THE DIRECT AND INDIRECT INFLUENCES OF SELF-COMPASSION ON ALCOHOL CONSUMPTION AMONG THAI BUSINESSMEN, MEDIATED BY STRESS AND DEPRESSION

Lihi Darnell

A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of
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in Counseling Psychology
Graduate School of Psychology
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By: LIHI DARNELL

Field of Study: MASTER OF SCIENCE IN COUNSELING PSYCHOLOGY

Thesis Advisor: DR. PARVATHY VARMA

Accepted by the Graduate School of Human Sciences, Assumption University in Partial Fulfillment of the Requirements for the Master Degree in Counseling Psychology

.....

(Assoc. Prof. Dr. Suwattana Eamoraphan)

Dean of the Graduate School of Human Sciences

Thesis Examination Committee

..... **Chair**

(Assoc. Prof. Dr. Suwattana Eamoraphan)

.....**Advisor**

(Dr. Parvathy Varma)

..... **Faculty Member**

(Dr. Santhosh Mohanan)

..... **Faculty Member**

(Dr. Donald Arthur Johanson)

..... **External Expert**

(Assoc. Prof. Dr. Dusadee Yoelao)

ABSTRACT

The current research aimed to explore the direct and indirect influences of self-compassion on alcohol consumption, being mediated by stress and depression among Thai businessmen in Bangkok, Thailand. This research investigation employed quantitative methods based on data derived from a self-report survey questionnaire on a population of 266 Thai businessmen (N=266). This study used the correlation approach via path analysis to determine if the targeted population's level of self-compassion can predict their level of alcohol consumption, both directly and indirectly, being mediated by their levels of stress and depression. The findings demonstrated significant direct influence of self-compassion on alcohol consumption. It was also found that self-compassion has negative direct influence on stress and depression, indicating that the more self-compassionate the participants are, the lower is their level of depression and stress. Surprisingly, this research did not find an indirect influence of self-compassion on alcohol consumption, being mediated by stress and depression. The findings, conclusions, limitations, and recommendations of the study were discussed accordingly.

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Conducting a scholarly research is a long, at times painful, process which unfolds much suffering along the way. Zen master Thich Nhat Hanh once said, "People are afraid of suffering, but suffering is a kind of mud to help the lotus flower of happiness grow. There can be no lotus flower without the mud" (Nhat Hanh, 2014).

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CHAPTER I

Introduction

Background of the Study

The National Household Survey for Substance and Alcohol Use of the Thai population from 2007 provides details of findings based on the survey on alcohol consumption in Thai society. The Audit score suggests that 6.7% of the Thai population may be under the classification of "hazardous drinkers", that 0.9% of Thais may be "harmful drinkers", and that 0.6% of the Thai population are probably "alcohol dependents". In 2007, researchers found that 42.8 million Thais who make up 71.7% of the population in Thailand, aged between 12 and 65 years had consumed an alcoholic beverage (Assanangkornchai, Sam-Angsri, Rengpongpan, & Lertnakorn, 2010). According to statistics from the Substance Abuse and Mental Health Services Administration in the U. S., one out of four American adults self-reported binge drinking during the past month (SAMHSA, 2014). 'Binge' is defined by a period of time when individuals heavily consume alcohol, followed by a period of time when individuals restrained themselves from consuming any alcoholic beverage (Tomsovic, 1974). Furthermore, approximately 6% of American adults met the criteria for alcohol consumption abuse or dependence in the last twelve months (SAMHSA, 2014).

Increased alcohol consumption has been found to cause aggravation in many serious medical conditions such as liver cirrhosis, coronary heart disease, stroke, liver cancer, mouth

cancer, epilepsy, and many others (Room, Babor, & Rehm, 2005). Additionally, the authors demonstrated that alcohol consumption was conjoined with heightened numbers of unintentional injuries, including road accidents, drowning, falls, poisonings, and violent crimes.

The National Institute of Drug Abuse suggested in their public education document publications that substances such as alcohol may be used and abused in order to create and feel a state of euphoria, and that substances are abused because of physical dependence. There is a wide range of opinions on the reasons for substance abuse, but the definition of 'addiction' remains clear: it is a state-of-being where both physical and psychological dependence are present (Weissman, 2005).

Research has shown that the absence of self-compassion in an individual's life causes increased vulnerability and risk of psychopathology (Barnard & Curry, 2012a). It had been suggested that the presence of self-compassion is a contributing factor when taking measures to maintain balance of extreme reactions, and that the existence of self-compassion supports one's ability to cope effectively when experiencing difficult times (Leary, Tate, Adams, Allen, & Hancock, 2007). It had also been shown that self-compassion is a contributing factor which increases motivation for change and acceptance of responsibility for mistakes (Neff, 2011).

A large-scale investigation concluded that self-compassion, specifically conceptualized with the components of self-kindness, mindfulness, and common humanity, is a healthy and effective alternative to both self-criticism and high self-esteem (Neff, 2003b). This is important because in populations of substance abusers, a large number of individuals attempt

to avoid or reduce self-criticism, and the result of this is that they may use drugs and alcohol in an attempt to gain the desired reduction of these feelings, control or remove unwanted experiences such as disturbing thoughts, difficult feelings, distressing sensations, and various other unpleasant and undesirable experiences (Wilson, Hayes, & Byrd, 1999). This is the rationale for hypothesizing that self-compassion may contribute towards a decrease in alcohol consumption. Thus, it is vital to reveal the psychological factors of substance consumption that may lead to substance abuse.

Substance abuse in the form of excessive alcohol consumption has a significant impact on individuals physically, emotionally, and financially, as well as on their friends and family. Alcohol is, currently, the most easily accessible substance commonly abused worldwide. According to the World Health Organization (2013), each year, 2.5 million deaths reported worldwide had been found to be linked to the abuse of alcohol. The WHO (2004) published a report estimating the number of individuals worldwide who are dealing with alcohol use disorder (AUD) to be as high as 76.3 million. This excessive rate of alcohol consumption is the main reason for an estimation of 80,000 yearly deaths in the United States alone (Centers for Disease Control and Prevention [CDC], 2008). In the United States, in 2011, 16 million individuals were classified under alcohol dependence or alcohol abuse. The current researcher believes that it is vital for researchers to further explore and unfold the factors associated with alcohol consumption with a view to helping those who are prone to or are involved in problematic alcohol consumption.

Statement of the Problem

Alcohol consumption is a frequently dealt with issue. For this reason, it is important to study what causes individuals to consume alcohol. Individuals generally suffer from excessive alcohol consumption. Not surprisingly, these individuals have been reported to have lower levels of self-compassion. Moreover, individuals with high levels of stress and depression have been reported to have high level of alcohol consumption. While research suggests that self-compassion helps to reduce stress and depression, little research exists to examine the relationship between self-compassion, depression, anxiety, and stress among individuals who consume alcohol (Brooks, Kay-Lambkin, Bowman, & Childs, 2012). Levels of self-compassion has a direct relationship on levels of subjectively reported feelings of shame and sadness when facing perceived, imagined and real difficult life events, this indicates that self-compassion creates modoration in the individual's response to negative situations. (Leary et al.,2007). Self-compassion provides the individuals a higher level of resilience demonstration of feelings (Neff, 2011), and has the capacity to protect against depression (Germer, 2009).

Purpose of the Study

The purpose of this study was to explore the direct and indirect influences of self-compassion on alcohol consumption, being mediated by stress and depression. The study aimed to explore if self-compassion has an effect on alcohol consumption among Thai

businessmen who form the cornerstone of prosperity in Thai society. Indeed, business companies create the resources that permit social development and welfare across the country. In effect, this study attempted to explore the pattern of relationship between self-compassion and alcohol consumption, being mediated by stress and depression.

Significance of the Study

There is a dearth of studies on the relationship between self-compassion and alcohol consumption within the Thai context. It is important to understand this relationship, being mediated by the psychological factors of stress and depression because of their present relevance and topical significance in Thai society. The findings of this research would benefit both mental health providers and individuals in the effort of helping people cope with alcohol consumption issues. The results of this study would shed light on the impact of self-compassion on alcohol consumption directly or indirectly, especially among Thai businessmen who form the cornerstone of prosperity in Thai society. Indeed, business companies create the resources that permit social development and welfare across the country. The relationship obtained in this study's path model would give future researchers in the field a better understanding of the core variables and may use that as a base for further investigation, particularly within the Thai setting.

Definition of Terms

Alcohol consumption.

Alcohol consumption is defined by the amount of alcohol one drinks in a course of time. The WHO suggests that a common measure of a drink is the volume of the alcoholic drink (such as one glass of wine, a can of beer, or a mixed drink containing distilled spirits) that contains about the same measurable grams of ethanol not related to the type of alcoholic drink consumed. In this paper, alcohol consumption was measured using a self-reported Alcohol Consumption Scale consisting of two questions (see Appendices).

Depression.

Depression is a mood disorder characterized by the presence of dysphoria, sadness, anxiety, withdrawal, hopelessness, despair, disturbance of sleep or increased need for sleep and, possibly, increased guilt feelings and thoughts (Kahn, 2001; Kraly, 2006; WHO, 2010). Physiological symptoms of depression frequently include headache, changes in appetite (increase or decrease), loss of energy, and gastrointestinal changes. Intellectual symptoms might be presented by slowed thinking, hard time making decisions, weak concentration, and impaired memory (Kahn, 2001). There is no one significant cause for depression. Predictors of depression may include age, race, gender, education level, and marital status (CDC, 2008). In addition, it may be related to many more factors including past family history and psychosocial stressors. Included among these psychosocial stressors are death of a spouse, employment loss or other major changes and, possibly, living in an urban environment (Kahn,

2001). In this study, depression was measured by means of the depression subscale of the Depression, Anxiety, and Stress Scales (DASS-21) developed by Sydney H. Lovibond and Peter F. Lovibond in 1995.

Self-compassion.

Self-compassion, according to Buddhist psychology, is the individual's' ability to view one's difficulties in a compassionate way. Self-compassion unfolds within itself three components: self kindness, mindfulness, and common humanity. Self-compassion is observed as a process that starts with the awareness of others and one's own suffering, allowing the experience of treating oneself with kindness when facing moments of suffering, while keeping a nonjudgmental understanding of one's own imperfections and failures, as well as being aware that one's own experiences are also actually being experienced by others as part of the common human experience (Neff, 2003a). In this study, self-compassion level was determined by measuring the means of the results of the Self-Compassion Scale (SCS) developed by Neff (2003b).

Stress.

Stress refers to a subjective understanding which an individual employs when facing challenging situations, intimidating events, or harmful conditions that threaten their own well-being. Stress is being induced when the individual is under a perceived environmental pressure or demand that taxes one's available resources (Lazarus & Folkman, 1984). Stress experiences can be emotionally or physiologically challenging and activate various stress

responses and adaptive processes to regain homeostasis (Cohen, Kessler, & Gordon, 1995). In this study, stress was measured by means of the stress subscale of the Depression, Anxiety, and Stress Scales (DASS-21) (Lovibond & Lovibond, 1995).

CHAPTER II

Literature Review

This chapter presents theoretical perspectives and models as well as closely connected research findings about the main variables of interest, namely: alcohol consumption, stress, depression, and self-compassion aimed at providing an organized and in-depth review of relevant literature. Based on the review of literature highlighting theoretical perspectives and empirical findings, the conceptual framework, research questions, and research hypotheses of the current investigation were drawn and presented towards the close of the chapter.

Alcohol Consumption

When consumed in moderation, alcohol functions as a depressant that reduces stress. When consumed at exaggerated levels, it may result in death (Australian Bureau of Statistics [ABS], 2006). In many Western countries, substance consumption, including alcohol consumption, is ranked as the second cause of deaths and hospitalization (Australian Institute of Health and Welfare [AIHW], 2004). The World Health Organization (WHO) laid out the description of alcohol as a global, multinational dispute that causes millions of deaths. Excessive alcohol consumption is rated as one of the main causes of injury, illness, preventable death as well as numerous health, mental health, and social issues in most global cultures and societies. Some examples are liver dysfunction, cancer, and fetus damage among

women who consume alcohol during their pregnancy. Moreover, there are social consequences such as reduced work-related productivity, injuries and deaths due to driving under the influence of alcohol, hostile behavior, and family-related divisions.

It is stated that alcohol consumption is common cross-culturally and globally. Although it is common for adults to consume alcohol, it is still noted as a safety and health hazard. This is rooted in the large variety of patterns in which alcohol consumption can occur; that is, from occasional risk-taking alcohol consumption to frequent alcohol consumption, it is marked as a significant public health and safety issue nearly globally (WHO, 2010).

Alcoholism has been described as a "chronic behavior disorder", distinguished by an excessive dietary and social consumption of alcohol in a repeated behavior which interferes with the individual's social, health, or financial functioning (WHO, 1952). The WHO pointed out that there are roughly 76.3 million individuals globally who live with 'alcohol use disorder' or AUD (WHO, 2004).

In 2013, the Diagnostic and Statistical Manual of Mental Disorders or DSM (5th ed.) combined *alcohol abuse* and *alcohol dependence* from their earlier appearance in the DSM-IV, into a new singular disorder: *alcohol use disorder* (AUD), with specific severity levels diagnosed by the amount of symptoms present: mild, moderate and severe.

'Alcohol abuse' was defined in the DSM-IV as a maladaptive pattern of excessive alcohol use that results in clinically compelling distress or significant impairment, as demonstrated within a period of one year by one or more of the following symptoms: recurrent alcohol consumption that repeatedly causes a failure to maintain productive work, or

school-related obligations or disturbances at home and in domestic functioning by incidences such as neglect of self or family member, suspension from work, repeated absences, and neglect of commitments. The result of recurrent excessive alcohol consumption may be physically hazardous in some situations such as driving a vehicle or operating heavy machinery. It may also result in legal problems such as getting arrested for misconduct or misbehavior related to alcohol consumption. Direct social and interpersonal results may be due to repeated excessive alcohol consumption behaviors that do not change, regardless of any recurrent or persistent interpersonal or social problem associated with the effect of alcohol consumption such as arguments and physical fights within the family. This may followed by lesser social interactions due to disappointments with the social environment (DSM - IV, 2000). AUDs in the form of alcohol abuse or alcohol dependence are directly related to mental health conditions including depression (Samokhvalov, Popova, Room, Ramonas, & Rehm, 2010).

The comorbidity between alcohol use disorders and psychiatric disorders is commonly found in clinical settings. As high as 94% of participants displayed comorbidity of alcohol use disorders and depression mainly among women (Almeida-Filho et al., 2007). In the attempt to provide an explanation for the high comorbidity between alcohol consumption and depression, several explanations have been proposed. One explanation suggested that the appearance of alcohol consumption related to depression increases pathological alcohol consumption. This explanation is often presented as the "self-medication hypothesis" (Kushner, Abrams, & Borchardt, 2000; Khantzian 2003). The self-medication hypothesis stresses the assumption that any kind of substance consumption, abuse, or dependency is an active self-regulation

effort aimed to achieve relaxation, or to moderate and/or manage any distressing experience the individual may be facing (Suh, Ruffins, Robins, Albanese, & Khantzian, 2008). Cooper, Russell, Skinner, Frone, and Mudar (1992) concluded that higher alcohol consumption will be present if the individual believes that consumption of alcohol will benefit his condition by reducing tension or relieving difficult emotions.

Mental health research had demonstrated that mood disorders are associated with alcohol consumption. For example, Grant et al. (2016) reported that more than 40% of the participants had alcohol use dependence and had been reported to be seeking treatment. Additionally, they had been found to have at least one mood disorder. A third of them had, at least, one recorded anxiety disorder. A study by Bouchery, Harwood, Sacks, Simon, and Brewer (2011) concluded that the economic and social costs of alcohol use dependence are very high. In 2006, the economic cost was $223.5 billion when the per capita cost was approximately $746 for each individual in the U.S. Examining the costs of treatment for alcohol dependence and/or abuse as well as the costs of impaired productivity due to loss of earnings, it was found that the percentage of individuals who self-reported binge drinking in a duration of a month in the national epidemiologic survey on alcohol and related conditions was 68.5% of the population, about the same as the percentage of deaths due to alcohol dependence or abuse that are directly related to binge drinking (Bouchery et al., 2011). The "global economic burden" of alcohol abuse was estimated to be around U$210 to U$665 billion in 2002 (Baumberg, 2006). A replication of the study revealed a more accurate estimation that came out to be U$223.5 billion. This indicates that as many as half of all adult

individuals in the United States has a relative or acquaintance who is an alcoholic (active or in remission), affirming the wide effect of alcohol abuse in the United States (Dawson & Grant, 1998). Caetano and Curadi (2002) estimated that about half of all social, legal, and interpersonal issues and problems that are alcohol consumption-related are caused by individuals with alcohol dependence.

Early research on alcohol consumption posited that depression and anxiety are its most commonly repeated and harmful symptoms, and that these symptoms are correlated positively with alcohol consumption and abuse (Borden, Peterson, & Jackson, 1991). It had been suggested that alcohol consumption is the favorite method individuals choose to face and cope with difficult or unpleasant situations and/or feelings and thoughts that might trigger depression, and that individuals who encounter depression may turn to alcohol consumption as a coping method (Huber, 1985). In a similar vein, it was found that consumption and abuse of alcohol can induce symptoms of depression and anxiety (Camatta & Nagoshi, 1995).

In accordance with the self-medication hypothesis, Goeders (2004) asserted that "those predisposed to substance abuse suffer painful affective states" (p. 33). On a related note, Khantzian (1985) argued that, based on the hypothesis, "the specific psychotropic effects of these drugs interact with psychiatric disturbances and painful affect states to make them compelling in susceptible individuals" (p. 1259). In addition, it had been recognized that the subjective experiences of alcohol addicted individuals provided with indicators of how often they felt overwhelmed and disturbed by the effects were similar to the effects shown in depression. Furthermore, the substance they chose to consume in order to cope and fight the

symptoms they were having was contributed by substance consumption.

Cooper, Frone, Russell, and Mudar (1995) found that alcohol consumption can also be used to activate positive emotions. The authors explained that a behavior that functions to escape from internal discomfort is characterized by (1) a feeling of being 'powerless' – a repeated failure to control the behavior; (2) "unmanageability" – when the individual suffers from critical negative outcomes of the behavior and yet continues to display it. Starting to consume alcohol may offer the individual some relief from difficult feelings, thoughts, and discomfort. This temporary comfort might alter and progress into an attempt to avoid pain in the future (Peterson & Cangemi, 1993).

Another process found to be part of abuse of alcohol consumption is that it serves as an agent in reducing self-awareness. This had been described in an earlier model of alcohol consumption by Hull (1981) called the *self-awareness model*. This model suggests that consuming alcohol as a regulator aims to achieve a reduction in anxiety – the type that university students feel in stressful social settings. This model implies that the consumption of alcohol reduces the individual's responsiveness to stimuli for common behaviors and, therefore, reduces the individual's self-awareness. Moreover, alcohol consumption allows individuals to participate and take actions they wouldn't engage in otherwise as it reduces or removes restrictions (Hull, 1981). A good example for this is a study of alcohol abuse, posttraumatic stress syndrome, and domestic violence conducted with police officers. The researchers found that individuals who were alcohol dependent were eight times more likely to report being physically violent toward their intimate partner (Oehme, Donnelly, & Martin,

2012). The significant positive correlation between alcohol abuse and domestic violence ranges across cultures as diverse as Indian and Mexican (Valdez- Santiago, Hijar, Martinez, & Burgos, 2013).

Theories of alcohol abuse.

Biological theory. A summary of the latest research conducted on the role of the brain in addiction, published by the World Health Organization (WHO, 2004), stated that a genetic predisposition component had been found as evidence in some individuals with dependant family members. This predisposition puts the individual in a higher risk of developing similar conditions. Despite that, the individual may have inherited certain genetic characteristics and components that result in putting the individual at a higher risk of developing alcohol dependency, if engaging in heavy drinking. According to the WHO, the reason a genetic component affects some individuals is still uncertain. There are some chemicals such as dopamine and serotonin in the brain that contribute toward creating addiction and other compulsive behaviors (WHO, 2004). Echoing the WHO report, another health institution stated that dopamine and serotonin are suspected to be heavily involved. Stress is related to low levels of dopamine, and high levels of the same chemical are related to elevating feelings such as pleasure. It is known that alcohol can increase levels of dopamine temporarily which causes the individual to feel increased pleasure. The individual, then, might turn to use alcohol repeatedly to achieve the elevated feeling of pleasure. It has been shown that repeated alcohol consumption alters and interferes in the normal functioning of the brain as well as brain chemistry. Excessive alcohol consumption is a health hazard as it may lead to liver

dysfunction and pancreas, causing the individual's health to deteriorate as the absorbing and processing of nutrients such as vitamins and proteins will be damaged (National Institutes of mental Health, 2008, 2014). Evidence of differences in the way individuals process alcohol had been demonstrated. Chemical imbalance may contribute to the appearance of depression and anxiety due to lack of nutrients which may lead some individuals into further alcohol consumption as a self-medicating coping attempt (Rotgers, Kern, & Hoeltzel, 2002).

Disease theory. In the 1960's, the American Medical Association asserted that excessive alcohol consumption, also known as alcoholism, is a 'disease' (Erickson, 2005). The WHO aligned itself with this statement and, with the strong belief by alcohol treatment approaches in the U.S. as well as medical professionals, concurred that addiction is, in fact, a physical disease that is inherited, habitual, continual, hazardous, and can be deadly. According to the theory, with regard to alcohol consumption, individuals with an inherited addiction disease cannot control their level of consumption. At the onset of the first alcohol consumption, innate addiction is triggered. This allows the disease to develop and lead the individual to consume larger quantities of alcohol which accelerates sabotage in the individual in all aspects of life: physical, mental, and spiritual (WHO, 2004). The disease model aimed to provide an explanation for the reason why individuals who are addicted to one form of substance may have a history of addiction to other substances as well. This brought up the understanding that, due to inbred endorphin deficiency in substance-abusing individuals, the tendency towards addiction is predisposed. The social psychological concept of substance dependency is the result of "self-induced changes in neurotransmission" (Peele, 1985). McLellan, Lewis, O'Brien, and Kleber (2000) argued that there is a predisposition to

substance dependency by genetic factors. It had been noted that involuntary factors combined with free will and involuntary actions contributed to addiction.

Psychosocial theory. According to the WHO (2004), the status quo is that the development of a problematic drinking pattern or hazardous habit of alcohol consumption is contributed to by environmental events, social interactions, and psychological events. Learned behavior had been shown to contribute to hazardous alcohol consumption. Individuals learn how, when, and what to consume as well as what to expect from alcohol consumption from family members, peer group, and role models. When an individual is exposed to alcohol consumption that is uncontrolled and hazardous, the individual most likely internalizes and learns to consume alcohol in the same way. Research shows that individuals choose behaviors with positive consequences which outweigh negative outcomes (e.g., hangover, domestic issues, etc.). Thus, when a certain alcohol consumption behavior is accepted by the family or social environment, it is translated as a positive feedback and will contribute to further alcohol consumption and hazardous drinking behavior. It was stated in a Social Issues Research Centre (SIRC, 1998, p. 6) report on the social and cultural aspects of drinking that there is a great amount of worldwide, historical, and cross-cultural documentation that provided solid proof that individuals learn how, what, and when to consume alcohol, as well as what to expect from the results of alcohol consumption as part of the socialization process. This means that while consuming alcohol, individuals will act and behave in the way they expect themselves to behave due to social learning, despite the unlikeliness of most individuals to realize that they are actually acting by their beliefs. In addition, research indicates that substance abuse takes place when social conditions are characterized by low socioeconomic

status, and contributed to by factors such as poverty and unemployment, low educational level, unstable social and/or domestic situation, and lack of support network and resources (Single, 1999, p. 19).

Biopsychosocial model. The biopsychosocial model was introduced by Engel (1977) who hypothesized that a combination of biological, psychological, and social factors influence disease and illness. Psychological theories mainly generated ideas that allowed a better understanding of relapsing compulsive behaviors (e.g., alcohol consumption abuse, dependence, etc.) to have a "sensitizing role" (West, 2006). The American Psychiatric Association (2013) suggested an additional component to this model – spirituality. Spirituality, in this context, is defined as moral values, self-esteem, and belief in a 'higher power' greater than the self. In a state of active addiction, there is a tendency for individuals to become self-absorbed and generally 'selfish' in meeting their needs. This is the time when addiction takes over and spirituality which includes values and morality is lost. This is known as "spiritual bankruptcy"; for this reason, in addiction treatment, there is a need for spirituality in order to re-build the individual's set of values and morality.

Alcohol consumption from the Thai perspective.

Consumption of alcoholic beverages is a common activity that is generally accepted by societies across the globe. In Thailand, according to a Thai-based study, alcohol consumption serves to increase social interactions within the community. Not unexpectedly, it is especially common on public holidays and parties (Assanangkornchai et al., 2010).

Thai society perceives alcohol consumption as a masculine activity and, as such, social

alcohol consumption is generally accepted among men, and less acceptable among women. A research done on the Thai population found that women tend to consume alcohol when at home or when attending parties, while men often consume alcohol in their workplace and in bars (Assanangkornchai et al., 2010; Rungreangkulkij et al., 2012). The status report on alcohol consumption provided by the WHO (2004) indicates that Thailand is in the top 20 countries with the highest beverage-specific adult per capita (APC) consumption. Thailand's APC was marked at 7.13.

Moulinsart and Jongudomkarn (2012) provided an explanation for the high level of alcohol consumption among Thais by highlighting the Northeastern people's belief that alcohol could be used as a remedy for common problems involving sleep, appetite, muscle, and blood circulation. It is also a customary habit to consume alcohol alongside dinner. It is interesting to note that despite the fact that Thailand is fundamentally a Buddhist country, and although Buddhism advises that good individuals should avoid intoxicating their minds, alcohol is easily accessible and commonly used (Thamarangsi, 2006; Thamarangsi & Puangsuwan, 2010). Thamarangsi (2006) pointed out that the Thai alcohol consumption pattern was heavily influenced by the Chinese since the early Ayutthaya period (1350-1767). Historically, in that period of time, the Chinese introduced the production of alcohol to the people of Thailand, and started the manufacturing of alcoholic beverages in the country. The alcohol market developed and grew rapidly from that time and, thus, heavily influenced Thai society (Thamarangsi, 2006).

According to the World Health Organization, most of the interventions that are being offered to treat alcohol addiction are pinpointed to treating the disease as well as its physical

symptoms, but do not provide long-term and progressive focus on the cause – the addiction itself (WHO, 2010). This was demonstrated in a research in the Thai setting in which the culture is heavily influenced by consumption of all kinds, and where health beliefs contribute healing aspects to alcohol. This is combined with the pattern of alcohol dependence in which treatment-seeking creates a situation where men who are generally reluctant to seek health care services will less frequently reach out to get alcohol-related treatment (Assanangkornchai et al., 2010). Research suggests that when they do reach out for treatment, they would seek help in symptom reduction but will not focus on their mental or emotional condition (Schofield, Connell, Walker, Wood, & Butland, 2000).

Since 2002, Thailand has been administering a universal healthcare program which entitles Thai people to receive governmental and non-governmental healthcare services at a minimal cost, including substance abuse treatment (Suraratdecha et al., 2005). According to a hospital-based report, despite the availability of substance treatment, including alcohol dependence treatment, there is only a small number of alcohol dependent male patients who seek healthcare services to treat their dependency or abuse (Tanyarak Hospital, 2013).

Stress

Stress refers to a subjective understanding which an individual employs when facing challenging situations, intimidating events, or harmful conditions that threaten one's own well-being. Stress is being induced when the individual is under a perceived environmental pressure or demand that taxes one's available resources (Lazarus & Folkman, 1984). The most

common form of stress is *acute stress* which comes from demands and pressures of the recent past and anticipated demands or pressures of the near future. Alternatively, it is described as the result of past events combined with perceiving and foreseeing the forthcoming future (Miller & Smith, 2014). It is generally short-lived and arises as a direct consequence of an exceptionally stressful life event. Interestingly, low levels of stress can be perceived as exciting and positively stimulating, but cases of repeated acute stress can accelerate negative psychological symptoms such as headaches caused by tension and psychological distress. Acute stress is highly treatable and manageable and, when treated, it does not cause a lot of damage in the long run. However, if it is not treated in good time, it may develop into a more severe physical condition commonly called by cardiologists as "Type A", also known as episodic acute stress by mental health professionals. Episodic acute stress is characterized by constant worrying where the individual perceives the world as a hazardous place, and generally sees the world through a negative point of view, constantly waiting for negative things to occur.

When acute stress persists for a long period of time, diagnosis changes from acute stress to chronic stress. *Chronic stress* had been found to be related to career dissatisfaction, unhappy relationship, and dysfunctional domestic situation (Miller & Smith, 2014). The lack of ability to observe the positive aspects of life is a clear characteristic of chronic stress. Individuals who live with chronic stress mostly focus on the negative aspects of life, and perceive life as tasks needed to be done. Chronic stress affects the way an individual views and experiences the world, and may be rooted in past childhood trauma that the person never

dealt with in an effective manner (Miller & Smith, 2014). The same authors argued that, in contrast to acute stress, chronic stress may become fatal if not treated. Individuals who live with chronic stress are in a constant state of alert. Their body may wear down physically as it works harder than its capacity, leading to conditions such as rapid heart rate, stroke, or cancer. Chronic stress is emotionally exhausting, and may lead some individuals to attempt or commit suicide. A study on the health behavior of university students during their exam period reported that stress is linked to a significant decrease in physical activity and increased negative and harmful behavior such as smoking (Steptoe, Wardle, Pollard, & Canaan, 1996).

Most theories of addiction, including substance (e.g., alcohol) addiction propose that stress, acute or chronic, has an important contribution to triggering and provoking substance consumption and abuse that may result in addiction (Russell & Mehrabian 1975; Marlatt & Gordon, 1985; Wills & Shiffman 1985; Koob & Le Moal, 1997). For example, the *stress coping model of addiction* argues that the use of substance known to be addictive is an attempt to increase positive feelings and reduce aversive feelings, thus, reinforcing substance consumption as an effective, albeit maladaptive, coping strategy (Wills & Shiffman 1985). Another model is the *Marlatt relapse prevention model* which suggests that individuals with impaired coping resources combined with psychological, social, and biological factors such as peer pressure and family history have a higher risk of turning into substance use that may cause addiction – an outcome of substance consumption (Marlatt & Gordon, 1985). The *self-medication model* proposes that motivated individuals who consume substances such as alcohol can improve their mood as well as reduce their emotional distress, as observed in

acute and chronic stress conditions (Khantzian, 1985). Thus, any substance, when consumed in moderation, may be used in an attempt to adjust and tolerate tension or distress. When the behavior is repeated with a perceived successful outcome, the behavior may become the first choice of coping when facing the same or similar feeling or situation in the future. The self-medication model suggests that this is the factor that enhances substance consumption accountability. A model based on preclinical findings proposed that stress may trigger a change in the brain circuits that cause high sensitivity, thus, reinforcing certain properties of substance consumption which promptly increase the tendency to compulsively consume the substance (Koob & Le Moal, 1997).

Depression

The National Institute of Mental Health reported depression to be a widespread and crucial mental health condition in America, with an estimated 6.4% of Americans suffering from major depressive disorder in any year that had been examined (NIMH, 2008). Common symptoms associated with depression include: feeling of worthlessness and hopelessness, loss of interest in daily activities, disrupted sleep patterns, and suicidal thoughts. Clinical depression (or major depressive disorder) tends to be more prolonged and severe compared to a mild level of depression (NIMH, 2014).

Numerous mental conditions and physical health consequences are identified with the onset of depression (NIMH, 2014). For instance, less stressful life events were reported by

individuals with little or no depression-related symptoms, whereas individuals who reported suffering from depression also reported experiencing more stressful life events (Hammen, 2005; Hammen, 2006). Individuals who reported higher level of depression experienced impairment in creating and maintaining relationships (Judd et al., 2000). Engagement in rumination is commonly prevalent in individuals who suffer from depression; this includes a repetitive focus and highlighting negative emotions and thoughts which mostly contribute to increasing the severity of depressive episodes and other disorders which may be chronically comorbid (Nolen-Hoeksema, 2000). In most extreme cases, self-harm and suicide may become the most severe outcomes of depression. Individuals suffering from depression are at higher risk to engage in more dangerous behaviors such as self-harm, including suicide ideation, gestures, and attempts (Kessler, Borges, & Walters, 1999).

Depression had been found to contribute to a significant amount of health problems such as greater risk for coronary heart disease, stroke, Parkinson's disease, and other physical disorders found in patients diagnosed with depression (Barth, Schumacher, & Herrmann-Lingen, 2004; Evans et al., 2005). On top of that, depression symptoms are associated with great economic cost, as observed in the Netherlands which lost about 160 million dollars a year for non-medical costs (e.g., loss of labor) (Cuijpers et al., 2007).

Self-Compassion

Self-compassion entitles the acknowledgment of suffering, failure, and inadequacies of

being human. All individuals are worthy of compassion, including the self. This does not mean self-pity. Self-compassion is interdependent with the feelings of compassion and altruistic care. Being self-compassionate is not the state of being egocentric or selfish by prioritizing personal needs over the needs of others (Goldstein & Kornfield, 1987). Self-compassion is characterized by the ability to be forgiving to ourselves, being gentle and accepting, while using the power of mindfulness to come back to our original nature and out of an egocentric point of view, as well as feeling truly connected with society and humanity, as opposed to having a sense of isolation. Compassion unfolds within it an awareness of the suffering of others and being affected by the emotions it triggers in a way that drives the individual to act to ease their suffering. Being a compassionate individual means the individual offers support in a nonjudgmental understanding, kindness, and patience while believing that mistakes and imperfections are part of being human. This applies to self-compassion when the individual feels the aforementioned components of compassion toward one's own suffering, recognizes it as a part of common human experience, and treat himself with kindness (Neff, 2003a).

It's important to differentiate and acknowledge that self-compassion does not mean being selfish or self centered. Having self-compassion does not mean being egocentric and self-centered. It also should be distinct from self-pity. All of these tend to increase feelings of disconnectedness and isolation. They accelerate personal suffering. Self-compassion has an opposite effect, as it brings the individual into mindful balance (Goldstein and Kornfield, 1987)

Although self-compassion is a relatively new concept, there is growing interest in its nature and consequences. Research had demonstrated its significant positive relationship with conscientiousness, extraversion, happiness, optimism, wisdom, self-innovativeness, curiosity, exploration, and other positive factors. In addition, it was found to have a significant negative mental connection with negative impact and neuroticism. By measuring the levels of self-compassion, it is possible to predict the individual's psychological health (Neff, Rude, & Kirkpatrick, 2007).

The definition of self-compassion provided by Neff (2003b) in the self-compassion scale she developed was: "being kind and understanding toward oneself in instances of pain or failure rather than being harshly self-critical; perceiving one's experiences as part of the larger human experience rather than seeing them as isolating; and holding painful thoughts and feelings in mindful awareness rather than over identifying with them" (p. 229).

The self-compassion scale has been used in a number of studies in which self-compassion was found to be closely related with numerous positive outcomes such as: increased willingness to undertake self-improvement (Breines & Chen, 2012); conscientiousness, optimistic view in daily living, and perceived happiness (Neff, Kirkpatrick, & Rude, 2007); and lower levels of negative mental health symptoms such as social withdrawal, anhedonia, and impaired attention (MacBeth & Gumley, 2012).

Many other related studies revealed more interesting findings about self-compassion. For example, recovery from addiction was found to be associated with self-compassion (Brooks et al., 2012). The authors conducted a 15-week public drug and alcohol treatment

program and by the end of the program, participants reported a significant increase in their level of self-compassion. Self-compassion was also found to be positively related to mental health and adaptive psychological functioning. In particular, lower levels of depressive symptoms, anxiety, rumination, shame, self-criticism, fear of failure, workplace burnout, higher life satisfaction, emotional intelligence, the ability to connect socially, and stronger goal achievement were all found to be associated with greater reported levels of self-compassion (Barnard & Curry, 2011; Neff, 2012).

Self-compassion and alcohol consumption.

Self-compassion unfolds three elements within it: self-kindness, common humanity, and mindfulness. The following section elaborates on these three elements.

Self-kindness. This involves the urge to reduce suffering and manifest healing in oneself while being open in a compassionate manner to one's own suffering (Neff, 2003a). It is also a nonjudgmental point of view of one's failures, imperfections, weaknesses, pain, and other difficult experiences. Self-kindness is being aware of one's own feelings and understanding them. The exact contrast of self-kindness is being extremely judgmental towards oneself. In practice, a person is being judgmental when being extremely self-critical when facing difficulties, failure, and pain. Interestingly, the element of self-kindness may be able to function as a protective component against psychopathology (such as excessive alcohol consumption). A study involving students found that they take alcohol as a coping mechanism in dealing with failure and self-criticism. The same study argued that the reason for this is rooted in the assumption that self-compassion is the opposite of self-criticism (Neff,

2003a). Self-criticism itself had been found to be related to alcohol consumption and substance abuse (Peterson at el., 1993) Previous study had shown that it is not uncommon for individuals to turn to alcohol as an attempt to cope with difficult feelings, self-criticism, discomfort, self-awareness, and psychopathology (Camatta & Nagoshi, 1995; Pullen, 1994; Wilson & Byrd, 2005). Neff (2003a) suggested that the approach in which individuals accept themselves with kindness may reduce their own tendency to self-criticism which is known to be present in states of depression, stress, and anxiety. The element of self-kindness may enable individuals to be aware of their own suffering, painful emotion, and discomfort. It is not surprising to see individuals turning to self-compassion to ease their own emotional difficulties with the sensitivity and soothing effect of self-kindness.

Common humanity. This is described as the ability to understand and perceive one's experiences in the global communal context in which experiencing difficulty, failure, suffering, and weakness is a common human experience. The aspect of human experience helps reduce feelings and thoughts of isolation (Neff, 2003a). Accepting the notion that one's own experiences are part of a shared or common human experience promotes self-compassion and not self-judgment which is believed to characterize individuals who consume alcohol recklessly (Campbell, 1993). When an individual realizes difficult feelings being felt are common and shared by others in the same situation, the awareness of common humanity will grow and may become a contributing factor in combating feelings of isolation associated with alcohol consumption.

Mindfulness. This element involves recognizing painful thoughts and feelings which

contribute to difficulties in carrying out balanced awareness, without over-identifying with these feelings and being aware that they are temporary. Mindfulness theories claim that ignoring or disregarding any difficulty is less effective than being aware and being able to see clearly the roots of the difficulty. The mindfulness element of self-compassion functions as a stimulating component to manifest change, when and where it is needed; for example: hazardous, disturbing, or destructive behavioral patterns which hold the individual back. Mindfulness, thus, allows optimization and supports health as well as general functioning in the individual's life (Neff, 2003a; 2003b). In this manner, mindfulness may alter the way individuals view and relate to impaired thoughts and negative emotions, instead of altering and ending the situations independently. Mindfulness points out the common tendency individuals have to be aware of, understand, and accept all negative and positive aspects in their own self (Neff et al., 2007).

Early research by Kabat-Zinn (1990) had shown that improvement in mindfulness by training and practice assists the progress of numerous outcome factors of well-being. The author noted that later studies illustrated significant effects associated with the practice of mindfulness meditation, including effects such as lesser symptoms of depression, reduced anxiety level, reduced hostility, and reduction in the presence of medical symptoms.

A cognitive framework was presented in an attempt to explain the possible link between alcohol consumption and negative effects when facing difficult situations (Breslin, Zack, & McMain, 2002). The authors posited that maintaining mindfulness may alter the way individuals generally deal with difficult emotions and painful thoughts. In addition,

mindfulness may be potentially beneficial in fighting alcohol abuse by helping the individual to recognize automatic behavior. In other words, mindfulness can help the individual to stop, be aware of the present moment, and choose how to act before using their automatically activated behavior such as reaching for an alcoholic drink. As a result of greater emotional clarity, self-compassion may be a successful and useful coping strategy in helping individuals combat difficulty and achieve emotional balance while accepting emotions that might float in compassionate awareness, as opposed to experiencing overwhelming feelings and negative emotions, and being navigated by these emotions (Neff, 2005).

Self-compassion, stress, and alcohol consumption.

Self-compassion equips the individual with a higher level of emotional resilience (Neff, 2011).

Self-compassion had been suggested as an important part of the positive mental state related to mindfulness, while using mindfulness-based interventions in clinical research. Numerous studies that focused on self-compassion indicated that some elements in self-compassion, particularly the elements of self-kindness and forgiveness, are significant stress-soothing agents which help reduce symptoms of depression. Thus, it can be said that self-compassion may function as a protective component against depression (Germer, 2009). Self-compassion has the capacity to moderate an individual's reaction to distressing experiences in that a higher level of self-compassion has a direct relation to lower levels or reported feelings of sadness and embarrassment when experiencing negative life events,

whether imagined, perceived, or real (Leary et al., 2007).

Lazarus and Folkman (1984) introduced stress as a subjective appraisal that individuals apply to situations deemed challenging, threatening, or harmful toward maintaining their well-being. Stress occurs when individuals perceive environmental demands that exceed their resources. Stress exposure includes threatening or harmful external stimuli that may trigger alertness, anger, fear, and sadness with a potential negative outcome (Sinha, 2001, 2008). In an attempt to reveal and pinpoint the factor that triggers high alcohol consumption, stress reaction had been examined as that which individuals employ to cope with and control tension (Ham & Hope, 2003; Hussong, 2003). Exposure to varying forms of stress is part of general life experience that can aggravate reactions of all sorts. Research on substance use, including alcohol, and on psychological and psychiatric conditions, the term "stress" commonly indicates experiences which symbolize difficulty (Dohrenwend, 2000). On a different note, past research has pointed out that daily stress on its own does not necessarily lead to excessive alcohol consumption (Rutledge & Sher, 2001; Cooper et al., 1992).

Stress occurs when individuals perceive environmental demands that exceed their resources and, furthermore, it results from subjective appraisals placed upon situations that challenge, threaten, or harm their well-being (Lazarus & Folkman, 1984). The authors explained that coping occurs when an individual attempts to deal with external demands and with the emotions that arise from the interaction. Corporate culture in different industries may have influenced the pattern of alcohol use. Certain stress levels such as moderate and mild may be difficult but challenging, leading the individual to feel that he or she is capable of

facing the difficulty. The risk of psychopathology increases when the individual does not have the capacity and tools to cope with the difficult situation (Lazarus 1999; Levine 2005; McEwen 2007; Selye 1976; Sinha 2008). Ames, Grube, and Moore (2000) concluded that organizational alcohol consumption norms can predict work-related alcohol consumption patterns and behaviors among employees within one industry, and different patterns in other work environments. Ames described the complex influences of work that form and maintain alcohol beliefs as "normative regulation of drinking." Moreover, travel-related stress may be linked to negative health behaviors including excessive alcohol consumption (DeFrank, Konopaske, & Ivancevich, 2000).

Further review of the literature revealed more empirical evidence of an association between stress and alcohol consumption. For example, adult alcohol relapse after alcoholism treatment was found to be related to increased vulnerability to stress (Brown, Vik, Patterson, Grant, & Schuckit, 1995). A study conducted among police officers established that stress is related to excessive alcohol consumption on account of their experience with unique and difficult content events as part of their job demands (Violanti, Marshall, & Howe, 1985). In the research, the officers were asked to complete a written questionnaire to measure their unique position demands, their coping responses, and their perceived stress. The results showed that their stress level had a significant effect on their alcohol consumption, and that stress and alcohol consumption did not develop separately from the unique occupation. The occupational protocol forbade behaviors that may interfere with the police officers' occupational goals. This emphasized the notion that the police station as a workplace does not

provide specific skills and coping techniques for the officers to be able to deal with their work-related stress and, as a result, officers were left to search for other coping mechanisms such as taking alcohol to relieve stress.

Self-compassion, depression, and alcohol consumption.

Research on self-compassion and its impact on depression is still developing; thus, there is limited data and theory concerning the matter (MacBeth & Gumley, 2012). Notwithstanding the limitation, researchers hypothesized self-compassion to have a contributory role in reducing the onset of depression symptoms in a few pathways. For example, Raes (2010) posited that self-compassion neutralizes the possible effects of risk factors. Hence, self-compassion can take part in reducing high risk components known to trigger depression symptoms. In addition, it is claimed that self-compassion works behind the scenes, allowing individuals with various interpersonal resources to protect themselves against depression. Self-compassion is essential in developing resilience (Neff, 2011), and functions as a protective mechanism against depression (Luthar, Cicchetti, & Becker, 2000). Individuals who present high level of self-compassion may also experience positive emotional states such as being peaceful, calm, and contented – factors that yield higher level of perceived psychological well-being and general life satisfaction (Neff et al., 2007). MacBeth and Gumley (2012) examined the relationship between self-compassion and depression, and established self-compassion as a protective factor against depression. However, studies that attempted to investigate how self-compassion applies its beneficial effects on depression may be few and far between, but are increasing exponentially with the passage of time. When

practiced and applied, self-compassion may lessen the impact of aversive life experiences and act as an instrument of reducing, as much as possible, the risk for experiencing depression (Gilbert & Procter, 2006; Neff, 2011).

The findings of a German-based study revealed that self-compassion has the potential to enable depressed individuals to tolerate their negative emotions and, as such, provide them with the support needed in the process of coping with their depressive symptoms. The results indicated that systematic practice of self-compassion through specific compassion-focused interventions may lead to the reduction of depressive symptoms. This may be made possible by improving the person's ability to regulate his or her emotions, specifically by the ability to tolerate one's negative emotions (Dietrich, Burger, Kirchner, & Berking, 2016). This conclusion is aligned with theories that assume that the tendency to avoid aversive innate experiences such as unwanted emotions may be functioning as a contributory factor in the onset of depressive symptoms. Increasing the tolerance towards these experiences contributes towards restoring and maintaining mental health (Berking, Neacsiu, Comtois, & Linehan, 2009; Hayes, Beevers, Feldman, Laurenceau, & Perlman, 2005). More recent studies demonstrated that self-compassion has an important function as a positive coping strategy. For instance, self-compassion initiates "relaxed or soothing" responses to challenging events that may cause stress, as opposed to activating the threat system in the individual facing the stressful event (Gilbert et al., 2008). Johnson and O'Brien (2013) asserted that this outcome ultimately reduces symptoms associated with depression over a relatively short period of time. There are a few empirical studies that reported a causal relationship between self-compassion

and depression. For example, Neff et al. (2007) found that a higher score in the self-compassion scale is associated with lower score of depression. Raes (2010), in a study using a non-clinical sample, found that individuals who presented with higher scores of self-compassion reported to have lower levels of depression in a period of five months. In a clinical research conducted by Gilbert and Procter (2006), individuals who took part in a *compassionate mind training* (CMT) were trained to be self-compassionate. Results revealed that lower levels of depression were reported within a period of 12 weeks. Additionally, in a pilot study of *mindful self-compassion* (MSC) which integrated self-compassion and mindfulness, the individuals who took part in the program reported lower levels of symptoms related to depression after a period of 8 weeks (Neff, 2012).

Johnson and O'Brien (2013) run a test in which experimental participants were asked to recall a shameful memory, followed by a writing-based self-compassion task. This group of participants reported experiencing reduced level of depression, compared to the control group who were given a broad emotion-based expressive writing task. The finding strengthened the implication that individuals who achieve higher scores of self-compassion recover from negative experiences faster and in a way that reduces the risk of experiencing depression. Furthermore, a high score in the self-compassion scale weakened the relationship between negative experiences and depression. On a different note, a large number of individuals in the substance-abusing population attempted to avoid or eliminate self-criticism as well as criticism from others (stigma). As a result, individuals often turn to consume substances such as alcohol for the purpose of managing or reducing their aversive experiences, thoughts,

feelings, and sensations (Wilson & Byrd, 2005).

In his book, *The Mindful Path to Self-Compassion: Freeing Yourself From Destructive Thoughts and Emotions*, Germer (2009) argued that, quite often, individuals feel the urge to avoid pain actively. Absorbing the pain and responding compassionately to faults or imperfections (or relapses) without judgment or self-blame may help individuals to punish themselves less, and make active and productive steps toward self-healing. In addition, Germer posited that self-compassion is easier when patients submit and "give up the struggle" in order to feel better, stop trying to "fix" their problems/faults/failings/imperfections, and simply start caring for themselves and treating themselves with compassion (Germer, 2009). The principle of "giving up the struggle" may be specifically helpful to the substance-abusing population as it reflects or mimics the Alcoholics Anonymous theme of the "gift of desperation" (Alcoholics Anonymous, 2001). Learning how to submit to the struggle, experience the feeling of pain, tolerate it, and take action in response to it in a compassionate way, without judgment, may be specifically helpful for individuals in the battle of overcoming addiction. Petersen and Zettle (2009) attempted to examine in-patients with comorbid depression and alcohol consumption and compared them with the usual counterparts. Results revealed that the patients, while using *acceptance and commitment therapy* (ACT) which incorporates mindfulness, had met the criteria for discharge from hospitalization with less consultation or therapy meetings, and within a shorter period of time.

Excessive alcohol consumption had been linked with impaired coping methods and negative affect such as depression (Camatta & Nagoshi, 1995). According to Wilson and Byrd

(2005), alcohol consumption is an attempt to remove, weaken, or reduce painful experiences such as thoughts, emotions, bodily sensations, and behavioral predispositions. Leary et al. (2007) proved that substance abusers who seek treatment might find interventions that increase their level of self-compassion. Self-compassion is beneficial as it incorporates mindfulness and allows awareness of personal faults and mistakes (e.g., relapses) without being judgmental or becoming overwhelmed by self-talk, shame, or self-judgment. Substance users who keep a compassionate orientation towards their own impurities or failures are more likely to take healthy approaches to address these in an effective way.

Considering all the aforementioned perspectives, findings, and models, the current researcher attempted to demonstrate that self-compassion has direct and indirect influences on alcohol consumption, being mediated by stress and depression. In addition, this study targeted the population of Thai businessmen because they form the cornerstone of prosperity in Thai society. This unique population creates the resources that permit social development and welfare across the country.

The following Figure 1 presents the conceptual framework or direction of the present investigation.

Conceptual Framework

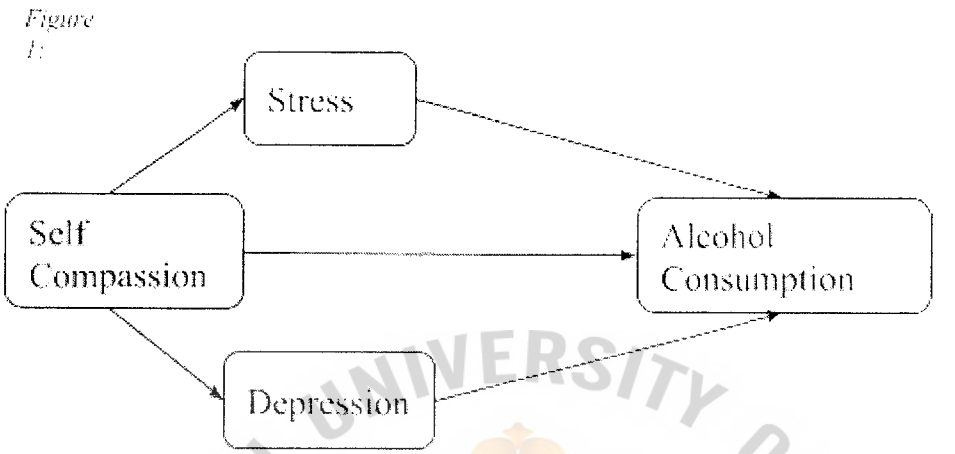

Figure 1. The conceptual framework of the study.

Research Questions

Based on the conceptual framework and review of literature, the following research questions were drawn:

1. Does self-compassion directly influence alcohol consumption among Thai businessmen?
2. Does self-compassion indirectly influence alcohol consumption among Thai businessmen, being mediated by stress and depression?

Research Hypotheses

In an attempt to answer the above research questions, the following hypotheses were generated for testing:

H1. Self-compassion directly influences alcohol consumption among Thai businessmen such that the higher their level of self-compassion, the lower will be their level of alcohol consumption.

H2. Self-compassion indirectly influences alcohol consumption among Thai businessmen, being mediated by stress and depression such that the higher their level of self-compassion, the lower will be their level of stress and depression and, subsequently, the lower will be their level of alcohol consumption.

CHAPTER III

Methodology

As gleaned from the conceptual framework (Figure 1), the current study aimed to examine the direct and indirect influences of self-compassion on alcohol consumption, being mediated by stress and depression, through the inferential statistical method of path analysis. This chapter describes details pertaining to the research methodology employed in the conduct of the study, comprising the research design, participants of the study, research instrumentation, data collection procedure, and data analysis.

Research Design

The current study employed a descriptive research type of inquiry to meet the objectives of the study in which a self-report survey questionnaire was utilized in order to obtain information that was subsequently subjected to statistical analysis and interpretation. A cross-sectional survey was the method of choice as the current researcher intended to collect data at one point in time. There was no attempt to control conditions or manipulate variables in the conduct of the study. For the purposes of the study, self-administered questionnaires were distributed to a group of Thai businessmen by means of business networking meetings and email survey. This was done to ensure the most time-efficient and cost-effective system of data collection to ensure a high response rate and ease in reaching potential participants. In both ways, the researcher provided assistance as and when required. Additionally, this study

used the correlation approach via path analysis in order to determine if the targeted population's level of self-compassion can predict their level of alcohol consumption, both directly and indirectly, being mediated by their levels of stress and depression.

Participants of the Study

This study involved the selection of a sample of people from a pre-determined population – Thai businessmen, followed by the collection of data from this population of choice. For the purpose of the study, the researcher used the information gathered from the targeted sample group to make some deductions about the wider population. The subjects of the present study were Thai businessmen who were active in business networking events in the capital city of Bangkok, Thailand. The sampling method allowed the utilization of participants who were close at hand, readily available, and easily accessible. Purposive sampling method was employed.

As the proposed path model was tested via multiple regression analysis, the sample size required was determined by both the power of the statistical test, the effect size of the predictor variables, and the number of predictor variables in the model. Power in multiple regression analysis refers to the probability of detecting as statistically significant a specific level of R-square, or a regression coefficient at a specified significance level (Hair, Anderson, Tatham, & Black, 1995). Effect size is defined as the probability that the predictor variables in the regression model do have a real effect in predicting the dependent variable, i.e., the

sensitivity of the predictor variables. The statistical program G* Power 3 (Faul, Erdfelder, Lang, & Buchner, 2007) was employed to determine the required sample size. Setting the significance level at .05, power at .95, and effect size at .15 (medium) for five predictor variables, the required minimum sample size was determined to be 132. However, in order to enhance the external validity of the obtained findings, it was decided to increase the recommended sample size to approximately 250 respondents.

Research Instrumentation

The research instrument used in this study was a self-administered four-part Thai-translated survey questionnaire (see Appendices). The following section presents a more detailed description of each section of the questionnaire.

Part 1: Personal Information.

The first part of the questionnaire was a researcher-constructed set of questions designed to tap the respondent's demographic characteristics of age, gender, nationality, and ethnicity/religion. The study ethically followed the rule of confidentiality whereby sensitive and personal information not related to the research were not included in the questionnaire.

Part 2: Self-Reported Alcohol Consumption.

In this study, alcohol consumption was measured by presenting the questions: (1) *How many alcoholic drinks do you typically consume on one occasion?* (2) *How many units do you*

drink per month? Respondents were asked to rate their answers using a Likert-type scale.

Part 3: Self-Compassion Scale.

The 26-item *Self-Compassion Scale* (SCS) developed by Neff (2003b) is a self-reporting test designed to measure the levels of self-compassion in adult participants. There are three measurable components in self-compassion, each being measured by two sub-components, while one is reversed scored. The six sub-components are self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification. Items include: *"I try to be loving towards myself when I'm feeling emotional pain"* (self-kindness); "*When I fail at something important to me, I become consumed by feelings of inadequacy"* (self-judgment); *"I try to see my failings as part of the human condition"* (common humanity); *"When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world"* (isolation); *"When something upsets me, I try to keep my emotions in balance"* (mindfulness); "*When I'm feeling down, I tend to obsess and fixate on everything that's wrong"* (over-identification).

Inspecting the mean of each subscale and adding the subscales together yielded the total self-compassion score. According to the scale developer Neff (2003b), there have been several studies that confirmed the validity and reliability of this scale, However, in this current investigation, the researcher calculated only the total score. Each item on the self-compassion scale was measured using a five-point Likert scale where 1 = *Almost Never* to 5 = *Almost Always,* with total scores ranging from 26-130. Higher scores indicate greater levels of self-compassion and low levels of self-judgment. The SCS was found to have good internal

consistency ($\alpha = .92$) and excellent construct validity, as evidenced by high correlations with self-esteem in a sample of college students (Neff, 2003b).

Part 4: Depression, Anxiety, and Stress Scales.

The original 21-item *Depression, Anxiety, and Stress Scales* (DASS-21) developed by Lovibond and Lovibond (1995) aimed to measure the negative emotional states of depression, anxiety, and stress. The DASS-21 consists of three subscales and was created to allow relatively clear measurements of the three common interrelated negative affective states. Every subscale is structured by seven items highlighting negative affective symptoms experienced by the subject. Each item was to be scored on a four-point Likert scale using the following ratings: 0 = *Did not apply to me at all, or never;* 1 = *Applied to me to some degree, or some of the time*; 2 = *Applied to me to a considerable degree, or a good part of the time*; and 3 = *Applied to me very much, or most of the time.* As this study did not deal with the anxiety component, the final score for each of the subscale of depression and stress was measured by summing up the items that made up the subscale. With anxiety being beyond the scope of this study, it was deemed necessary to utilize only 14 items out of the original 21.

In their study, Lovibond and Lovibond (1995) administered the DASS-21 to a sample of 2,914 adults in an attempt to norm the scale. The mean of depression, anxiety, and stress subscales were 6.34, 4.7, and 10.11, respectively, the standard deviations were 6.97, 4.91, and 7.91. Moreover, a clinical sample reported means of 10.65, 10.90, and 21.1, respectively, with standard deviations of 9.3, 8.12, and 11.15. From a clinical sample of 437 participants, the DASS-21 showed excellent internal consistency, with Cronbach's alphas of .96, .89, and .93

for depression, anxiety, and stress, respectively. By the same token, test-retest reliability coefficients over a two-week period were .71, .79, and .81 for depression, anxiety, and stress, respectively.

Instrument translation.

The Part 1: Personal Information and Part 2: Self-Reported Alcohol Consumption were created specifically for this research and translated from English to Thai and back-translated to English to ensure that the translation was accurate. The Part 3: Self-Compassion Scale was sent to the researcher by the developer of this scale, Kristin Neff, PhD with a note that this scale was never validated in Thailand. The current researcher used the Thai-translated scale although it was not validated. A pre-test was performed on a sample of 18 participants to make sure all the items were understood properly before conducting the research. The Thai-translated Part 4: Depression, Anxiety, and Stress Scale was retrieved from the Chulalongkorn University Library.

Data Collection Procedure

The researcher attended Thai businessmen networking meetings/events during which attendees were asked to participate in the study. No incentives were offered and the businessmen were requested to contribute their anonymous information out of goodwill. In addition, in order to ensure that the researcher met the amount of subjects needed for the study, survey questionnaires were sent out via email. The estimated duration for data

collection was approximately four weeks. Upon completion of the data gathering exercise, the researcher examined every completed questionnaire to rule out any obvious errors, and used only the valid questionnaires for statistical analysis. In this process about 30 questionnaires found to be invalid: incomplete or had not been completed as instructed.

Data Analysis

Data analysis was conducted through the following statistical methods:

Descriptive statistics.

Descriptive statistics was applied in order to present the frequency and percentage distribution of the demographic data obtained from the respondents. Furthermore, the means and standard deviations of scores derived from the survey questionnaire were calculated and, subsequently, presented in the next chapter.

Inferential statistics.

Path analysis through multiple regression analysis was used to test the hypothesized direct and indirect impacts of self-compassion on alcohol consumption among Thai businessmen in Bangkok, being mediated by their levels of depression and stress.

CHAPTER IV

Results

This chapter presents the results of the analyses conducted to test the hypotheses generated from the path model (see Figure 1). Descriptive statistics for the variables of self-compassion, depression, stress, and alcohol consumption are also presented. The analyses conducted and the results obtained are presented in the following sequence:

1. Demographic profile of respondents
2. Reliability test of items that represent the factors of self-compassion, depression, and stress
3. Means and standard deviations of the factors of self-compassion, depression, and stress

1. Path analysis was conducted via three regression analysis first with alcohol consumption as the dependent variable and the rest as the predictors, second stress as the dependent and self compassion as the predictor and third depression as the dependent and self compassion as the predictor to test the hypothesized path model (Figure 1)

Demographic Profile of Respondents

The sample consisted of 266 male Thai businessmen, aged between 21 to 77 years, who are all active in business networking events in the capital city of Bangkok, Thailand.

Reliability Analysis of Scales Employed

Reliability analysis was conducted on the scales of measures of self-compassion, depression, and stress. The purpose of the reliability analysis was to maximize the internal consistency of the three measures by identifying those items that are internally consistent (i.e., reliable), and to discard those items that are not. The criteria employed for retaining items are: (1) any item with 'Corrected Item-Total Correlation' (I-T) $\geq .33$ will be retained ($.33^2$ represents approximately 10% of the variance of the total scale accounted for), and (2) deletion of an item will not lower the scale's Cronbach's alpha (Hair, Black, Babin, & Anderson, 2010).

Table 1 presents the retained items for the three scales, together with their I-T coefficients and Cronbach's alphas.

Table 1

Scale Items Together With Their Corrected Item-Total Correlations and Cronbach's Alphas

Self-compassion	**Corrected Item-Total Correlations**
I'm disapproving and judgmental about my own flaws and inadequacies.(SCS1)	.42
When I'm feeling down, I tend to obsess and fixate on everything that's wrong. (SCS2)	.55
When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world. (SCS4)	.70
When I fail at something important to me, I become consumed by feelings of inadequacy. (SCS6)	.55
I'm intolerant and impatient towards those aspects of my personality I don't like. (SCS11)	.52
When I'm feeling down, I tend to feel like most other people are probably happier than I am. (SCS13)	.57
When I see aspects of myself that I don't like, I get down on myself. (SCS16)	.55
When I'm really struggling, I tend to feel like other people must be having an easier time of it. (SCS18)	.54
When something upsets me, I get carried away with my feelings. (SCS20)	.60
When something painful happens, I tend to blow the incident out of proportion. (SCS24)	.54
When I fail at something that's important to me, I tend to feel alone in my failure. (SCS25)	.55
Cronbach's Alpha =.861	

Stress	Corrected Item-Total Correlations
I found it hard to wind down. (DASS21-1)	.50
I tended to over-react to situations. (DASS21-4)	.46
I felt that I was rather touchy. (DASS21-5)	.57
I found it difficult to relax. (DASS21-7)	.53
I felt that I was using a lot of nervous energy. (DASS21-8)	.61
I was intolerant of anything that kept me from getting on with what I was doing. (DASS21-10)	.49
I found myself getting agitated. (DASS21-13)	.38
Cronbach's Alpha = .78	

Depression	Corrected Item Total Correlations
I couldn't seem to experience any positive feeling at all. (DASS21-2)	.46
I felt that I had nothing to look forward to. (DASS21-6)	.52
I felt down-hearted and blue. (DASS21-9)	.48
I was unable to become enthusiastic about anything. (DASS21-11)	.58
I felt I wasn't worth much as a person. (DASS21-12)	.47
I felt that life was meaningless. (DASS21-14)	.55
Cronbach's Alpha = .77	

As can be seen from Table 1, only 11 items (out of 26) were retained to represent the measure of self-compassion; all the 7 items were retained to represent the measure of stress; 6 items were retained (out of 7) to represent the measure of depression. The computed Cronbach's alpha coefficients for all three scales were adequate and ranged from .77 to .86. Each of the factors of self-compassion, stress, and depression was, subsequently, computed by summing across the items that make up that factor. Alcohol consumption was measured as the number of units consumed per month. The means and standard deviations of all the variables were computed.

Means and Standard Deviations for the Four Computed Factors

Table 2 presents the means and standard deviations for the four computed factors of self-compassion, stress, depression, and alcohol consumption.

Table 2

Means and Standard Deviations for the Four Computed Factors

	Mean	SD	Mid-point
• Self-compassion	3.40	0.68	3.00
• Stress	1.88	0.52	2.50
• Depression	1.73	0.53	2.50
• Alcohol consumption	4.83	1.05	4.00

Table 2 presents the means and standard deviations for the four computed factors and their mid-point. Based on the mean, it is clear that the participants reported having above average levels of self-compassion and low levels of stress and depression. Their alcohol consumption was above average as their score was above the mid-point. Alcohol consumption was measured by means of a five-point scale where respondents were asked how many units they consumed per month and score 1 was given to those who typically do not drink and 2 for one unit, 3 for two units, 4 for three units, 5 for four units, 6 for five units, and 7 for more than five units. A total of 46 (17.3%) reported that they typically do not drink, 21 participants (7.9%) reported that they drink a unit per month on average, 21 participants (7.9%) reported that they drink two units per month on average, 16 participants (6%) reported that they drink three units per month on average, 23 participants (8.3%) reported that they drink four units per month on average, 19 participants (7.1%) reported that they drink five units per month on average, and 120 participants (45%) reported that they drink more than 6 units a month on average. Those who reported more than 5 units a month were asked to specify how many units they consumed per month and of the 120 (45%) participants, 31 participants reported 5-10 units per month, 68 participants reported 11-20 units of per month, 10 participants reported 21-25 units per month, 2 participants reported as much as 30 units per month, and 2 as much as 35 units per month. When asked about their religion and ethnicity 35 (13.2%) reported being Thai, 165 (62%) reported being Buddhist, 55 (20.7%) reported being Christian, 1 (.4%) being Muslim, and 10 (3.8%) being 'others'.

Path Analysis to Test the Hypothesized Path Model

In order to test the hypothesized direct and indirect relationships represented by the path model (see Figure 1), path analysis via regression analysis was conducted. The analysis involved: (1) regressing the dependent variable of alcohol consumption by the predictor variable of self-compassion, stress, and depression; (2) regressing the mediator variable of stress by the predictor variable of self-compassion; and (3) regressing the mediator variable of depression by the predictor variable of self-compassion.

The results of path analyses are depicted in Figure 2. In order to aid the interpretation of results, only path coefficients that are statistically significant ($p<.05$) were included in the figure.

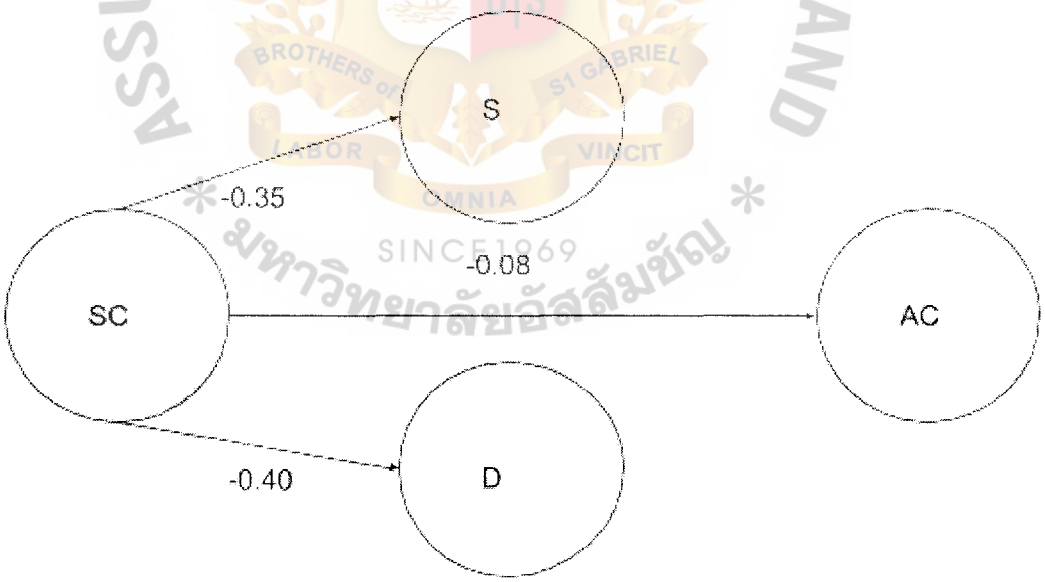

Figure 2. Path model of self-compassion as a function of the direct and indirect influences of alcohol consumption, being mediated by stress and depression.

The findings yielded a significant direct negative influence of self-compassion on alcohol consumption (Beta=0.08;p>0.05). This indicates that the more self-compassionate the participants are, the lower is their tendency to consume alcohol. There was no indirect influence of self-compassion on alcohol consumption mediated by stress (Beta=-0.35;p<0.01; Beta=-0.09;p>0.05) and by depression (Beta=-0.40;p<0.01; Beta=0.06;p>0.05). Additionally, self-compassion has a negative influence on stress (Beta=-0.35;p<0.01) and depression (Beta=-0.40;p<0.01). It can, thus, be inferred that the higher the participants' level of self-compassion, the lower are their levels of stress and depression.

CHAPTER V

Discussion

The present study attempted to examine the direct and indirect influences of self-compassion on alcohol consumption, mediated by stress and depression. A total of 266 male Thai businessmen who were active in business networking events in Bangkok, Thailand participated in this investigation. For the purpose of data gathering and subsequent statistical analysis, a four-part Thai-translated survey questionnaire was used. The study employed path analysis to investigate the relationships among the key variables of the study: self-compassion, alcohol consumption, stress, and depression.

This final chapter comprises the following sections: (1) Discussion of findings; (2) Conclusions; (3) Limitations of the study; and (4) Recommendations.

Discussion of Findings

Direct relationship between self-compassion and alcohol consumption.

Path analysis revealed that the participants' level of self-compassion has a significant direct negative relationship with their amount of alcohol consumption.

The current research involved a non-clinical sample. Based on the class mark (mid-point) of the self reported alcohol consumption scale used in this research, it may be that

although some individuals do drink excessively, average Thai businessmen do not show signs of problematic alcohol consumption.

The findings of the current research stand aligned with those of Kristin Neff (2003a) who suggested that turning to self-compassion with soothing self-kindness to ease one's own emotional difficulties should be the coping mechanism of choice for individuals facing difficulties (Neff, 2003a). Past research had shown that many individuals turn to alcohol when facing unpleasant experiences or disturbing feelings as a way to cope with difficult feelings, self-criticism, discomfort, self-awareness, and psychopathology (Camatta & Nagoshi, 1995; Pullen, 1994; Wilson & Byrd, 2005). The current researcher posits that teaching individuals how to treat themselves with kindness may prove to be a valuable tool in helping themselves during difficult times, instead of reaching to alcohol consumption as a coping mechanism.

Influence of self-compassion on stress and depression.

The results of data analysis in this research indicate that self-compassion has a negative influence on stress and depression such that the higher the level of self-compassion in individuals, the lower are their levels of stress and depression.

Self-compassion and depression.

The current findings indicate that self-compassion has a negative influence on depression such that the higher the level of self-compassion in individuals, the lower is their level of depression. This supports Neff's (2011) research results which stated that

self-compassion works behind the scenes to neutralize the possible effects of risk factors and, therefore, self-compassion contributes towards reducing high risk components known to trigger symptoms of depression (Neff, 2011) and, in fact, protects individuals from full blown depression (Luthar et al., 2000).

Germer (2009) who took part in developing the Mindful Self-Compassion Training Course, stated that practicing self-compassion protects individuals from depression. Self-compassion, when applied and practiced in daily life, has the capacity to reduce the impact of aversive life experiences as a tool in an attempt to reduce possible risk of depression (Gilbert & Procter, 2006; Neff, 2011). By the same token, the current research found that there is a significant negative relationship between self-compassion and depression.

Self-compassion and stress.

Self-compassion was found to be negatively associated with a variety of psychological factors including stress (Neff et al., 2007). In researches involving students, it was found that those who reported high levels of mindfulness and kindness among other strengths expressed experiencing lower level of stress (Shapiro, Brown, & Biegel, 2007). The latter study which involved health care professionals (i.e., nurses, physiotherapists, etc.) highlighted the relationship between greater levels of self-compassion and reduced levels of stress (Shapiro et al., 2007). The aforementioned findings clearly supported the current result which demonstrated a negative relationship between self-compassion and stress.

In a related study, stress was found to be significantly negatively correlated to the overall score for self-compassion (e.g., the higher the level of stress reported by the individual, the lower the self-compassion). Stressed individuals judged themselves more harshly, felt more isolated from others, and felt overly responsible for negative events that occurred in their lives (Brooks et al., 2012).

Indirect relationship between self-compassion and alcohol consumption, being mediated by stress and depression.

The current results did not support the research hypothesis, in that the path analysis provided no evidence of an indirect influence of self-compassion on alcohol consumption, being mediated by stress and depression.

The participant of this study were all businessmen; business owners and entrepreneurs active in networking events. In research done by Caird (1993) who researched entrepreneur's personality through psychological tests. The results of the psychological tests resulted with unique characteristics such as internal locus of control, characteristics of risk taking, preference for intuition and thinking, hig need for achievement, control and autonomy (Caird, 1993) This might indicate that the population of businessmen active in networking events, and therefore may be perceived as high achievers, may be having a unique set of charstrics which might provide an explanation of the surprising results.

In the current study, 165 individuals (62% of the research population) defined themselves as Buddhists. Buddha's teaching on the five precepts of Buddhism emphasized

that lay people should avoid taking alcohol and other substances as these can cause carelessness or unmindful behavior. Theravada Buddhism which is being practiced in Thailand, is the closest to the original Buddhist teaching and is being followed by most Thais (95%). Theravada Buddhism teaches that all human experiences are due to change over time, and that individuals' behaviors are rooted in the perception that individuals should not submit carelessly (Tiyavanich, 2003; Weisz et al., 1988).

Thailand's culture is rooted in Buddhism and the teachings of the Buddha in Theravada tradition (Hinayana) are integrated into life in the kingdom. The "Silas Ha" is commonly known in the West as the Five Precepts – a list of five behaviors Buddhist lay people should avoid, namely: destruction of life, taking what is not given, sexual misconduct, speaking words that are not true, and careless consumption of substances (e.g., alcohol and drugs). Lay people are expected to follow these precepts and diligent participants are expected to not consume alcohol (Assanangkornchai et al., 2010).

A great amount of research had been done in the past on the impact of religiosity on alcohol consumption and drug use, mostly among Christians, Muslims, Hindus, and Sikhs (Gartner, Larson, & Allen, 1991). A study by Ano and Vasconcelles (2005) found that religious practice can serve as a productive coping mechanism. Further studies revealed that religious practice alters the relationship between depression and alcohol consumption (Armeli, Conner, Cullum, & Tennen, 2010; Gonzalez, Bradizza, & Collins, 2009). These findings may provide an explanation for the indirect relationship between depression and alcohol consumption in the current research in which the vast majority (83%) of participants described

themselves as Buddhist or Christian, therefore, religious. Stoltzfus and Farkas (2012) attempted to examine alcohol use, daily hassles, and religious coping among students and reported that positive religious coping, in which a person turns to religion when experiencing stress, weakens alcohol consumption significantly.

Conclusions

Based on the findings of this study, the following conclusions were drawn:

1. There is a direct negative relationship between self-compassion and alcohol consumption among Thai businessmen.
2. Self-compassion has a negative influence on stress among Thai businessmen.
3. Self-compassion has a negative influence on depression among Thai businessmen.
4. There is no indirect relationship between the level of self-compassion and alcohol consumption, mediated by stress and depression, among Thai businessmen.

Limitations of the Study

As the current researcher is a non-Thai speaker, there may be a language barrier during the conduct of the study. This researcher's capacity to speak Thai is limited and, therefore, a native Thai speaker was requested to assist in explaining the purpose of the research to potential participants. Thus, the distribution of the survey questionnaire and dealing with queries about the survey was mostly accomplished by the Thai-speaking research assistant. It was difficult to discern whether the information given to participants was accurate or not.

Another issue noticed in the aftermath was that the full names of the measures were clearly identified as section titles in the questionnaire (e.g., Depression, Anxiety, and Stress Scales). This may have caused many participants to adjust their ratings to put themselves in a better social light and not to lose face (a typical Asian trait). The survey touched on subject matters that are still considered taboo in Thai society (e.g., alcohol use, stress, and depression).

Another limitation could be the fact that the survey was administered in networking events where businessmen come together to discuss matters pertaining to business and commerce, with the goal to make more money. Hence, suspending their business interests to allow time for the survey may have been seen by many participants as a waste of time and, consequently, a waste of money. It was observed that about 30 of questionnaires were not completed properly and, therefore, were not included in the process of data analysis. This

researcher is assuming that many participants simply rushed through the survey and, perhaps, completed the exercise with lack of commitment.

An additional point touching the population of this research is that this research was administered on a sample of Thai businessmen active in business networking events, which might differ them from other businessmen in Bangkok in a way that this sample may be defined as high functioning sub-group and therefore may not provide information about the general Thai business population .

Although the Thai-translated versions of the Western instruments had been used within the Thai setting in the past, the survey questionnaire may not be fully suitable when examining Thai populations due to different response styles that are culturally-based. Both the DASS-21 and the Self-Compassion Scale contain many western phrases and expressions which may not be translated with the same spirit into the Thai language. The cultural interpretation and cultural response style may cause biases in the research (Heine, 2012).

Smith (2004) suggested that cultural tendencies in response styles exhibited while participating in surveys may be rooted in deeper psychological constructs that may indicate fundamental differences in the way different cultures construe themselves and their social world. Cross-cultural research had concluded that there are differences in response styles across cultural groups (Hamamura, Heine, & Paulhus, 2008). This study raised concerns about the possible contaminating effect of response styles in cross-cultural research and, as a result, biased research results.

The findings of the current study should be interpreted with some caution because of some intervening or limiting factors beyond the scope of this study. Nonetheless, despite some identified limitations, it is anticipated that this study would provide valuable knowledge and database for a number of individuals and groups who are involved in mental health services, including counselors and psychologists within the Thai context. The contribution of this study towards expansion of the literature on the impact of self-compassion on alcohol consumption – a topical problem in most societies – cannot be overemphasized.

Recommendations

Research on self-compassion is still young and has been accomplished mainly in Western countries such as the United States and the United kingdom. The vast majority of current research theory is based on Western studies and may not yet be fully suitable for use with Asian populations. In the current research, items 3, 5, 7, 8, 9, 10, 12, 14, 15, 17, 19, 21, 23, and 26 were removed from the Self-Compassion Scale in order to maintain reliability in the statistical analysis. It is also important to note that the Thai-translated Self-Compassion Scale, although used in previous research in Thailand, has not yet been validated. The Thai version may be worth validating before further use in research among Thai populations. Furthermore, re-checking and improving the quality and accuracy of translation of the instruments used in this study is an avenue worth considering by future researchers.

In light of the current research results, it is clear that self-compassion has a direct negative influence on alcohol consumption, stress, and depression. Since self-compassion is a

topic of growing research interest (Brooks et al., 2012), it would be interesting to investigate the key variables with the inclusion of coping styles in the equation. In addition, it would be of great benefit to psychological science to examine the impact of mindful self-compassion training/intervention on alcohol consumption, stress, and depression and, more importantly, examine whether individuals whose self-compassion improved over time also reported improvement in depression, stress, and alcohol use at follow-up.

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APPENDIX A

Survey Questionnaire; consent

Hello,

My name is Lihi, I am a Master's student at the graduate school of psychology at Assumption University. I would like to ask you to participate in a study I am currently conducting about self-compassion and it's effect.

The questionnaire I will shortly hand to you is anonymous so please do not write your name on it. All the information in this questionnaire will be kept confidential; only the researcher and her advisor; Dr. Parvarthy Varma will have access to it, and all the information will be used only for the purpose of this research. All answers will be combined together with the rest of the participants of this study and there will be no way to identify any person who completed it.

There are no right or wrong answers. I would like to ask everyone to complete all parts of the questionnaire so please do not leave any blank answers.

Thank you for you time and your willingness to support my study.

Lihi Darnell

Graduate School of Psychology

Assumption University

APPENDIX B

Part 1. Personal Information

Directions: For each of the following items, please tick (√) the appropriate space provided and answer the other item questions accordingly.

1	Age:	
2	Gender: ( ) Male ( ) Female ( ) Other:	
3	Nationality:	
4	Ethnicity/ Religion:	Examples: *Thai/ Thai Chinese/ Thai Buddhist/ Thai Christian/ Thai Muslim*

Personal Information in Thai Language:

ส่วนที่ 1 ข้อมูลส่วนบุคคล

กรุณาใส่ √ ในช่องคำตอบที่เหมาะสม

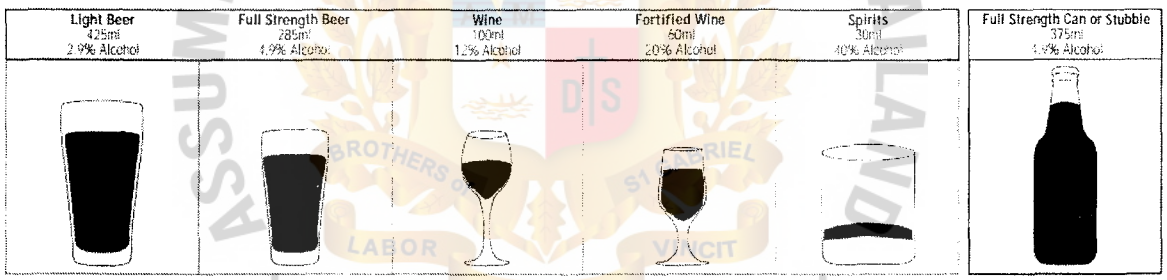
1	อายุ:	
2	เพศ: ( ) ชาย ( ) หญิง ( ) อื่นๆ:	
3	สัญชาติ:	
4	เชื้อชาติ/ศาสนา:	ตัวอย่าง ไทย/จีน/พุธ/คริสเตียน/มุสลิม

APPENDIX C

Part 2. Self-Reported Alcohol Consumption

Directions: For each of the following items, please circle (O) the appropriate number.

How many units of alcoholic drinks do you typically consume on one occasion?						
Typically Don't Drink	One Unit	Two Units	Three Units	Four Units	Five Drinks	More than five drinks. Please specify number of units:
0	1	2	3	4	5	6



The guide above contains examples of ***one standard drink.*** *A full strength can or stubbie contains* ***one and a half standard drinks***

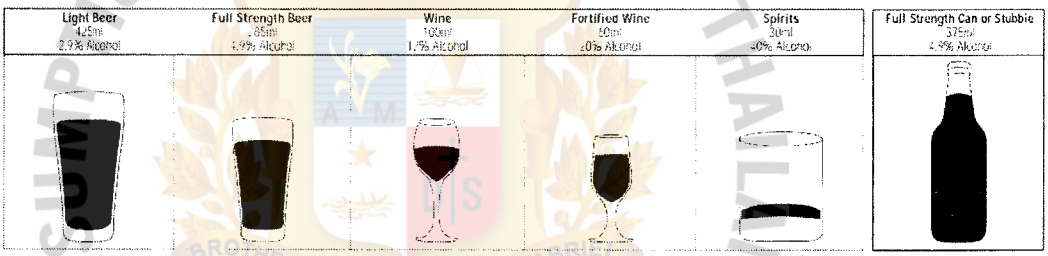
How many units do you drink per month?						
Typically Don't Drink	One Unit	Two Units	Three Units	Four Units	Five Drinks	More than five drinks. Please specify number of units
0	1	2	3	4	5	6

Self-Reported Alcohol Consumption in Thai Language:

ส่วนที่สอง ข้อมูลการบริโภคเครื่องดื่มแอลกอฮอล์ส่วนบุคคล

กรุณาวงกลมคำตอบที่เหมาะสม

ระบุปริมาณเครื่องดื่มแอลกอฮอล์ที่คุณมักจะบริโภคในโอกาสหนึ่งๆ						
ไม่ดื่มเลย	หนึ่งหน่วย	สองหน่วย	สามหน่วย	สี่หน่วย	ห้าหน่วย	ถ้ามากกว่าห้าหน่วย กรุณาระบุจำนวน
0	1	2	3	4	5	6



ระบุปริมาณเครื่องดื่มแอลกอฮอล์ที่คุณบริโภคเฉลี่ยในเวลาหนึ่งเดือน						
ไม่ดื่มเลย	หนึ่งหน่วย	สองหน่วย	สามหน่วย	สี่หน่วย	ห้าหน่วย	ถ้ามากกว่าห้าหน่วย กรุณาระบุจำนวน
0	1	2	3	4	5	6

APPENDIX D

Part 3: Self-Compassion Scale

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Directions: Please read each statement carefully before answering. To the left of each item, indicate how often you bchave in the stated manner, using the following scale:

Almost Never				Almost Always
1	2	3	4	5

___1. I'm disapproving and judgmental about my own flaws and inadequacies.

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

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

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

___ 5. I try to be loving towards myself when I'm feeling emotional pain.

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

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

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

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

___ 10.When I feel inadequate in some way, I try to remind myself that feelings of inadequacy

are shared by most people.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Self-compassion Scale in Thai Language:

คำชี แจง โปรดทำเครื่องหมาย O ในช่องที่พิจารณาแล้วเห็นว่า **ตรงกับตัวท่านมากที่สุด**

ข้อที	ข้อคำถาม	แทบจะไม่เคย 1	น้อยครัง 2	ปานกลาง 3	บ่อยๆ 4	แทบจะทุกครัง 5
1	ฉันรับไม่ได้ และดำหนิข้อบกพร่องของดนเอง	1	2	3	4	5
2	เวลารู้สึกหดหู่ท้อแท้ ฉันมักจะหมกมุ่นและคิดถึงแต่เรื่องด่างๆที่ฉันทำผิดพลาด	1	2	3	4	5
3	เวลามีเรื่องเลวร้ายเกิดขึ้น กับฉัน ฉันมองว่ามันเป็นส่วนหนึ่งของชีวิดที่ทุกคนด้องประสบ	1	2	3	4	5
4	เมื่อนึกถึงข้อบกพร่องของดนเอง ฉันมักจะรู้สึกโดดเดี่ยวและแปลกแยกเหมือนถูกดัดขาดออกจากคนอื่นๆในโลก	1	2	3	4	5
5	เวลาที่ฉันรู้สึกปวดร้าวใจ ฉันจะพยายามรักและใส่ใจดูแลตนเอง	1	2	3	4	5
6	เมื่อฉันทำเรื่องสำคัญๆล้มเหลว ฉันจะจมอยู่ในห้วงความรู้สึกว่าดัวเองไม่ดี่พอ	1	2	3	4	5
7	เมื่อรู้สึกหดหู่ ฉันมักจะเดือนดนเองว่ายังมีผู้คนอีกมากมายในโลกนีที่รู้สึกเช่นเดียวกับฉัน	1	2	3	4	5

ข้อที	ข้อคำถาม	แทบจะไม่เคย 1	น้อยครั้ง 2	ปานกลาง 3	บ่อยๆ 4	แทบจะทุกครั้ง 5
8	เมื่อเกิดปัญหาหรือมีความยุ่งยากต่างๆ เกิดขึ้น ฉันมักจะโทษตัวเอง	1	2	3	4	5
9	เมื่อมีอะไรมาทำให้ฉันรู้สึกหงุดหงิด ไม่มีความสุข ฉันพยายามควบคุมอารมณ์ให้เป็นปกติ	1	2	3	4	5
10	เมื่อฉันรู้สึกบกพร่องในเรื่องใดเรื่องหนึ่ง ฉันพยายามเตือนตนเองว่า คนส่วนใหญ่ก็เป็นเช่นเดียวกัน	1	2	3	4	5
11	ฉันทนไม่ได้และหงุดหงิดต่บุคลิกลักษณะของฉันที่ฉันไม่ถูกใจ	1	2	3	4	5
12	เมื่อฉันพบเจอช่วงเวลาที่ยากลำบาก ฉันดูแลถนอมจิตใจตนเองอย่างที่ควรเป็น	1	2	3	4	5
13	เมื่อฉันรู้สึกหดหู่ ฉันมักรู้สึกว่าคนอื่นๆ อาจจะมีความสุขกว่าฉัน	1	2	3	4	5
14	เมื่อมีเรื่องมาทำให้ฉันเจ็บปวดใจ ฉันจะพยายามมองเรื่องนั้นอย่างเป็นกลางจากหลายๆแง่มุม	1	2	3	4	5
15	ฉันพยายามมองว่าความล้มเหลวต่างๆ ของฉันเป็นส่วนหนึ่งของความเป็นมนุษย์	1	2	3	4	5
16	เมื่อฉันเห็นตัวตนด้านที่ไม่ถูกใจ ฉันจะตำหนิตนเองอย่างรุนแรง	1	2	3	4	5

	คงมีแต่ฉันเท่านั้นที่ล้มเหลว					
26	ฉันพยายามเข้าใจและยอมรับ บุคลิกลักษณะของตัวเองที่ฉันไม่ถูกใจ	1	2	3	4	5

APPENDIX E

Part 4: Depression, Anxiety, and Stress Scales (DASS - 21) Adaptation

Directions: Please consider each of the statements listed below and then decide how often the situation described in that statement applies to you. Using the rating scale below, please circle (O) the number that best reflects your opinion. There are no right or wrong answers.

0 = Did not apply to me at all

1 = Applied to me to some degree, or some of the time

2 = Applied to me to a considerable degree, or a good part of the time

3 = Applied to me very much, or most of the time

1	I was aware of dryness of my mouth.	0	1	2	3
2	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion).	0	1	2	3
3	I found it difficult to relax.	0	1	2	3
4	I felt that I had nothing to look forward to.	0	1	2	3
5	I felt I wasn't worth much as a person.	0	1	2	3
6	I felt scared without any good reason.	0	1	2	3
7	I found it hard to wind down.	0	1	2	3
8	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat).	0	1	2	3

9	I felt downhearted and blue.	0	1	2	3
10	I felt I was close to panic.	0	1	2	3
11	I was intolerant of anything that kept me from getting on with what I was doing.	0	1	2	3
12	I felt that life was meaningless.	0	1	2	3
13	I found myself getting agitated.	0	1	2	3
14	I found it difficult to work up the initiative to do things.	0	1	2	3

Depression, Anxiety, and Stress Scales (DASS - 21) Adaptation in Thai Language:

โปรดอ่านข้อความแต่ละข้อและวงกลมหมายเลข 0, 1, 2 หรือ 3 ที่ระบุข้อความได้ตรงกับท่านมากสุดในช่วงสัปดาห์ที่ผ่านมา ทั้งนี้ ไม่มีคำตอบที่ถูกหรือคำตอบที่ผิด ท่านไม่ควรใช้เวลามากนักในแต่ละข้อความ.

เกณฑ์การประเมินมีดังนี้:
0 = ไม่ตรงกับข้าพเจ้าเลย
1 = ตรงกับข้าพเจ้าบ้าง หรือเกิดขึ้นเป็นบางครั้ง
2 = ตรงกับข้าพเจ้า หรือเกิดขึ้นบ่อย
3 = ตรงกับข้าพเจ้ามาก หรือเกิดขึ้นบ่อยมากที่สุด

1	ข้าพเจ้ารู้สึกว่ายากที่จะผ่อนคลายอารมณ์	0	1	2	3
2	ข้าพเจ้ารู้สึกไม่ดีขึ้นเลย	0	1	2	3
3	ข้าพเจ้ารู้สึกว่าทำกิจกรรมด้วยตนเองได้ค่อนข้างสำบาก	0	1	2	3
4	ข้าพเจ้าเริ่มมีปฏิกิริยาตอบสนองต่อสิ่งต่าง ๆ มากเกินไป	0	1	2	3
5	ข้าพเจ้ารู้สึกว่าข้าพเจ้าวิตกกังวลมาก	0	1	2	3

6	ข้าพเจ้ารู้สึกว่าข้าพเจ้าไม่มีเป้าหมาย	0	1	2	3
7	ข้าพเจ้าเริ่มรู้สึกว่าข้าพเจ้ามีอาการกระวนกระวายใจ	0	1	2	3
8	ข้าพเจ้ารู้สึกไม่ผ่อนคลาย	0	1	2	3
9	ข้าพเจ้ารู้สึกจิตใจเหงาหงอยและเศร้าซึม	0	1	2	3
10	ข้าพเจ้าทนไม่ได้กับภาวะใดก็ตามที่ทำให้ข้าพเจ้าไม่สามารถทำอะไรต่อจากที่ข้าพเจ้ากำลังกระทำอยู่	0	1	2	3
11	ข้าพเจ้าไม่รู้สึกกระตือรือร้นต่อสิ่งใด	0	1	2	3
12	ข้าพเจ้ารู้สึกเป็นคนไม่มีคุณค่า	0	1	2	3
13	ข้าพเจ้ารู้สึกว่าข้าพเจ้าค่อนข้างมีอารมณ์ฉุนเฉียวง่าย	0	1	2	3
14	ข้าพเจ้ารู้สึกว่าชีวิตไม่มีความหมาย	0	1	2	3

APPENDIX F

Reliability

Scale: Self compassion

Case Processing Summary

		N	%
Cases	Valid	266	100.0
	Excluded[a]	0	.0
	Total	266	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.861	11

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
SCS_1	33.72	50.345	.419	.859
SCS_2	33.96	48.161	.551	.850
SCS_4	33.90	44.612	.703	.838
SCS_6	34.15	46.760	.550	.850
SCS_11	33.99	47.958	.520	.852
SCS_13	34.08	45.960	.572	.848
SCS_16	33.90	47.862	.550	.850
SCS_18	33.87	47.523	.535	.851
SCS_20	34.21	46.753	.607	.846
SCS_24	33.88	46.846	.537	.851
SCS_25	33.80	46.430	.554	.850

Scale: stress

Case Processing Summary

		N	%
Cases	Valid	266	100.0
	Excluded[a]	0	.0
	Total	266	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.778	7

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
DASS21_1	11.36	10.095	.501	.750
DASS21_4	11.27	10.162	.465	.757
DASS21_5	11.20	9.609	.569	.736
DASS21_7	11.27	9.987	.530	.745
DASS21_8	11.33	9.475	.606	.728
DASS21_10	11.26	10.153	.458	.759
DASS21_13	11.26	10.419	.384	.774

Scale: depression

Case Processing Summary

		N	%
Cases	Valid	266	100.0
	Excluded[a]	0	.0
	Total	266	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.765	6

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
DASS21_2	8.66	7.757	.461	.742
DASS21_6	8.41	6.847	.518	.730
DASS21_9	8.56	7.530	.482	.736
DASS21_11	8.51	6.990	.579	.710
DASS21_12	8.75	7.817	.466	.740
DASS21_14	8.92	7.504	.548	.721

Regression

Variables Entered/Removed[a]

Model	Variables Entered	Variables Removed	Method
1	stress, self compassion, depression[b]	.	Enter

a. Dependent Variable: How many units do you drink per month?
b. All requested variables entered.

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.209[a]	.043	.033	2.353

a. Predictors: (Constant), stress, self compassion, depression

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	65.920	3	21.973	3.970	.009[b]
	Residual	1450.125	262	5.535		
	Total	1516.045	265			

a. Dependent Variable: How many units do you drink per month?
b. Predictors: (Constant), stress, self compassion, depression

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	6.513	1.178		5.530	.000
	self compassion	-.624	.233	-.178	-2.683	.008
	stress	-.041	.375	-.009	-.108	.914
	depression	.295	.372	.066	.792	.429

a. Dependent Variable: How many units do you drink per month?

Regression

Variables Entered/Removed[a]

Model	Variables Entered	Variables Removed	Method
1	self compassion[b]	.	Enter

a. Dependent Variable: stress
b. All requested variables entered.

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.350[a]	.123	.119	.48537

a. Predictors: (Constant), self compassion

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	8.692	1	8.692	36.897	.000[b]
	Residual	62.193	264	.236		
	Total	70.885	265			

a. Dependent Variable: stress

b. Predictors: (Constant), self compassion

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.781	.151		18.378	.000
	self compassion	-.265	.044	-.350	-6.074	.000

a. Dependent Variable: stress

Regression

Variables Entered/Removed[a]

Model	Variables Entered	Variables Removed	Method
1	self compassion[b]	.	Enter

a. Dependent Variable: depression
b. All requested variables entered.

Model Summary

Model	R	R Square	Adjusted R	Std. Error of

			Square	the Estimate
1	.397[a]	.157	.154	.48926

a. Predictors: (Constant), self compassion

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	11.794	1	11.794	49.267	.000[b]
	Residual	63.19 6	264	.239		
	Total	74.990	265			

a. Dependent Variable: depression
b. Predictors: (Constant), self compassion

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.777	.153		18.207	.000
	self compassion	-.309	.044	-.397	-7.019	.000

a. Dependent Variable: depression

Descriptives

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Age:	266	21	228	44.43	15.811
How many units do you drink per month?	266	1	7	4.83	2.392
self compassion	266	1.27	4.82	3.3951	.68232
stress	266	1.00	3.86	1.8797	.51720
depression	266	1.00	3.50	1.7274	.53196
Valid N (listwise)	266				

DESCRIPTIVES VARIABLES=Age Units_drink_month selfcompassion stress depression
/STATISTICS=MEAN STDDEV MIN MAX.

Descriptives

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Age:	266	21	77	43.68	11.103
How many units do you drink per month?	266	1	7	4.83	2.392
self compassion	266	1.27	4.82	3.3951	.68232
stress	266	1.00	3.86	1.8797	.51720
depression	266	1.00	3.50	1.7274	.53196
Valid N (listwise)	266				

Correlations

		alcohol	self compassion	Depression	stress
alcohol	Pearson Correlation	1	.132	.191**	.116
	Sig. (2-tailed)		.052	.004	.087
	N	219	219	219	219
self compassion	Pearson Correlation	.132	1	-.007	-.002
	Sig. (2-tailed)	.052		.916	.971
	N	219	219	219	219
Depression	Pearson Correlation	.191**	-.007	1	.667**
	Sig. (2-tailed)	.004	.916		.000
	N	219	219	219	219
stress	Pearson Correlation	.116	-.002	.667**	1
	Sig. (2-tailed)	.087	.971	.000	
	N	219	219	219	219

**. Correlation is significant at the 0.01 level (2-tailed).