employing specific modalities (e.g., group work), and reports summaries of epidemiological and preventive intervention research. All submissions to the publication undergo blind review by an editorial board jury, and those selected for publication are distributed nationally through electronic and hard copies.

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Submission Guidelines

The Prevention Section of the Society of Counseling Psychology publishes Prevention in Counseling Psychology: Theory, Research, Practice and Training. This is a blind peer-reviewed publication presenting scholarly work in the field of prevention that is distributed nationally. Contributions can focus on prevention theory, research, practice or training, or a combination of these topics. We welcome student submissions. As a publication of the Prevention Section of Division 17, presentations and awards sponsored by the section will be highlighted in these issues. We will also publish condensed reviews of research or theoretical work pertaining to the field of prevention. All submissions need to clearly articulate the prevention nature of the work. Submissions to this publication need to conform to APA style. All submissions must be electronically submitted. Please send your documents prepared for blind review with a cover letter including all identifying information for our records. Submissions should be emailed to Julie Koch, Managing Editor, at julie.koch@okstate.edu.
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Le’Roy Reese
Morehouse School of Medicine

Prevention Section Update and Welcome
Recently I became Chair of the Prevention Section and in that role I have both the opportunity and responsibility of building upon the exemplary leadership of previous Chairs as we continue to define and refine the scope and role of prevention within the Society of Counseling Psychology and how we contribute to efforts to improve the health of the nation’s citizenry. I want to thank previous Chairs Sally Hage and Jonathan Schwartz for their support and assistance helping me transition to the role of Chair.

The Prevention Section is at an important cross roads, as this year represents an unique opportunity for the Section. Current Society President Andy Horne has made prevention the theme of his presidency and in that role he will be able to infuse prevention initiatives throughout the important work of the various Sections of the Society. With prevention as the theme of his Presidency, there will be multiple opportunities for leadership and making contributions by members of the Prevention Section and I want encourage active participation by our members. Andy’s leadership also represents an opportunity to grow the membership of the Section.

Another important way to support the work of the Section is by contributing to our publication, Prevention in Counseling Psychology: Theory, Research, Practice and Training published twice a year in February and July. As my predecessors have done, I invite you to contribute your brief research reports, theory based literature reviews as well as novel and innovative ideas that may advance the work of prevention practitioners and researchers.

I am pleased to share that the Prevention Guidelines for Psychologists have undergone final revisions and will soon be published and may be available by the time the next issue is published. I want to thank our colleagues for their committed stewardship in seeing the production of this document through a long and arduous process.

Finally, I want to encourage each of you as colleagues and citizens committed to the advancement of prevention to the well-being and health of our communities to review the proposed budget for fiscal year 2013 http://www.hhs.gov/budget/hhs-general-budget-justification-fy2013.pdf. While this is not light reading, it speaks directly to the important role of prevention advocates within the Society, the APA and though APA’s Office of Government Relations to inform the Congress and others about the obstinate health problems facing our citizens and the need for prevention resources to attend to these problems and meet the Healthy People 2020 goals which lays out the nations public health goals.

Thanks to all of you including my colleagues putting this publication together who continue to make pursuit of healthy people and healthy communities a priority. Continued peace!
Greetings from the Editorial Board

Welcome to the Fall 2012 issue of Prevention in Counseling Psychology: Theory, Research, Practice and Training, the publication of the Prevention Section of the Society of Counseling Psychology. The goal of this publication is to promote prevention theory and research. Within these pages, you will find new contributions that highlight recent efforts in prevention.

First, we offer a brief piece by doctoral student Jonathan Kodet, who shared his ideas with us at the student poster session at APA in August. He expanded this work into a conceptual piece that reminds us of our social responsibility as counseling psychologists. We encourage members of the Prevention Section to respond with brief opinion pieces in our next issue.

We are pleased to showcase the work of Clark, Aleksandrova-Howell, Coser, Schultz, and Roberts who describe their substance abuse prevention via group telehealth to Native American adolescents. In this example of prevention in action, the authors provide a narrative about the methods they used to begin and maintain this group, the curriculum they used, and the limitations they encountered in providing telehealth services to Native teens scattered throughout rural areas. This work partners cutting-edge technology with traditional Native beliefs and healing practices.

We also present a literature review by Swagerty and Koch that introduces the importance of self-compassion as a construct related to women’s physical and mental health and well-being. Implications for counseling psychologists are discussed.

Next issue, we would like to publish a description of your prevention work. We accept manuscripts addressing prevention theory, research, practice and training. We believe this is an excellent forum for sharing your work with prevention oriented colleagues. We especially would like to see more submissions that are the product of student-faculty collaboration. We encourage you to submit your own work for our next issue to Julie Koch, Managing Editor, at Julie.koch@okstate.edu. The deadline for our Winter 2012 issue is December 15th, 2012.
Message from Your Graduate Student Representative

Erin Ring  
*University at Albany*

Welcome to another semester! I am the graduate student representative of Division 17’s Prevention Section, and am writing to let you know a bit about our section and tell you about some of the student opportunities we have to become involved.

When telling others about my involvement in the Prevention Section, people often pause and respond, “Prevention of what?” The section is great in that our members have very diverse interests, yet share the common goals of ending problem behaviors, delaying their onset, and reducing their negative impacts. We foster the psychological well-being of others and simultaneously work to prevent negative consequences on a personal, organizational, and community-wide level. Hence, areas of interest often include the prevention of risk-taking behaviors, violence and bullying, and the development of mental disorders, among others.

To students who are interested in prevention, we strongly encourage you to join our section (it’s free!). There are several ways to become involved, including opportunities to present and publish research, join listserv discussions, meet with other professionals in the field, and serve on the Editorial Board of this peer-reviewed publication. We also have potential leadership opportunities for those interested in serving as an officer of the section.

To those who continue as members: Thank you! This year’s APA Convention went extremely well, and we’d like to thank all of the students who helped make it happen. Several students presented their work at the Division 17 Social Hour, which was well attended. We also had a student poster session at our annual awards ceremony with some great research and theoretical pieces relevant to Prevention. Students traveled from several different states and programs to present their work, and the contributions were very well received by students and professionals alike. Finally, we’d like to congratulate those who received our section’s annual research and achievement awards. Their work is invaluable to our field and we look forward to seeing future accomplishments by our students, ECPs, and experienced professionals.

As we proceed through another academic year, there are several reasons to become excited. We are thrilled to have Dr. Andy Horne as SCP president this year, particularly due to his presidential initiatives in obesity and violence prevention. He has been an invaluable member of the Section for quite some time, and we look forward to collaborating with him throughout the next year to continue to address the importance of prevention in our field. Please keep an eye out for APA 2013 Convention updates—we hope to combine our own interests in prevention with Dr. Horne’s initiatives to create some exciting programs. Stay tuned for updates over the next several months, as I’m sure there will be ways to become involved!

Lastly, if you would like to join the section, hold an interest in any of the above opportunities, or have additional ideas for your involvement, please don’t hesitate to contact me at ering@albany.edu. I can provide you with some more information at that time. Best of luck with the rest of the academic year, and I look forward to hearing from you!
The ethics of social responsibility, prevention, and social justice within the field of psychology are being given greater attention as more researchers, academics, and clinicians examine the influence of sociocultural contexts on individual well-being and human development (Bronfenbrenner, 2005; Evans, 2004; Greenleaf & Williams, 2009; Goodman et al., 2004; Hage & Kenny, 2009; Kitchener & Anderson, 2011; Prilleltensky, 2008; Romano & Hage, 2000; Sue & Sue, 2013; Vera & Speight, 2003). A myriad of voices are actively critiquing the status quo of psychology’s individualistic and intrapsychic framework of intervention and formulating ways to meet the challenges of systemic and environmental barriers to mental health and wellbeing (Albee, 2000; Aldarondo, 2007; Chung & Bemak, 2012; Conyne & Cook, 2004; Ellis & Carlson, 2009; Fox, Prilleltensky, & Austin, 2009; Hage et al., 2007; Montero & Sonn, 2009; Prilleltensky & Nelson, 2002; Ratts, 2009; Toporek, 2006; Worell & Remer, 2003). One shared goal in this movement, to use an ecological metaphor, is to stop what or who is poisoning the river at its headwaters, instead of only helping people access and cope with drinking from it further downstream. With this image in mind, prevention work can be recognized as one of the most integral ways for psychologists to demonstrate social responsibility and work to bring about social justice (Romano & Hage, 2000).

In 2002, a contrasting development occurred within the American Psychological Association’s (APA) “Ethical Principles of Psychologists and Code of Conduct,” hereafter referred to as the APA Ethics Code. The previous General Principles (competence, integrity, professional and scientific responsibility, respect for people’s rights and dignity, concern for other’s welfare, and social responsibility) (APA, 1992) were replaced with the current framework of five principles: beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people’s rights and dignity (APA, 2002). Through this revision, one rarely discussed or recognized casualty was the concept of social responsibility (Knapp & VandeCreek, 2003; Wise, 2005) and specific language supporting prevention.

What is social responsibility? While psychologists have been writing about social responsibility for decades, it is rarely defined explicitly. Based on Charles R. Clark’s discussion of social responsibility ethics (1993), social responsibility is defined here as the duty to reduce human suffering and further human rights by improving society at large, extending beyond ethical obligations owed to individuals who are participants in professional relationships. With this definitional model of social responsibility in mind, Clark (1993) asserts that “[A]ll other ethical obligations are subordinate to it. As used here, social responsibility ethics is the delineation of psychology’s broadest overarching ethical imperative, and it involves the subordination of private and personal goals to the greater consideration of human welfare” (p. 313).

The most significant references of social responsibility excluded from the 2002 revision were (a) “mitigate the causes of human suffering” (APA, 1992, p. 1600) and (b) “encourage the development of law and social policy that serve the interests of their patients and clients and the public” (APA, 1992, p. 1600). In excluding language of mitigating causes, the 2002 revision effectively removed the only proactive reference supporting primary prevention from the General Principles. Likewise, the most explicit message encouraging psychologists to be involved with shaping the social policies is no longer communicated in the current APA Ethics Code.

Three contextual considerations highlight the importance of the above exclusions of social responsibility and prevention from the APA Ethics Code. First, as the authoritative document for psychologists in the United States, the APA Ethics Code remains the single most utilized ethics training document for the next generation of American psychologists and therefore has a normative function in influencing the identity of the profession of psychology. Second, professional codes of ethics are influenced by the cultural values of their creators (De Las Fuentes, Willmuth, & Yarrow, 2005; Kitchener & Anderson, 2011). Finally, the APA General Principles are aspirational in nature and are specifically meant to encourage psychologists toward optimal professional action (Knapp & VandeCreek, 2003). In comparison, within the United States, the National Organization for Human Services and the National Association of Social Workers both present a code...
of ethics document with an undisputedly strong social responsibility ethic. Likewise, both the American Counseling Association’s ethics code and the American Psychiatric Association’s ethics code present political advocacy as part of the professional identity of practitioners. Internationally, the “Code of Ethics for Psychologists Working in Aotearoa/New Zealand” devotes two pages addressing practice implications and extensive commentary about social responsibility. Perhaps most exhaustively, the “Canadian Code of Ethics for Psychologists” dedicates over four pages to the principle of social responsibility.

In conclusion, the current General Principles within the APA’s Ethics Code do not carry the same explicit emphasis on the systemic sphere of influence and use of social epidemiological language as did Principle F: Social Responsibility (APA, 1992). When these exclusions are contrasted with the increasing number of voices from counseling psychology and other specialties calling for psychologists’ involvement in prevention and social justice advocacy, it is imperative that this incongruity be considered in future revisions of the APA Ethics Code. Social responsibility requires attention to prevention strategies and calls for psychologists to be involved in mitigating the causes of human suffering and shaping social policies for the public good. Given the normative role and aspirational nature of the APA General Principles in training future psychologists, these principles would better reflect a prevention approach by reintegrating and expanding upon these concepts lost from the previous Principle F: Social Responsibility.

References


Tools for prevention: Utilizing tele-behavioral health services in a rural Native American community

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This article illustrates the collaborative relationship between a major university and a tribal nation. Polycom capabilities were used to reach a rural Native American (NA) population for the purpose of conducting a tele-behavioral mental health group. The group was designed to provide psycho education on the prevention of substance misuse and suicide. The treatment team included two Native American psychologists, two Native American master’s students and one Russian doctoral student. Based on the team’s personal and professional experiences as Native people and their collective knowledge of the unique socio-cultural history of Native Americans, the team wanted to provide culturally infused and holistic prevention education for Native American adolescents that integrated openness to traditional healing, spirituality, and aspects of cultural connectedness. This article provides an outline, as well as a discussion of the limitations and future direction, of this exploratory project. This information can be used for future collaborations and expansion of such prevention focused programs.

It is well documented that Native Americans (NA) have a higher rate of marijuana, cocaine, and hallucinogen abuse compared to other minority groups (2010 NSDUH: Summary of National Findings, SAMHSA, CBHSQ). Native American adolescents report the highest rates of use compared to any other racial group and inhalant use among NA youth is consistently increasing (Johnston, O’Malley, Bachman, & Schulenberg, 2012). It is also common for Native communities to be located in geographically rural locations. Kast (2001) noted rural communities have advantages as well as disadvantages. A lack of employment opportunities that provide adequate income, as well as health care benefits, may be one disadvantage for those living in rural areas. Advantages may include a stronger sense of a cohesiveness that supports community members and their families. Oftentimes rural, as well as ethnic minority populations will seek help among themselves or the clergy. Many rural communities also have strong foundations built upon self-sufficiency. These values may limit seeking help from outsiders, especially if the type of help sought, such as mental health services, could be stigmatized by others in the community. Lack of privacy and lack of access to resources were also noted as impediments to help seeking among rural, non-reservation Native American adolescents in a southwest state (Gray & Winterowd, 2002).

Research has shown that aside from cultural and ethnic characteristics, adolescents with substance use and misuse issues generally benefit from prevention interventions (Catalano, Hawkins, Berglund, Pollard, & Arthur, 2002). Native American populations may generally be more receptive to holistic culturally grounded prevention measures as opposed to remediation measures based on the medical model (Baldwin, Johnson, & Benally, 2009). Generally speaking, from the Native world viewpoint, wellness means balance and harmony with the environment and in relationships with oneself, other individuals, families, and communities (Wright, Nebelkopf, King, Maas, Patel, & Samuel, 2011). Currently, for many tribes, prevention is part of contemporary tribal wellness programs and may fit well with the holistic paradigms that are interwoven throughout many Native American populations.

In attempts to prevent substance use and misuse in rural Native American communities, an element of creativity may be necessary in order to bridge the gap in services available. Given the geographical challenges faced by rural communities, including access to economic resources and transportation, a relatively new and growing concept to reach rural populations is tele-mental or tele-behavioral health models used to provide mental health services from a distance (Evidence-Based Practice for Telemental Health, 2009). Telemental health services have been used in a variety of ways (Simms, Gibson, & O’Donnell, 2011). Each telemental health experience has helped inform the use of tele-behavioral health as a means of reaching groups who may not otherwise have access to behavioral health services. It has been successfully used in group therapy (Morland, Pierce, & Wong, 2004; Frueh, Monnier, Yim, Grubaugh, Hammer, & Knapp, 2007) and there is some evidence that tele-behavioral health has been effective with Native American youth (Savin, Garry, Zuccaro, & Novins, 2006).

As noted earlier, rural populations often face challenges in
accessing health and education services due to limited personal and community resources which are influenced by geographical location (Gray & Winterowd, 2002; Kast, 2001). Therefore, approaching this project from a collaborative model was key in order to reach this rural population (Thomas, Donovan, Sigo, Austin, & Marlatt, 2009). The endeavor discussed in this article was unique in that it was a collaborative project between a tribe and a major university, utilizing each organization’s telecommunication resources to reach a rural population.

According to the Indian Health Service (IHS) data, (n.d.) methamphetamine use and abuse has continued to increase both on and off reservations to the point of reaching epidemic proportions. This is a major problem that is detrimental to a population already ravaged by the effects of alcohol and other drugs and its related effects on communities, families, and tribal groups creating major socio-economic and health problems. Recently, IHS determined a strong impact could be made on these problems through well planned prevention and education efforts of individual tribes. Initial funds for this effort were authorized by Congress with P.L. 110-161, the Consolidated Appropriations Act of 2008. The enactment of P.L. 111-8, the Omnibus Appropriations Act of 2009, targeted additional funds for Native American communities to further combat issues related to methamphetamine use and suicide (IHS, n.d.).

Collaboratively the authors of this article were able to combine the resources of a small federally recognized tribe and a major university in the mid-central area of the United States to provide tele-behavioral health services to a small group of Native American adolescents living in a rural community. This article outlines the process, challenges and future direction of this collaborative effort at preventing substance misuse and suicide among Native teens.

In 2009, the tribe was informed that they were one of 23 tribes in an area served by IHS to be awarded funding for the development of a three-year Methamphetamine and Suicide Prevention Initiative (MSPI) project. Currently, the number of enrolled members of this tribe is less than 3,600 and according to the U.S. Census (2008) about 2,300 members reside on tribal land. The county in which this tribe is located is reported to have a population of approximately 46,000 with 26% living in a rural setting and 26% living in a rural setting; Native Americans make up 8.3% of that population. Within this county 18.4% of the residents report living at or below the poverty line and, among those 46.3% are reported to be Native American, representing the highest percent of poverty across all ethnic minority groups in that county.

Upon receiving notification of funding, the tribe hired a Psychologist/Behavioral Health Director (PBHD). The first six months of the three-year project were devoted to hiring a coordinator, planning activities, and meeting with other intra-tribal programs and outside agencies to formulate the implementation phase. Honoring specific cultural prevention, intervention or treatment programs that promote the healing of communities, families and victims was a key component of publicizing the educational aspects of the project to the community. In order to plan and strategize the best methodology for implementing a tele-behavioral health system the PBHD met with the tribe’s health center staff. Aside from ensuring the chosen poly-com system would be compatible with the health center’s technological system, it was important that the tribal community was made aware of the plan to implement a tele-behavioral health system. This was accomplished via a newsletter and the tribe’s website.

During this time the PBHD agreed to supervise the clinical work of two master’s level community counseling students and one counseling psychology doctoral student. These students, all enrolled at the same university, were completing the practicum and internship requirements for their degree programs. Placement at the tribal behavioral health unit was an appropriate fit, as it met the supervision and client contact hours required by their academic programs. The PBHD contacted the first author, a faculty member within the students’ academic programs, about collaborating with the tribe’s tele-behavioral health program endeavor utilizing the university’s poly-com system. Use of the university’s polycom system would allow the students and faculty member to provide telemental health services from two different campus locations. In order to address the needs of the community and utilize the MSPI funding, a group focusing on adolescent substance use prevention was formed.

One of the first challenges faced by the therapeutic team was selecting a curriculum that was culturally and developmentally appropriate for teens. The majority of existing culturally focused substance abuse related treatment options for Native American adults and adolescents target those with severe alcohol and drug issues. For Native youth with mild to moderate drug related issues the area of effective prevention models is under-developed (Winters, Dewolfe, & Graham, 2006).

When selecting the curriculum and planning the focus of the tele-behavioral health group the team wanted to encourage prevention through education about the historical, societal and cultural factors that have influenced substance use across both older and contemporary generations. The cultural competence of the therapeutic team, now made up of two Native American psychologists, two Native American master’s students and one Russian doctoral student, is an important factor when doing research and providing health services in Native communities (Baldwin, 1999; Whitbeck, 2011). Whitbeck’s (2011) study showed that Euro-American centered prevention programs often ignore culturally specific protective components valuable to ethnic minority groups thereby losing the opportunity to utilize participants’ cultural strengths, values and ownership of moving towards wellness. The most effective prevention model needs to be tailored to the culture, age and gender of the population at risk (Baldwin et al., 2009) and research affirms that making prevention models culturally sensitive increases their effectiveness (Botvin, Baker, Dusenbury, Tortu, & Botvin, 1990).

Utilizing a group therapy format the team wanted to provide holistic education on preventing substance misuse for Native American adolescents that integrated openness to traditional healing practices, spirituality, along with cultural awareness and connectedness. Some of the goals of the team were to raise group members’ motivation to be substance free, provide education about risks associated with using, and enhance the effectiveness of protective factors that may be available at the individual, family, peer, school, community, and societal levels (Hawkins, Cata-
A holistic focus was desired given some of the historical attempts at assimilation such as education via the Indian boarding school system. Many who attended not only lost their families, culture, language, and spiritual ceremonies, they were not given the essential tools for parenting and healthy relationships. The methods of coping with these losses, and the associated unresolved grief, have typically not been healthy ones as is seen in the high rates of substance use, obesity and domestic violence in many Native communities (Clark & Winterowd, 2012; Omidy & Clark, 2012). In order to raise awareness about these historical influences in conjunction with peer pressure, reasons for use, consequences of use on academic performance and long term goals, the team wanted to utilize a culturally specific curriculum that addressed some of the unique socio-cultural challenges faced by many Native Americans.

In designing their treatment goals, the team wanted group members to holistically examine factors that may influence, or inhibit, substance use. They also wanted to encourage discussions related to group member’s positive sense of self-worth, ability to make good decisions, personal responsibility, and the ability to act independently of others (Beauvais & Trimble, 2003). Identified goals were to initiate conversations and activities related to communication skills, cultural identity, tribal affiliation, openness to diversity, and knowledge of personal cultural heritage. Assessing knowledge about the dangers of substance use, own experiences of substance use, and understanding family history of substance use was important as was identifying family resiliency factors. Individual strengths and personal and career aspirations were deemed important to identify. Finally, the team wanted to take into account any Native American cultural characteristics, expectations, beliefs, or culturally rooted skepticism about westernized interventions.

Curricula

The initial curriculum selected for use with this group was, “Through the Diamond Threshold: Promoting Cultural Competency in Understanding Native American Substance Misuse” (Robbins, Asetoyer, Nelson, Stilen, & Tall Bear, 2011), a curriculum written by Native American health care providers that makes use of stories, music, and experiential exercises that reflect some of the historical and cultural contexts of the Native American community. This curriculum addresses familial use of substances, experiences of discrimination, and shame inducing stereotypes that may perpetuate various forms of oppression. It takes into account a cultural revitalization of the Native American population and its transition to healing, which may help redefine the foundation and nature of alcohol and drug problems. This curriculum addresses broad concepts that are unique to Native Americans specifically, but group facilitators observed the need to narrow these complex ideas to be more developmentally appropriate for teens. Thereby the team agreed to add a second curriculum, “Substance Abuse Prevention Activities: Just for the Health of It,” specifically developed for children and adolescents (Rizzo Toner, 1993). The team agreed that before addressing how the historical influences of assimilation practices may influence substance use among Native Americans, basic education needed to take place about substance use in general. Worksheets were utilized from the second curriculum in order to help illustrate and narrow the broader concepts of the initial curriculum. Worksheets utilized to encourage insight, education and discussion covered general knowledge about substances, factors that influence addiction and abuse, myths about use, and abstaining from use. In order to begin exploring the broader concepts of racism, discrimination and micro aggressions, the group discussed some of the stereotypes about Native Americans.

The Group

Participants were accepted via referrals from their therapist (25%), parents (42%), or were court ordered by the local Municipal Court System Juvenile Division (33%). The group consisted of 10 females and 2 males, ranging in age between 10 and 23 years old. Seven participants were from single parent homes and three participants were from homes with a mother or father who were in a partnered relationship but not married. Participants indicated they held 12 different tribal affiliations. While all participants were affected by alcohol abuse of family members, only six participants were personally involved in substance use and abuse. The 23 year old group member attended two sessions. As part of her therapeutic work with her psychologist she volunteered to serve as a mentor to the younger group members based upon her history of substance misuse. The therapeutic team agreed to allow this young adult to participate in keeping with the cultural norms and values of the community. Culturally speaking, elders typically serve in this type of role; however, this particular community recently experienced the death of a tribal member who was considered to be the last living elder. Elders are considered those who carry the knowledge, wisdom and stories of a tribe. More often than not, with each death, transmission of the culture dies as well. Therefore, it is sometimes prudent to utilize those who are willing to serve in that role even though they may not meet the true historical cultural meaning of the term or role of “elder.”

The group met weekly for 15 weeks at the tribal health clinic and the first author was located at a satellite campus of the university. The typical format was that the first author would introduce the topic to the group and the other four members of the therapeutic team would facilitate the group by handing out and explaining worksheet instructions and terms and sometimes illustrating concepts on the dry erase board. Each member of the therapeutic team would offer reflections, observations and summaries about the content, or behaviors observed, as well as engage the group and other facilitators in process questions.

From their observations, the therapeutic team noticed that during the first few weeks, group members did not seem highly motivated to take an active stance and were often either silent or constrained in their overall emotional and verbal input to the group. However, during the last five sessions of the group, most group members exhibited behaviors indicating more investment in group activities as demonstrated by sharing their experiences and plans for the future more openly.

Pre-and post-surveys

The collaborative effort to provide prevention education utilizing technology to Native American adolescents living in a ru-
nal community may be one of the first of its kind in this area of the United States. Since this was not designed as a formal research project, but rather an exploratory endeavor to assess the needs of the community, only basic demographic information was collected along with pre- and post-assessment on knowledge of the topic, and finally a brief survey with questions assessing the group experience. The pre-and post-group surveys utilized questions from the initial curriculum, “Through the Diamond Threshold: Promoting Cultural Competency in Understanding Native American Substance Misuse” (Robbins et al., 2011). Three participants out of the group of 12 (25%) submitted answers to the pre-test, and eight participants out of this group (67%) responded to the post-test.

Answering the first pre and post-test question, “What names or labels are sometimes given to persons with drug and alcohol problems that are hurtful to their healing?” all participants (100%) demonstrated broad knowledge of such names and labels. Responses to the second question, “What are the four dimensions of life where one strives to feel comfort and a sense of existence?” demonstrated that when the group started there were no participants (0%) who had any knowledge of these four main dimensions of life. However, by the end of the group, five out of eight participants (63%) responded with all four dimensions, one participant (12%) responded with three of the dimensions, and two (25%) responded with two of the four dimensions. Answering the pre-test question, “What are some of the prevailing stereotypes we hear about Native Americans?” only two out of three who responded had good insight to the stereotypes heard about Native Americans. The results of the post-test show that by the end of the group sessions all participants (100%) had good knowledge about stereotypes related to Native Americans. Comparison of the pre and post-test answers to the question, “What are the benefits or problems of respecting, accepting, and honoring diversity?,” demonstrated that at the beginning of the group, only two participants had good insight to the benefits of respecting, accepting, and honoring diversity, but by the end of the sessions four out of eight participants (50%) responded with stated benefits, two (25%) responded with stated problems, and one (12%) participant responded, “I don’t know.” Furthermore, although all participants had personal insight to the question, “Why might Native American people create distance and remain alienated from Euro-American and the dominant culture?” when they entered the group, by the end of the group sessions their answers changed. According to the pre-test, they responded with such answers as “anger,” “fear of being made fun of,” and “cultural differences,” as reasons to avoid the dominant culture. By the end of the therapy sessions, two participants responded with references to racism, and two responded, “just being different.” Others responded, “There may still be anger or bitterness,” referring to “cultural differences,” or, “personal differences,” and explained the distance by such statements as, “Because they make up stereotypes about us,” and “fear of death.” Finally, only one participant answered the pre-test question, “What is it about Native American ceremonies that help someone heal?” This person stated, “They feel the spiritual magic working and they feel better.” By the end of the fifteen sessions, answering the same question, four participants (50%) responded that “the spiritual aspects and prayers help us to heal.” Among other single responses there were such statements as “not sure” (12%), “they don’t help” (12%), and “makes them happy” (12%).

**Evaluation Surveys**

The last group session was used to discuss group members’ experiences and to administer post group evaluation surveys. Eight participants out of 12 (67%) submitted their responses to the evaluation survey. In response to the statement, “I learned a lot in group,” six participants (75%) said “yes,” and two participants (25%) said “no.” Seven participants (88%) enjoyed the topics discussed in the group, and one participant (12%) reported not enjoying the topics discussed. Seven participants (88%) reported that talking about reasons for using substances was helpful, while one participant (12%) denied its usefulness. Moreover, although goal setting procedures were helpful for six participants (75%), two participants (25%) reported that goal setting procedures were not helpful.

When responding to the statement, “I would like to have talked more about” three participants (38%) would like to have talked more about “drugs” or “substance abuse,” two participants (25%) would like to have talked more about “Native American culture,” two participants (25%) responded, “I don’t know,” and one participant (12%) responded, “problems in life other than drugs or alcohol.”

Responses to the statement, “The thing I liked most about the group” varied as each participant came up with a different response (12%). Participants reported that they liked “talking about stereotypes,” “communicating,” “how people were comfortable around each other,” “worksheets,” “everyone was friendly,” “it was easy to express myself,” and “I like to come here because when I think about doing drugs then I come here and the thought goes away.”

Responses to the statement, “The thing I liked least about the group” included such responses as “I don’t dislike anything” (three participants, 38%), “participating,” and “attending” (two participants, 25%). There were also such single responses as “I don’t know,” “It starts at 3:30 PM,” and “storytelling” (one participant, 12% per each of these responses).

**Limitations**

Over the course of the 15 weeks, the team discovered some challenges and limitations to providing tele-behavioral health services to Native teens with varying backgrounds of use and reasons for attending the group. One of the main intentions of the group was prevention of adolescent substance misuse. In order to garner community participation the student group facilitators advertised counseling services to the community through health fairs, pow-wows, and tribal youth programs. While some members of the community may have initially expressed interest during recruitment, the resulting group was made up of adolescents that were court-ordered or referred by their parent or therapist. Consequently, group members’ commitment and motivation to participate at the outset of the group may have been lacking. Motivation, as defined by Battjes, Gordon, O’Grady, Kinlock, and Carswell (2003), is a construct that contributes to participants’ engagement in the group activities and towards the overall group.
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therapy outcome. The team’s observations of the group demonstrated that although participants’ motivation to participate in group activities fluctuated from session to session, it appeared to be much higher by the end of the 15 weeks. Once the group members began to actively engage in discussion with fellow group members and facilitators, commitment and motivation to participate appeared to increase.

Another challenge was the use of a curriculum that, while culturally appropriate, was designed more for adults. While key cultural aspects of the curriculum were related to loss of cultural practices and knowledge, and effects of intergenerational trauma, it was discovered that these concepts needed to be restructured for use with adolescents. Although group members enjoyed talking about some of the topics stimulated by the initial curriculum, such as stereotypes of Native Americans, many of the terms and concepts had to be explained in a more developmentally appropriate manner. During post-group discussions, the therapeutic team realized that “Through the Diamond Threshold” presents broad concepts that may require more in-depth understanding and knowledge of the historical events and traumas experienced by Native American tribes and how these events affected tribal groups across generations. The second curriculum seemed to narrow these broader concepts into smaller more understandable and developmentally appropriate concepts. Group members were given more age appropriate activities that allowed them to discuss unhealthy substance related behaviors, the consequences of such behaviors and explore healthy alternatives to such behaviors. The material presented in the second curriculum seemed to be easier for group members to comprehend and follow. Almost all group members later commented that they enjoyed games, worksheets, and skits from the second curriculum. By utilizing the worksheets, group facilitators were able to infuse the broader culturally specific elements introduced by the first curriculum as well as incorporate personal and professional knowledge and experiences.

Differences in group members’ ages and relationship to one another, either familial or outside of the group, also affected group dynamics, cohesion, rapport, and level of participation. Facilitators observed what appeared to be hesitation or resistance towards authentic sharing given the familial, social or community nature of some group members. Another limitation seemed to be whether or not the group member was attending due to another’s substance misuse or personal misuse. Those who had misused shared different experiences than those whose family members were users. Time constraints on the group were imposed due to the acquired group meeting space being within the tribal health clinic once a week after school. Halfway through the fifteen weeks an agreement was reached with the clinic director to hold the group after clinic hours. As a result, the group was able to meet longer which enhanced development of group cohesion and rapport.

Additionally, a majority of parents were uncooperative in terms of intake procedures and screening. Even though parents had been contacted by phone and home visits from the youth program director, intake and screening forms were returned unanswered or with questions on intake forms and screeners left unanswered. Many parents were unresponsive when contacted for further information. According to Walls, Johnson, Whitbeck, & Hoyt (2006), parents and caretakers of Native American adolescents may prefer to see their children receiving informal and traditional help. It is possible that if parents knew that the curriculum was designed for Native Americans by Native Americans and that group facilitators were either Native American themselves or were highly sensitive to cultural expectations and needs of Native American adolescents, they would be more cooperative and might welcome the possibility for their children to get professional help. The court-ordered group members seemed to be absent more often or arrived late to group even though they may have been also been suspended from school at the time.

Future directions

Currently the team is working on modifying or creating a curriculum that is more developmentally appropriate in vocabulary and concepts for Native American teens. Some of the key components of a culturally appropriate curriculum are to address concerns of both users and non-users as well as the socio-cultural and historical factors that may influence family members’ use across multiple generations. The authors believe that by providing a historical context to Native American adolescents growing up in communities or situations where substance misuse has affected them and/or their family functioning, a level of understanding and awareness will be created that may prevent the misuse of substances and thereby the resultant negative outcomes for future generations.

References

Self-compassion, health and wellness in women

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Self-compassion, or maintaining an attitude of self-kindness and self-care in spite of failures, inadequacies, and painful experiences in life, may be linked with positive health choices and healthy living. Rather than setting and pursuing health goals to meet external standards or to fit an ideal, women who are self-compassionate may be more likely to make positive lifestyle choices out of a sense of caring for oneself. A self-compassionate woman may also be more resilient when facing barriers to wellness, such as setbacks, challenges or failures. Since self-compassion seems to improve with practice, self-compassion may be an effective intervention to consider in addressing both physical and psychological difficulties in women. This review provides an overview of the established correlates with self-compassion and the literature relevant to this exciting prospective tool in health promotion and disease prevention for women.

Introduction

Despite advances in the research illuminating the enormous impact of diet and exercise among other health behaviors on wellness, it seems that Americans are becoming increasingly less healthy and many people’s unhealthy choices contribute to their own morbidity and premature death. In 1995, no state had an obesity rate of over 20%; by 2010 every state had an obesity rate of at least 20%, with a national average of 33.8% (Centers for Disease Control and Prevention, 2011b). Statistics show about 20 million American women are currently obese or overweight (Setse et al., 2008). Additionally, research demonstrates a strong link between obesity and depression, especially among women (Ma & Xiao, 2010; Simon et al., 2008; Simon et al., 2006). Not only have health status and physical activity levels been shown to vary based on gender, with women shown to be less active than men (Center for Disease Control, 2007a), but also to vary among women, based on factors such as socioeconomic status and race (UCLA Center for Health Policy Research, 2008), health behavior, psychosocial stress (Dishman, Sallis, & Orenstein, 1985; Eyler, Brownson, King, Brown, & Donatelle, 1997; United States Department of Health and Human Services, 1996); acculturation, and perceived health status (Pender, Murdaugh, & Parsons, 2002). Overall, populations with lower income, lower education, or of a minority status show consistently lower engagement in healthy behaviors and increased engagement in risky behaviors (American Cancer Society, 2008; Crespo, Smit, Andersen, Carter -Pokras, & Ainsworth, 2000; U.S. Department of Health and Human Services, 1996, 2001). Socioeconomic variables can often impact women’s access to important health-related resources such as fitness facilities, childcare, and fresh produce. Women from lower SES backgrounds often cite cost as a major perceived barrier to healthy eating (Buchholz, Huffman, & McKenna, 2012). These findings reflect an overall negative trend in healthy lifestyle behaviors and associated wellness issues, demonstrating the relevance of such health issues for women and the importance of cultural variables in women’s health.

When considering women’s health and lifestyles, especially issues related to fitness and weight, women seem to bear a “double burden” as the female body tends to be the object of much greater scrutiny, with femininity characterized by bodily appearance, mainly, thinness (Lupton, 1996; Malson, 1998; Markula, Burns, & Riley, 2008; Orbach, 2006). Today’s women are inundated with pressures to attain this ideal of female thinness (Stice, Maxfield, & Wells, 2003). Such cultural messages about beauty and fitness uphold an unrealistic standard of thinness and lifestyle behaviors that starkly contrast with the realities of average everyday living in the US. In fact, when women do engage in healthy lifestyle behaviors such as exercise, many attribute their motivation to a desire to be thin (Markland & Hardy, 1993; McDonald & Thompson, 1992). To further illustrate important gender differences related to lifestyle, wellness, and societal pressure, women are often viewed as responsible not only for their own health, but also for the health of their children and spouses (Tischner & Malson, 2011). Finally, women have been shown to identify self-esteem as significantly more important than men as a major barrier in implementing healthy lifestyle changes (Mosca, McGillen, & Rubenfire, 1998). Pressures to meet societal standards for women often impact a woman’s view of herself and contribute to the many obstacles she may face in making healthy choices that promote well-being. The prevalence of critical health issues that impact women today, such as obesity and depression, and the impact of a woman’s view of her self on her health behaviors and well-being, reveal a need to further consider the relationship among these factors.

Self-Compassion

An alternative self-construct. In exploring women’s view of self, the construct of self-compassion currently offers an alter-
native way to conceptualize a healthy way of relating to one’s self. This newer construct emerging out of the recent focus on mindfulness has already been applied to health and wellness on a theoretical level (Terry & Leary, 2011). Self-compassion is the opposite of self-criticism; rather, it is characterized by self-acceptance. Self-criticism, on the other hand, breeds negative feelings that may prevent a positive or adaptive view of self (Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982). Self-compassion, as described by Neff (2003a), involves “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 experience is part of the common human experience” (p. 224). Neff identifies three interrelated facets of self-compassion that are expressed in moments of perceived disappointment or pain. Each facet consists of a component and its counterpart: self-kindness, or a stance of understanding toward oneself as opposed to self-criticism; common humanity, viewing one’s imperfect and at times, painful, existence as related to the human experience in general versus as in isolation; and mindfulness, or maintaining a balanced awareness of thoughts and feelings rather than getting carried away with one’s emotions or evaluations.

Framework for conceptualizing the self: Self-compassion versus self-esteem. An adaptive attitude towards oneself proves potentially relevant in examining contributing factors toward participation in healthy lifestyle behaviors. While self-esteem has already been identified as significant in engagement in healthy behaviors (Mosca, McGillen, & Rubenfire, 1998), self-compassion has also been positively linked to engagement in healthy behaviors, such as exercise (Magnus, Kowalski, McHugh 2010). Various reasons explain why self-compassion might be advantageous over self-esteem as a construct capturing one’s view of self. High self-esteem has been linked to negative outcomes such as narcissism and self-centeredness (Baumeister, Bushman, & Campbell, 2000; Neff 2003a; Neff 2003b). Self-compassion, on the other hand, appears to relate to many of the same psychological benefits of self-esteem, but proves a bit harder as a construct. Self-compassion does not hinge on performance evaluations or social comparisons and so does not relate to the need to maintain an unrealistically positive view of self. Theoretically, self-compassion should be easier to improve than self-esteem because it does not involve the need to maintain an unrealistic view of self (Neff, 2003a). The very appeal of self-esteem lies in its capacity to motivate actions aimed to reduce dissonance among a person’s ideal and actual self (Rosenberg, 1979) and the fact that it is “not unconditional” (Kaplan, 1995). Yet, self-compassion essentially defies this need to hold oneself in a high regard based on merit, success, or even mastery; it prescribes self-acceptance based on an inherent sense of one’s worth as a living being. The idea is that when one can promote a stance of self-kindness and self-acceptance, one becomes free to strive less to meet arbitrary standards, imposed by self, others, or society. Therefore, it may be high self-compassion that can more fully and securely allow the gap to decrease between the ideal and the actual self.

The distinctions Neff has drawn in differentiating the construct of self-compassion from self-esteem can be seen as sifting out many of the aspects of self-esteem that can be negative or maladaptive: self-comparison, self-evaluation, and a need to exceed or measure up to standards imposed by self, others, or societal values. Self-compassion, alternatively, reflects an acceptance of flaws and an attitude of kindness toward self while connecting with the common experiences of humankind. In exploring the relationship among women’s view of self and healthy lifestyle behaviors, it makes intuitive sense to utilize a self-related construct that captures a sense of acceptance in spite of inadequacies and failures versus a positive evaluation of self that may be more contingent on social comparison and situational factors.

Correlates and outcomes related to self-compassion. Though in its early stages as an operationalized construct in the social sciences, the area of self-compassion has already generated numerous studies since the Self-Compassion Scale was developed (Neff, 2003a). In a recently published overview of studies related to self-compassion, Barnard and Curry (2011) identified correlates to self-compassion in the following domains: affect, cognitive patterns, and social factors. For example, in the affect domain, self-compassion has been shown to be related to well-being (Neely, Schallert, Mohammed, Roberts, & Chen, 2009), being positively associated with psychological traits such as optimism and happiness (Neff, Rude, & Kirkpatrick, 2007), and negatively associated with depression and anxiety (Mills, Gilbert, Bellew, McEwan, & Gale, 2007; Neff, 2003a; Ying, 2009), and negative affect (Neff et al., 2007). Related to emotional regulation, self-compassion has been linked to emotional intelligence (Neff 2003a), approach coping strategies (Neff, Hsieh, & Dejitterat, 2005), and decreased reactivity to imagined distress and negative feedback (Leary, Tate, Adams, Allen, & Hancock, 2007). Self-compassion has been found to negatively correlate with rumination, thought suppression, and avoidance; and positively to mindfulness (Neff et al., 2005; Neff, Rude, & Kirkpatrick, 2007; Neff & Vonk, 2009; Raes, 2010; Thompson & Waltz, 2008). Additionally, self-compassion has been shown to relate to self-acceptance (Neff, 2003b), self-perceived competence (Leary et al., 2007; Neff et al., 2005), and social connectedness (Neff, 2003a; Neff et al., 2007).

As more studies demonstrate the significance of self-compassion in relation to many relevant domains of functioning, the question of whether self-compassion can be raised among individuals in a measurable and practical way has naturally emerged as a next step. Research on self-compassion has already extended to the intervention and experimental stage. Indeed, it has been shown that self-compassion can be increased with practice through implementation of self-compassion training programs (Gilbert & Proctor, 2003; Shapiro, Brown, & Biegel, 2007) and researchers are showing interest in exploring self-compassion from an experimental perspective (e.g., Leary, Tate, Adams, Allen, & Hancock, 2007). Other more established therapeutic interventions such as Dialectical Behavioral Therapy (Linehan, 1993), Acceptance Commitment Therapy (Hayes, Strosahl, & Wilson, 2003), and more recently, Mindfulness-Based Stress Reduction (Kabat-Zinn, 2003), share the common emphasis on components related to self-compassion.
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Self-Compassion and Health

While few studies related to self-compassion and health have been published to date, researchers have recently identified a theoretical rationale for exploring a link between self-compassion and health behaviors. Ironically, initial reactions to the construct of self-compassion include a concern that too much self-compassion might lead to over-indulgence, apathy, or laziness (Neff, 2003b). Yet, researchers in the area of self-compassion suggest just the opposite: Self-compassion involves the pursuit of one’s own health and well-being and is associated with higher levels of motivation to make needed changes in one’s life (Neff, Rude, & Kirkpatrick, 2007). Self-compassion may engender healthier choices and lifestyles by helping people to observe and track their health goals with greater focus and less defensiveness, remain balanced when facing setbacks, pursue goals that are in their best interests, seek medical attention when needed, adhere to prescribed treatments, and regulate negative affect (Terry & Leary, 2011).

Self-compassion may have a key role in enabling women to manage the intense pressures to be thin and meet societal standards of ideal beauty and fitness, while still promoting healthy choices (Neff, 2009). Magnus, McHugh, and Kowalski (2010) emphasize the promotion of healthy perspectives of the self as essential in improving women’s exercise experience and psychological well-being. Self-compassion fits well as a construct to utilize in this process of investigating women’s attitudes toward self in relation to their health behaviors. Overall health and well-being is most fully pursued and achieved by individuals who engage in healthy behaviors out of a sense of kindness and compassion toward self that has to do simply with being human, not out of a desire to obtain a particular state of fitness or an externally-reinforced outcome (Neff, 2004). Magnus et al. (2003) put it this way: “... self-compassion [gives] rise to proactive behaviors aimed at promoting or enhancing well-being” (p. 366). Chang (2010) reinforces this intuitive connection between healthful lifestyle behaviors and self-compassion: “Adopting health-promoting behaviours as a lifestyle component is an expression of the human tendency to actualize and is directed at elevating individual well-being, self-actualisation and personal fulfillment” (p. 191). In looking at what may impact women’s lifestyle behaviors and the benefits of healthy behaviors, the attribute of self-compassion provides an appropriate and useful lens to examine women’s view of self.

Though much of the work to date representing the intersection of self-compassion and health is largely theoretical, two studies have been published related to self-compassion and women’s health. Both studies look at specific health behaviors, exercise and eating, among women. The first study investigated whether inducing a self-compassionate state would reduce the likelihood of college women engaging in overeating after eating unhealthy food (Adams & Leary, 2007). The induction of self-compassion did moderate effects of food consumption levels after the initial serving of unhealthy food and reduced negative affect. These findings highlight the role of self-compassion in contributing to more healthful behaviors among young women and have direct implications for women who are restrictive eaters. The self-criticism and negative affect associated both with being a highly restrictive eater and with eating as a means to cope with and regulate emotions can be targeted and decreased by fostering self-compassion. Authors of the study suggest that helping people make dietary choices in a less rigid way and react in more adaptive ways to diet failure may promote healthier eating behaviors. These findings also support the idea that self-compassion may enable people to think and react more clearly after a disappointment or mistake.

Magnus, McHugh, and Kowalski (2010) provide further support for uncovering the relationship between women’s view of self and health behaviors, specifically exercise. Neff (2009) addresses this very topic in a straightforward manner: “Because people with self-compassion care about themselves, they want to engage in healthy behavior. They do not need to motivate themselves by fear of self-punishment or the judgments of others; their motivation stems from the intrinsic desire for well-being” (p. 564). Magnus et al. hypothesized that self-compassion would be positively related to more autonomous motivation for exercise and mastery-oriented goal styles and that self-compassion would predict autonomous motivation to exercise and lower social physique anxiety over and above self-esteem. Findings supported this hypothesis: In many areas, self-compassion explained a significant amount of variance over and above self-esteem (goal orientation, self-determination, and social physique anxiety). Researchers concluded that self-compassion appears to be strongly linked to well-being for women exercisers. Findings confirmed previous research linking self-compassion to more adaptive self-regulation and goal orientations.

Framework for Conceptualizing Health: Positive versus Medical Model

The emergence of self-compassion as an alternative to self-esteem in considering women’s health was discussed earlier. In further exploring theory related to women’s health, it becomes important to explore the positive health model as a workable framework. Health behavior has been defined as “an action taken by a person to maintain, attain, or regain good health and to prevent illness” (Anderson, Keith, & Novak, 2002, p. 784). In Pender’s Health Promotion Model (1987), Pender defines health-promoting behavior as “an expression of the human actualizing tendency” and “directed toward sustaining or increasing the individual’s level of well-being, self-actualization, and personal fulfillment” (Walker, Sechrist, & Pender, p. 76). She distinguishes this from health-protecting behavior, which reflects the human tendency to preserve homeostasis and decrease one’s risk of illness. This distinction reflects the paradigm shift from the medical model, where health is viewed as absence of disease, to a more expansive one of positive health, where health is viewed as an optimal state (Gill et al., 2010). The definition of health by the World Health Organization reaffirms this positive and integrated conceptualization of health: “Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity” (1946, p. 1). In Pender’s revised version of the Health Promotion Model (2002), she emphasizes the trend away from a curative and biomedical model to a multidimensional phenomenon with biopsychosocial, spiritual, environmental, and cultural dimensions, and stresses that health promotion should “focus on available resources, potentials, and capabilities as well as dysfunction and potential risks” (p. 29).
Advantages to a positive health framework over a medical model in exploring women’s health are many. The focus on disease and pathology fosters a narrow and impersonal quality of health care. A positive health perspective entails a more integrative and holistic approach in all aspects of health ranging from prevention and promotion to treatment. In taking a negativistic approach to health more representative of the medical model, health-related prevention efforts are prohibitive in nature and consist of identifying poor health behaviors that should be avoided. Alternatively, a positive health orientation involves the promotion of behaviors and lifestyles that enhance wellness. A positive health framework is empowering, collaborative, holistic, and strength-based.

Pender’s Health Promotion Model (Pender et al., 2006) makes apparent the connection between a woman’s self-compassion, or attitude of self-kindness and non-judgment in light of her inadequacies and failures, and her engagement in healthy lifestyle behaviors. Self-compassion could provide one the ability to experience failure or setbacks related to health goals with resilience; to remain content even in the face of challenges or difficulties related to health behaviors; and to place increased value on health behaviors based on the pursuit of enhancing one’s wellness rather than avoiding illness. Self-compassion could lessen and negate the pressures from external sources, such as messages from the media about what it means to be beautiful or feminine, or criticism from partners, physicians, and friends. Overall, the consideration of the relationship between women’s view of self and engagement in healthy lifestyle behaviors, the framework of positive health, and the construct of self-compassion enables a focus on enhancement rather than reduction; mind and body versus disease; and pursuit of health for health’s sake rather than prescriptions or prohibitions.

Healthy Lifestyle Behaviors

Another area where further exploration is warranted is the intersection of self-compassion and wellness. Understanding why or how a woman is able to engage in healthy lifestyle behaviors is of paramount importance in a society where women often encounter pressures to stay thin and to balance career, family, and home, while national and global statistics reflect that overall health appears to be worsening and health disparities increasing. As mentioned earlier, the importance of lifestyle behaviors in promoting overall health has been well established. Across a variety of health and psychological problems, lifestyle interventions appear to be at least as effective as drug treatment (Blumenthal et al., 2007; Dunn, Trivedi, Kampert, Clark, & Chambliss, 2005; Gillies et al., 2008; Mather et al., 2002; Walsh, 2011). Exercise, diet, social support, recreation, stress management, and religious/spiritual involvement exemplify some of the domains that have been shown to contribute to one’s physical and psychological health (Walsh, 2011). Especially pertinent for women, physical exercise has been shown to significantly improve health problems and physical transitions related to hormonal changes, including perceived ratings of pain and quality of life (Moriyama et al., 2008). Across cultures, research has demonstrated that healthy lifestyles earlier in life can prevent and/or delay many chronic health conditions in later life (Cicconetti et al., 2002). Physical activity by itself has demonstrated positive benefits across many facets of wellness including physical health, disease risk reduction, life satisfaction, cognitive functioning, and psychological well-being (Carek, Laibstein, & Carek, 2011). By exploring the connection among women’s view of self and participation in healthy behaviors, mechanisms factoring into maintaining healthy lifestyles among women may be more closely considered and understood.

Gaps in the Literature

While many researchers have identified the potential value of the construct of self-compassion in relation to health, only two empirical studies have been published to date directly exploring the relationship between self-compassion and health behavior. While Magnus et al. (2010) examined the relationship between self-compassion, exercise, and self-determined motivation among women, there is a need to further consider the relationship between self-compassion and broader constructs related to health such as lifestyle behaviors across other domains as well as physical activity. Terry and Leary (2011) suggest a need to consider self-compassion in relation to self-regulation and health as a broader construct, but at this time, no studies have been published incorporating such variables. When current health disparities and unequal societal pressures related to women’s health are taken into account, the need to consider demographic and cultural variables among women and the potential impact on their health behaviors is further highlighted. Women have been identified as less active than men, with minority women designated to be the least active population (Center for Disease Control, 2007). These discrepancies cannot be ignored. With such a host of barriers that women, and especially minority women and women of lower socioeconomic backgrounds may face, it is important to seize the opportunity to discover a potential source of resilience and hope that the construct of self-compassion offers in women’s capacity to overcome obstacles to wellness.

Implications

Self-compassion, a new and exciting construct in the social sciences correlated with increased optimal functioning and wellness, proves a promising area for future research and practice in the field of promotion and prevention in women’s health. In a time when health care costs are skyrocketing, preventable health problems such as obesity and diabetes are also on the rise, especially among women. Empirical research and theoretical literature support the notion that self-compassion may lead to positive health practices and increased wellness. More self-compassionate women are expected to be more motivated to engage in practices that promote their own wellness, to bounce back more easily from setbacks, to more effectively monitor and regulate their own health choices, to seek treatment and support when needed, and to sustain a more accepting and appreciative attitude towards their own bodies.

Preliminary experimental findings, as mentioned earlier, show that self-compassion can be improved. Such results warrant further research to investigate the intersection of self-compassion and health in women, uncover the mechanisms of raising self-
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compassion, and develop programs to support the utilization of such training in health promotion and prevention for women. Empirical studies may continue to illuminate strong relationships between self-compassion and positive health practices, beliefs, and attitudes. Further research is needed to demonstrate whether this relationship might be causal, or whether raising self-compassion will improve a woman’s ability to make better health choices that will lead to increased wellness. As such experimental studies continue to shed light on these and other effects of self-compassion, self-compassion training may be incorporated into counseling and health interventions for women.

Research also is needed to highlight specifics about how self-compassion may be effectively improved in women long-term. For example, how many training sessions of what length may result in long-lasting improved levels of self-compassion? Would self-compassion training be more effective delivered in groups or individually? What kind of training should be required for facilitators? These and many other questions need to be answered before self-compassion can be fully utilized as an effective and trusted means to promote health and prevent disease among women.

The existing research does suggest that self-compassion training could be a cost-effective and brief intervention with little to no risk for the women participating. An attractive characteristic of self-compassion training would be the ease of delivery to underserved and often overlooked populations in the community. Self-compassion training could be easily provided to populations of women who are at-risk or in greater need such as incarcerated, impoverished, and homeless women, through services offered in prisons or through community agencies such as the YWCA, children’s and family services, or domestic violence agencies.

If self-compassion proves instrumental in choosing healthy lifestyle behaviors, self-compassion training could potentially be beneficial for any issue impacted by lifestyle. The possibilities then are endless, and self-compassion training could positively impact women experiencing a wide variety of obstacles to wellness, such as anxiety, depression, substance abuse, obesity, cardiac disease, diabetes, parenting issues, gambling, and smoking addiction, among others. Self-compassion could be integrated into programs aimed at broader preventive efforts in women’s health, such as programs designed to improve inter-conception health for women or even more general health initiatives designed to prevent obesity or cardiac disease in women.

Mindfulness techniques and interventions have been empirically supported as effective in the treatment of many mental health issues such as depression and anxiety. It is possible that practicing counseling psychologists could incorporate self-compassion training into their work with clients, similar to how they may currently incorporate relaxation training, mindfulness interventions, or other psychoeducation in therapy. Other possible applications of self-compassion training include populations of women who are impacted by problems with body image and/or disordered eating behaviors. Self-compassion training could enhance women’s ability to accept their bodies, view their mistakes with patience and gentleness, and have the clarity and motivation to identify values and future goals. Additionally, self-compassion training appears promising in the training and practice of counseling psychologists and other practitioners in the helping professions for preventing burnout and improving self-care.

Since initially being addressed in the field of counseling psychology by Neff over ten years ago, the construct of self-compassion has garnered a lot of attention and has been linked across social, cognitive, and affective domains of functioning. Maybe one reason self-compassion has captured the focus of many researchers and practitioners alike in the field of counseling psychology is its intuitive application to mental health and overall wellness. The characteristics of self-compassion involve a forgiving and accepting stance toward oneself, a balanced experience of painful emotions, and a sense of connection to others amidst difficult situations. When a woman holds a realistic and adaptive view of self that is not dependent on social comparison or situational success, she can be more resilient in the face of hardships. When she appreciates and accepts her physical, psychological, and emotional being as a whole, she is more inclined to pursue activities and make choices that lead to wellness. While more research is needed to fully examine the construct of self-compassion and its implications for practice in counseling psychology and health care in general, it appears to have great potential to positively and meaningfully affect many aspects of women’s lives.

References


Buchholz, S.W., Huffman, D., & McKenna, J.C. (2012). Over-
Self-Compassion, Health, and Wellness in Women


Neff, K.D. (2003a). The development and validation of a scale to
Self-Compassion, Health, and Wellness in Women

- Thompson, B.L., & Waltz, J. (2008). Self


