A portfolio of research work, including an investigation into how heterosexual Generation X males experience internet pornography

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Submitted to the University of Surrey in partial fulfilment of the degree of Practitioner Doctorate (PsychD) in Psychotherapeutic and Counselling Psychology

July 2017

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Statement of anonymity

All names, identities, and identifying information have been replaced by pseudonyms, altered, or omitted, to preserve the confidentiality and anonymity of clients and research participants.
Acknowledgements

Many people have supported me throughout this journey. I would like to thank my doctoral peers, in particular Jake Elwood, who has been alongside me, as a student and friend, from the beginning of my MSc, and who has always been a rock of support.

I would also like to thank my research supervisors (Dr Riccardo Draghi-Lorenz, Dr Michele Birtel and Dr Ben Rumble) for their guidance on my projects, and all of those who took part in the studies. I have also been privileged to work with fantastic clinical supervisors.

Thank you also to all of the clients I have worked with. Your stories have touched my life deeply and made me into the therapist and person I am today.

My family have been incredibly supportive, both emotionally and financially. Thank you so much Mum, Dad, Fiona and Ben.

I am also grateful to my friends for regularly offering me a place to lay my head while working away from home in London. Thank you especially Dan Britcher. You mean the world to me.

A big thank you also to my journalistic colleagues at Sky News who have bent over backwards to offer me shifts which suit my doctoral commitments. I would be more than £100,000 in debt if weren’t for you. It’s good to know Rupert M’s money has gone towards something worthwhile.

Finally, I would like to thank my beautiful partner Harriet Dudley, who made the terrible mistake of starting to date me three months before I began this doctorate. I would not have completed this without you - and I apologise for my many tantrums and meltdowns. You really are a star.
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Abstract

This thesis presents doctoral research while training as a counselling psychologist. My research begins with a brief introduction to three self-contained projects; a literature review, a quantitative research study and a qualitative investigation. The literature review focuses on research into Buddhist-derived compassion meditation and implications for working with children. The second project explores the relationship between Alcoholics Anonymous, self-compassion and shame, while the third piece of work draws on interpretative phenomenological analysis to explore how Generation X males experience internet pornography.
Research Development Dossier

Overview

My research projects encompass three self-contained reports, which embrace different epistemologies and separate topics. They are loosely connected by my interest in the psychological constructs of shame and compassion.

Project 1 - Literature review: ‘Compassion meditation: A review of the literature and implications for use as a psychological intervention in pre-adolescent children’

My literature review on compassion meditation and its implications for working with children emerged from my own interest in this form of Buddhist meditation, developed during a series of retreats over the last decade. The review focused strongly on neurobiological studies, linking these studies to theoretical frameworks of child development. The process of reviewing such studies, in considerable detail, helped me to develop a critical stance to epistemological frameworks, which were underpinned by neuroscientific data. It also endowed me with a preliminary grasp of neurobiological concepts and anatomy, which I have found helpful in some aspects of my clinical work, for example working with children to explain the fight/flight/freeze response, or in presentations of trauma.

The review concluded that Buddhist-derived compassion meditation appeared to impact areas of the brain involved in empathy and safety, and could be a helpful intervention for children, especially those from traumatic backgrounds or those characterised by neglect. Over the past few years I have made connections with the UK's only Buddhist primary school - based in Brighton, where I live - and my plan, upon qualification, is to build upon this review, and these connections, to conduct some psychological research in this area.
Project 2 – Quantitative research: ‘Does participation in the programme of Alcoholics Anonymous predict self-compassion, shame and wellbeing?’

My second project was a quantitative investigation exploring the relationship between self-compassion, shame and the programme of Alcoholics Anonymous. I accessed more than 100 participants, members of AA, in a questionnaire-led, cross-sectional study. Here I was able to develop my knowledge of SPSS, and how to conduct and report on regression analyses, using several variables, as well as test mediation models. I also learned, in more depth, how to evaluate the limitations of this epistemological approach.

I felt research in this area could prove especially useful for the CoP profession. This is especially true given the increasing number of AA members who are accessing therapy in conjunction with the 12 Step programme. Working with this population raised several interesting ethical issues relating to dual roles, which are addressed in the report.

As predicted this original research found that participation in particular aspects of AA’s programme was associated with reduced shame and that this was mediated by increased self-compassion. Overviews of the research have attracted favourable attention from compassion researchers, and I will be submitting this project for publication, when I have some time.

Project 3 – Qualitative research: ‘How do heterosexual Generation X males experience internet pornography? An Interpretative Phenomenological Analysis’

My third research project was a phenomenological investigation into how males, who identify as heterosexual, and from a certain generational cohort - defined as Generation X (born between 1961 and 1981) - experienced internet pornography. This was driven by a particular interest in male mental health, and a personal curiosity stemming from my observation that none of my male friends or colleagues spoke about their experience with this medium. Also, this generational cohort of males has been largely
neglected in the psychological literature and it felt like an appropriate project to undertake given evidence suggesting this population may be especially prone to distress.

Although I was apprehensive about how willing participants would be to reveal their lived experience, I was pleased with how vivid and rich the accounts of my sample were. Moreover, I particularly enjoyed the research process, as it enabled me to connect with, and appreciate my participants, in ways that I could not do before with the correlational study. I also enjoyed exploring the nuances of language and meaning, as well as writing the project up, a process, that overall, I felt had some similarities with the best, most ethical parts of my previous career as a journalist. The findings revealed that, unlike more recent generational cohorts in previous studies, males in this sample felt many tensions arising from viewing internet pornography, especially relating to their ages. In compelling detail, they described how it impacted their capacity for intimacy, sense of self and starting relationships. I discuss the accounts with reference to prominent theories of masculinity, ageing and dissonance and raise implications for clinicians. Again, this study has attracted some attention in terms of publication.
Project 1. Compassion meditation: A review of the literature and implications for use as a psychological intervention in pre-adolescent children

Supervised by Dr Riccardo Draghi-Lorenz

Word count: 9898

For submission to Child Development

See Appendix 1 for Journal Notes to Contributors
Abstract

Tightening NHS budgets have increased emphasis on early intervention strategies for mental health, and research suggests mindfulness meditation is an appropriate intervention for children. Lately, psychologists have investigated the psychological impact of compassion meditation in adults and adolescents. However, there is very little empirical research exploring the potential of compassion meditation as an intervention for younger children. The latest research on compassion meditation is reviewed here and implications for use with pre-adolescent children are considered. Preliminary evidence indicates that compassion meditation may enhance emotional regulation, improve empathy skills and lead to pro-social behaviour. Considered within the framework of theories of neuroplasticity and child development, compassion meditation may be a useful intervention for children and further research is encouraged.

Key words: compassion, meditation, mindfulness, loving, kindness, Buddhism, neuroscience
Introduction

The 14th Dalai Lama has quite a temper, apparently. Recalling his early childhood he describes frequent temper tantrums and fights with siblings (Lama, D, 2005). His mother, Diki Tsering, recounts similar episodes: the fiery young monk once hurled a ball made of yak butter at his elder brother during dinner (Tsering, 2000). Today, such childhood tantrums might well have earned the boy a newly fashioned diagnostic label from the recently published DSM-5, (APA, 2013) - disruptive mood dysregulation disorder, for example, and a prescription of anti-depressants. The Dalai Lama (2005) insists, however, that his only medicine was the kindness of his mother – compassion that inspired a lifelong commitment to contemplative forms of meditation. One in 10 children in the UK have a diagnosed mental health condition (CAMHS, 2013), and there are loudening calls for early psychological interventions (Bell, 2011). Recent evidence suggests that mindfulness meditation may be an effective intervention in children with diagnosed with depression, anxiety and ADHD (Harnett & Dawe, 2012). However, research into the benefits of compassion-based meditation – endorsed so strongly by the Dalai Lama – has only just begun. This review evaluates the emerging evidence from the psychological literature on the topic of compassion meditation, and then considers its implications for children. The report is set within the framework of Buddhist contemplative psychology and guided by theories of neuroplasticity and child development, including developmental psychopathology (Schore, 2005).

Background

In October 1987, the 14th Dalai Lama hosted the first conference of the Mind and Life Institute in the North Indian city of Dharamsala. A handful of scientists and one philosopher engaged him in a weeklong discussion on the convergence of cognitive science and Buddhism. The Dalai Lama was so inspired by the discussions that he ordered science be put on the curriculum of Tibetan schools and monastic colleges (Lama, 2005). Since then, leading scientists have met with the Dalai Lama and other
Buddhist scholars in India for mutually enriching discussions. In 2004, the topic for
discussion was neuroplasticity, a subject the Dalai Lama found interesting because of
clear parallels between the idea of a changeable brain and the Buddhist conviction that
the mind can be transformed by mental training (Begley, 2007). News that London taxi
drivers had enlarged hippocampi, which corresponded with their expertise in street
navigation (Maguire, Gadian, Johnsrude, Good, Ashburner, Frackowiak & Frith, 2000)
reportedly met with shrieks of excitement from his Holiness.

Neuroplasticity refers to changes in neural pathways and synapses resulting from
changes in behaviour, the environment and even the way we think (Pascual-Leone,
Amedi, Fregni, & Merabet, 2005). It replaces the previous notion that, aside from critical
periods in childhood, the brain is a static organ (Rakic, 2002) and plasticity is widely
accepted as a core mechanism in healthy development, memory, learning, and recovery
from physical brain damage and psychological trauma (Pascual-Leone et al., 2005).
Experience can change both the brain's structure and functional organisation (Pascual-
Leone, Amedi, Fregni, & Merabet, 2005. The fundamental principle behind plasticity is
linked to synaptic pruning – the idea that individual connections within the brain are
constantly being deleted or created, depending upon how they are used. It can be
summed up by the aphorism that “neurons that fire together, wire together” - rooted in
Hebb’s theory of associative learning (Hebb, 1961).

Putting Buddhist monks in brain scanners has become a popular pastime in recent years:
they have been prodded, poked, burned, shocked and startled. Most of this research
has investigated the neural effects of mindfulness meditation and indicates that, among
other things, practice increases activation in parts of the brain associated with attention
and awareness (for a recent review, see Tang, Hölzel, & Posner, 2015). Such studies
have moulded the development of psychological interventions such as Mindfulness-
based Stress Reduction (MBSR) (Kabat-Zinn, 1994). Practitioners are encouraged to
focus on their breath or bodily sensations, cultivating a new relationship with thoughts
and feelings. Thoughts are seen as mental events and not the truth. While cognitive
therapy (Beck, 1987) encourages individuals to challenge thoughts, mindfulness fosters an accepting, non-judgemental attitude to them (Kabat-Zinn, 1994). Recently, attention has turned towards compassion-based meditations, welcoming a new wave of experts, in their brightly coloured robes, into the laboratories of curious psychologists.

Compassion-based meditation differs from mindfulness meditation in important ways. The latter encourages practitioners to accept feelings that may or may not arise naturally during practice while compassion meditators are encouraged to cultivate certain feelings – those of loving kindness and compassion. In the Buddhist tradition, loving kindness (metta) is a desire for all beings (including the self) to be happy, while compassion (karunaa) embodies a wish for all beings to be free from suffering (Hoffman, Grossman, & Hinton, 2011). Buddhists believe that compassion and loving kindness can be cultivated by practicing meditation, and they are often combined into one compassion-based meditation practice (Salzberg, & Kabat-Zinn, 2004). A typical session may start by imagining feelings of kindness and compassion emerging from the heart. These feelings are then directed to the self, then to a loved one, to a stranger, to an enemy and finally to all beings. Mantras may be recited such as: “May I/you be free from suffering. May I/you be happy. May I/you be loved. May I/you be at peace.” (Salzberg & Kabat-Zinn, 2004). By actually cultivating the feelings of compassion and loving-kindness, it is hoped that meditators will generate insight into the nature of these emotions (Hoffman, 2011). Practice is understood to enhance positive emotions and decrease personal suffering by shifting an individual’s basic view of the self in relation to others, increasing feelings of connection (Lama & Cutler, 1998).

For the purpose of this review compassion, meditation refers to Buddhist-derived meditation practices, which focus on cultivating compassion and/or loving kindness for the self and/or others. Articles were sourced using the computer-based literature search PsychINFO. The review sets out to evaluate the psychological impact of meditation practice. Studies which focus on compassion, without meditation as the main ingredient, are not considered in detail.
Extant Literature

Earlier Review

Hoffman, Grossman, and Hinton (2011) reviewed the literature on compassion meditation to investigate its potential as a psychological intervention. The review identified research which explored the impact of meditation on neural activity, emotional and immune response and mental health disorders. Hutcherson, Sepala and Gross (2008) found that individuals who imagined exchanging loving feelings with loved ones had more positive feelings towards people’s faces on a computer screen (in an implicit priming task) than those who were asked to imagine the physical details of strangers. The researchers suggested that even a brief seven-minute exercise was sufficient to induce feelings of social connection. Fredrickson, Cohn, Coffey, Pek, & Finkel (2008) compared individuals on a seven-week loving kindness course with a waiting list control and found more positive emotions in the former, but no difference in negative emotions. Carson et al. (2005) demonstrated that participants with chronic lower back pain reported more positive emotions, reduced negative emotions and less back pain after a loving kindness meditation course than those offered standard care. Meanwhile Pace et al. (2009) reported that increased compassion meditation was associated with decreased levels of the stress-induced cytokine, interleukin 6, as well as lower subjective anxiety to a performance task. The authors interpret the results as suggesting that compassion meditation reduces subjective and physiological responses to psychosocial stress.

The review (2011) reports on just one study (Lutz, Brefczynski-Lewis, Johnstone, & Davidson, 2008) investigating the neural correlates of compassion meditation. Fifteen meditators with more than 10,000 hours of practice and 15 novices were asked to either meditate or instead rest while being presented with human vocalisations that were positive (a laughing baby), neutral (background noise from a restaurant), or negative (distressed woman). Results indicated that during meditation, activation in the insula
was stronger while hearing negative sounds than positive or neutral sounds in the expert, compared to novices. Meditation was also associated with activation of the dorsal anterior cingulate cortex, the amygdala and the right temporal parietal juncture (TPJ). Lutz and colleagues (2008) explain that the insula has an important role in processing emotions, as does the amygdala, and the TPJ has been implicated in the perception of the emotional states of others (i.e. cognitive empathy). For example, neuroimaging studies suggest that observing or imagining another person's emotional state activates brain circuits, especially the insula and the anterior cingulate cortex, which are involved in processing that same state in oneself (Ruby & Decety, 2004; Singer et al., 2004). Finally, Hoffman et al. (2011) reviews two treatment studies. Gilbert and Proctor (2006) offered nine patients, diagnosed with a personality disorder, 12 weekly sessions of compassion focused therapy (CFT), incorporating elements of cognitive behavioural therapy (CBT) (Beck, 2005), Dialectical Behaviour Therapy (Linehan, 1993) and Acceptance Commitment Therapy (ACT) (Hayes, 2004), along with techniques to develop self-compassion such as, for example the contemplation of compassionate imagery. Three participants dropped out but those that remained reported a significant reduction in anxiety, depression and self-criticism. Another study (Mayhew & Gilbert, 2008) used the same treatment with individuals diagnosed with schizophrenia. Three of seven participants completed the treatment and reported that hostile voices had become less persecutory.

Hoffman concluded that compassion meditation might enhance the activation of brain areas that are involved in emotional processing and empathy, could be a promising intervention for reducing stress and improving mood, dealing with anger issues and interpersonal problems, and could be useful in relationship counselling. However, he noted several limitations; for example, the Frederickson study (2008) did not have an active control group and the treatment studies had small numbers, high dropout rates and no controls. He argued that CFT (see Gilbert, 2009) has little in common with Buddhist forms of meditation and that CFT studies are therefore difficult to evaluate.
within the framework of compassion meditation. It could be added that the intervention in the Carson study also included psycho-education, the cultivation of gratitude and body scan exercises making it difficult to isolate the effects of meditation. More broadly, this review raises important questions about the nature and impact of compassion meditation. For example, how does meditation impact brain activity when individuals are not actually meditating and does it have an enduring influence on mood and behaviour? Also, how does compassion meditation differ in its neural, affective and behavioural impact from mindfulness meditation? This is important because regions of the brain, including the insula, have been implicated in mindfulness studies before (e.g. Holzel et al., 2011). Furthermore, if we accept the point of Hoffman and colleagues that Gilbert’s treatment studies include little actual Buddhist-related meditation there is hardly any direct evidence from this review to indicate that this is an appropriate intervention in clinical populations. Finally, all of the studies so far have looked at adult populations - how appropriate is compassion meditation for children and adolescents?

**Neural correlates**

Following the review by Hoffman and colleagues (2011), several studies have sought to clarify the relationship between compassion meditation, brain activity and related behaviour. For example, the cross-sectional, single case study, design of research by Engstrom and Soderfeldt (2010) limits interpretation but it corroborates findings by Lutz (2008) linking compassion meditation with activity in brain areas including the anterior cingulate gyrus. One expert volunteer - who had been on two loving kindness retreats lasting three years, three months and three days - was observed as she 1) repeated a sentence in Swedish 2) repeated a sentence in Sanskrit or 3) performed compassion meditation while repeating the Buddhist mantra “Om mani padme hum” and visualizing Chenrezig, the four-armed Bodhisattva of compassion. Results indicated that while meditating, and not in other conditions, there was significant activation in the left medial prefrontal cortex (LMPC) extending to the anterior cingulate gyrus (ACG). It is suggested these areas are associated with empathic skills (e.g. Farrow, Zheng &
Wilkinson, 2001) and positive feelings (Rolls, 2009). Before jumping to conclusions, however, it should also be remembered that the LMPC and the ACG have also been associated with attention skills. Indeed, as we have seen, meditators trained in mindfulness meditation only (Holzel et al., 2008) showed similar brain activation patterns. The poorly controlled design means it is difficult to know the extent to which the LMPC and ACG were activated as a result of compassion meditation. Would these patterns have been observed in novices instructed to perform the same practice? Indeed, might the same patterns have been observed if the meditator had simply recited sentences containing words with an emotional valence, such as ‘love’ or ‘friend’? Moreover, the study tells us nothing about how compassion meditation might influence brain activity and subsequent behaviour in a non-meditative state.

An elegant functional magnetic resonance imaging (fMRI) study by Desbordes, Negi, Pace, Wallace, Raison, and Schwartz (2012) addresses some of the issues above, strengthening associations between compassion meditation and neural circuits associated with empathy and emotional regulation. It helps to distinguish the neural correlates of compassion meditation from mindfulness, while focusing on emotional responses in a non-meditative state. Thirty-six novices were randomly assigned to eight-week courses of mindfulness training or cognitively-based compassion training (CBCT) or a health discussion control group. All participants took part in two hours of class time per week. Participants spent 40 minutes of class time meditating and 20 minutes a day meditating outside of class. Before and after the intervention, brain activity of participants was observed and compared as they viewed images of people looking happy, distressed or in a neutral state. The researchers discovered a longitudinal decrease in amygdala response in the mindfulness group, particularly in relation to positive images. Those in the CBCT group, meanwhile, showed a trending increase in right amygdala response to negative images, which, interestingly, was significantly correlated with a decrease in depression score. No longitudinal effects or trends were observed in the control group. The authors suggest that decreased amygdala response
in mindfulness meditators reflects an improvement in attentional ability, which, in turn, reduces the involvement of the amygdala. Another possibility is that mindfulness increases baseline mood (as demonstrated by studies including Brown and Ryan, 2003) making the effect of positive-valence stimuli on the amygdala comparatively weaker (Desbordes et al., 2012). Increased amygdala activation, in compassion meditators, to negative images depicting human suffering, might be explained by a practice-induced enhancement in the capacity to understand the feelings or emotional states of others. Indeed this idea is consistent with several studies which report increased amygdala activation in empathy-related tasks (e.g. Klimecki et al., 2012), as well as the increased amygdala activation in experts in the study by Lutz et al., (2008). Intriguingly, as the authors point out, the inverse relationship between amygdala response and depression appears at first to contradict the well-established association between depression and enhanced amygdala response to negative stimuli (Drevets et al., 2008). However, research also indicates that depression is associated with impaired empathic skills, which improve with remission (e.g. Donges et al., 2005). The association between increased amygdala response and a decrease in depression may therefore be explained by an increased capacity for empathy after compassion training. This study is particularly interesting as it is the first to suggest that different types of meditation have different effects on brain activity, at least in the amygdala. Moreover, these differences are apparent in relative novices in non-meditative states. The evidence also corroborates previous research linking compassion meditation with improved mood (Frederickson et al., 2008) and empathy (Lutz et al., 2008).

The complex nature of the relationship between compassion meditation and emotional responses and the dissociable neural effects of mindfulness and compassion practice are further demonstrated by Lee et al. (2012). Of particular interest is fMRI evidence which may explain how compassion meditation increases sensitivity to emotional stimuli - enhancing empathic skills while at the same time reducing distress (as appears to be the case in the study by Desbordes and colleagues, 2012). Brain activity was observed while
mindfulness and compassion meditators (from novices to experts with up to 17,850 hours of experience) took part in tasks investigating attention (the cognitive performance test, CPT) or emotional processing (the emotional processing test, EPT). During the CPT, participants were asked to press a button as soon as they saw the number zero on a screen; in the EPT, volunteers were asked to rate their arousal to happy, sad and neutral images of humans, animals, objects and scenes. Before the tests, participants were given 30 minutes to enter meditative states. The results indicated that neural responses varied significantly, depending on expertise and the type of meditation practised. Mindfulness meditators showed greater expertise-related improvements in the attention task, reflected by activity in the thalamus, an area associated with attention skills (Lee et al., 2012). Compassion meditators showed the strongest activation to sad pictures in the left caudate and the middle frontal gyrus. Intriguingly, activation in these areas was also negatively correlated with lower self-reported arousal to sad pictures. Lee points out that activity in the left caudate seems to be associated with the arousal level of emotions. At the same time, activity of the middle frontal gyrus is implicated in voluntary and effortful regulation of emotional responses (Phillips, Drevets, & Lane, 2003). It is suggested that compassion meditation might thus be related to elevated emotion reactivity in conjunction with more efficient voluntary emotion regulation. The authors point out that this would be compatible with the idea that emotional regulation helps distinguish empathy from emotional distress (Decety & Jackson, 2004). By cultivating a compassionate, yet controlled, relationship with the suffering of others and the self, meditation may nurture a capacity for more efficient emotional regulation. The association between increased neural response and reduced subjective arousal is consistent with Desbordes et al. (2012), as well as with Buddhist accounts of compassion. The French monk Matthieu Ricard, who has 40 years of meditation experience, wrote that when we “experience a powerful sense of empathy with the suffering of others, our impotent resignation gives way to courage, depression to love, narrow-mindedness to openness toward all around us” (Ricard, 2006, p253).
Another way to consider the effects of meditation on the brain is to look for structural changes, using voxel-based morphometry (VPM). Previous studies have revealed significant changes in brain volume amongst experienced mindfulness meditators. For example, Holzel et al. (2008) found more grey matter in the inferior temporal gyrus of the left temporal lobe and suggested this may reflect increased attentional capacities. Leung, Chan, Yin, Lee, and Lee (2013) conducted the first VPM study on compassion meditation, comparing 10 experts with novices. Results indicated that experts had more grey matter in the left temporal lobe at a trend level, resonating with the previous findings on mindfulness (Holzel et al., 2008). A novel finding, however, was that experts also had more grey matter in the right angular and right posterior parahippocampal gyri. The researchers point out that both these areas have been implicated in neural circuits associated with empathy (Decety and Lamm, 2007). The right angular gyrus is one of the main regions that form the TPJ and is believed to be selectively recruited to understand others’ thoughts, desires and feelings (Saxe and Wexler, 2005). Such a skill is actively encouraged in compassion meditation. Furthermore, Leung et al. (2013) observe that abnormalities in grey matter volume or altered activity in these two regions have also been linked to depression (Gilbert et al., 2010), bipolar disorder (Chen et al., 2011) and schizophrenia (Gradin et al., 2011). Leung speculates that these enlarged areas may thus be responsible for decreases in anxiety and depression associated with some studies on compassion meditation (see Johnson et al., 2010 below). The research builds on previous work (Lutz et al., 2008) which reported that compassion experts had increased activity in the right angular gyrus when listening to emotional human vocalisations during compassion meditation. This VPM study also strengthens findings linking compassion meditation to amygdala activity (Desbordes et al., 2012), since the parahippocampal gyrus has strong interactions with the amygdala (Stein et al., 2007). Moreover, the association of these enlarged regions with mood disorders suggests compassion meditation may have a therapeutic role. However, since the experts considered in this study had at least 550 hours of experience (and reported no mental
health problems), the extent to which practice might modify brain structure in clinical patients remains to be seen.

A fascinating fMRI study by Mascaro, Rilling, Negi, and Raison (2012) adds a new dimension to the relationship between neural activity and specific forms of meditation and has interesting clinical implications. The research suggests that the extent to which individuals engage with either mindfulness or compassion meditations may be determined by certain neurological predispositions. Twenty-nine healthy participants were randomly assigned to either compassion based cognitive therapy (CBCT) or a health discussion control. The CBCT training begins with mindfulness training before focusing on compassion. Participants attended class for two hours a week for eight weeks and also practiced at home. Before and after training, brain activity was observed as participants were given electric shocks and also as they observed videos of university peers receiving shocks. Participants rated their own pain and how it felt to watch pain in others. Surprisingly, the researchers did not observe any impact on neural responses to self or other pain as a result of meditation training. Neither was there any difference in the self-report measures. However, what was interesting was that variances in neural activity before the intervention predicted the degree to which participants engaged in either the mindfulness or compassion parts of the training protocol. For example, those who showed the least activation in the left amygdala when they received shocks the first time reported practicing more mindfulness hours. By contrast, those that engaged more with the compassion meditation showed more activity in the anterior insula when observing the pain of others before training. It is suggested that the negative association between the amygdala and mindfulness practice could be explained by considering the amygdala’s role in pain regulation. It may be that those who are more sensitive to their own pain (which would be reflected by stronger amygdala activation) are less able to engage with the non-evaluative, non-analytical attitude to pain encouraged in mindfulness meditation. On the other hand, compassion meditation requires the contemplation of suffering and this is reflected in increased activation in the anterior
insula, a part of the brain that, as previously discussed (Lutz et al., 2009), is associated with empathy.

Mascaro and colleagues (2012) point specifically to evidence that activity in the anterior insula may reflect a simulated mapping of the observed individual's body state onto one's own (Singer, Critchley, & Preuschoff, 2009). Furthermore, activity in this area predicts pro-social, helping behaviour rather than distress (Hein & Singer, 2010). This fits in with the previously seen pattern of increased brain activity in regions associated with emotion yet decreased distress (Desbordes et al., 2012; Lee et al., 2012). Moreover, the findings of this study are consistent with the traditional Buddhist notion that feelings of loving kindness and compassion must be cultivated in the heart at the start of practice before they can be directed to the self and outwards to others (Lama, The Dalai, & Cutler, 1998). The study raises some important questions. It suggests we should be cautious when interpreting the findings of cross-sectional studies. For example, could it be that the experts in the study by Lutz and colleagues (2008) had stronger activation in the insula before meditating, something that inclined them towards practice in the first place, rather than the other way around? Also, from a clinical perspective, the research again raises the possibility that those who might benefit most from one form of meditation are those that engage less with the practice. The idea that pre-existing variables may influence engagement with meditation also resonates with some unpublished qualitative research by Pearse, Eisenberg, Ellwood & Shafiq (2013) which indicates that engagement with meditation is intimately connected to the unique emotional and social fabric of an individual’s life. Finally, the failure of the intervention to influence self-report or neural measures must be considered. One possibility, raised by the authors, is that participants were less moved by the pain of others as they had already had the shocks themselves and realised they did no real harm. Perhaps the results would have been different if participants had witnessed the pain of others first.
Behaviour

So far, we have seen some compelling evidence linking compassion meditation with areas of the brain associated with empathy and emotional regulation. But how do these changes in the brain impact on behaviour? Mascaro et al. (2013) examined whether eight weeks of CBCT would enhance empathic accuracy when compared to a health discussion group. Before and after the interventions brain activity was observed while volunteers viewed images depicting the eye regions of strangers and were asked to choose what that person was feeling. After the intervention, meditators guessed significantly more mental states than did the control group and task accuracy corresponded to increased activation in several brain areas, including the left inferior frontal gyrus (IFG) and the dorso-medial prefrontal cortex (dmPFC). As the authors point out, the IFG has been associated with putative mirror activity first identified in monkeys (Rizzolatti, Fadiga, Gallese & Fogassi, 1996), while the dmPFC has been implicated in the ability to understand the mental processes of dissimilar others (eg.Lieberman, 2007), which is clearly consistent with the focus of compassion meditation. The researchers offer a speculative hypothesis linking the meditation-induced improvement in empathic accuracy with enhancement of the brain’s oxytocin system. This is because multiple studies (eg.Bartz et al., 2010) indicate that performance in empathic tasks is improved by administration of oxytocin. This possibility assumes particular relevance later in the discussion on children.

Leiberg, Klimecki, and Singer (2011) explored whether compassion meditation training would increase pro-social behaviour in a newly developed computer game - the Zurich Prosocial Game (ZPG). Sixty female participants were assigned to compassion meditation or memory training groups. Meditators attended one six hour training day and were urged to practice for an hour at home in the nights preceding the game. The others had a one-day workshop in memory techniques. In the game participants were timed as they navigated a virtual character through a maze to reach treasure. At the same time, players saw the virtual character of an ostensible co-player “from another
"university”, trying to reach different treasure. As players moved through the maze, gates fell on the paths blocking the way and participants used keys to open them. Importantly, participants were also able to open gates for co-players who had run out of keys (and by implication could not return the favour). Results indicated that meditators helped co-players significantly more than the memory group and helping was directly associated with the number of meditation hours practiced. Both groups reported more positive feelings after the training, but only the meditators reported fewer negative feelings and an increase in compassionate feelings. Moreover, meditators felt more sensitive, secure and connected (resonating with Hutcherson, Sepala & Gross, 2008).

It is suggested that the increase in positive mood in both groups implies increased helping behaviour is not simply down to enhanced positivity, but rather qualities of compassion cultivated in the training. The findings are consistent with the neurological evidence (e.g. Desbordes et al., 2012) linking compassion meditation with increased activity in brain areas associated with social connection and empathy and reduced distress (Lee et al., 2013). It is further suggested that the non-reciprocal nature of the helping - and the fact it was targeted at complete strangers - provides some evidence for a differentiation between compassion-based and more conventional forms of helping behaviour (based on reciprocity). This raises the intriguing (albeit tentative) hypothesis that the cultivation of compassion might lead to behaviour which appears to transcend the rules governing altruistic behaviour held by mainstream evolutionary theory (e.g. Dawkins, 2006). Such an idea fits neatly with a Buddhist view that meditation facilitates non-reciprocal altruism by fostering a deep ontological realisation that the ‘self’ does not exist and that we are interconnected (Lama, The Dalai, & Cutler, 1998). The study is exciting because it indicates that compassion meditation may benefit both the practitioner and society as a whole. It is limited by the fact that the sample was all female - a choice the researchers based on evidence suggesting women are better in emotional tasks and have higher self-reported empathy (Derrntl et al., 2010).
Clinical studies

All of the participants in studies reviewed since Hofmman et al. (2011) have so far been from non-clinical populations and there is relatively little by way of new evidence. Gilbert and colleagues continue their promising line of research on compassion-focused therapy (CFT), demonstrating improvements in patients diagnosed with personality disorders (Lucre, & Corten, 2012), eating disorders (Gale, Goss, & Gilbert 2012) and trauma (Beaumont, Durkin, McAndrew, & Martin, 2016). However, as discussed, CFT includes relatively little by way of compassion meditation as such, and it is therefore difficult to evaluate the intervention within the framework of this review. In the same vein, another strand of research - focusing specifically on self-compassion - has been led by Kristin Neff and colleagues. This research suggests that enhancing self-compassion may have beneficial effects in several clinical populations, including clients diagnosed with eating disorders (Braun, Park, & Gorin, 2016; Palmeira, Cunha, & Pinto-Gouveia, 2017) and depression (Diedrich, Hofmann, & Berking, 2016). While these studies point to the considerable benefits of enhancing self-compassion, interventions are again difficult to evaluate within the context of this review, given their limited focus on compassion-specific meditation.

There are however a handful of recent studies, with a specific focus on compassion meditation, which did not appear in the review by Hoffman and colleagues (2011). Barnhofer, Chittka, Nightingale, Visser, and Crane (2010) compared the neural effects of mindfulness meditation and compassion meditation in 15 participants with at least one previous episode of depression. Electrical activity was observed in the brain (using electroencephalography, EEG) before and after 15 minutes of either compassion or mindfulness meditation. After meditating, all participants showed increased left prefrontal activation. This dominance of left over right has been associated with behavioural tendencies towards approach rather than avoidance (Davidson et al., 2003) and resonates with evidence suggesting that compassion meditation increases feelings of social connection (Leiberg, Klimecki, & Singer, 2011). However, since participants had
been recovered from depressive episodes for at least eight weeks it is difficult to know whether acutely depressed individuals, in more negative states, would show similar brain patterns. From a therapeutic perspective, it was also interesting how compassion meditators who reported more ruminative brooding in a pre-intervention questionnaire showed significantly less left-brain activation than non-brooders. This is explained by plausible suggestions that brooding arises as the result of attempts to reduce discrepancies between current and desired states, running counter to the idea of unconditional regard at the core of compassion meditation. The study strengthens findings (Mascaro, Rilling, Negi, & Raison, 2012) suggesting that pre-existing variables may influence how individuals engage with different types of meditation and reinforces the importance of having knowledgeable teachers at hand to help with difficulties.

Johnson (2010) conducted a pilot study to evaluate the potential of compassion meditation for individuals identified as having “negative symptoms of schizophrenia” (e.g. lack of motivation, low mood), based on previous research suggesting the intervention increased positive emotions (Fredrickson et al., 2008). Eighteen participants diagnosed with schizophrenia attended six weekly one-hour sessions of loving kindness meditation. Overall, participants reported big increases in the intensity and frequency of “positive emotions” and reduced negative symptoms, in particular anhedonia. They also reported more self-acceptance and life satisfaction and said they found the sessions relaxing, while a few participants found it difficult to send loving-kindness to “all people of the world”. This was an uncontrolled study and therefore it is difficult to isolate the effects of meditation from other variables, such as social interaction. However, at the very least it is promising because it suggests that participants with low mood engage well with compassion meditation.

Very recently, researchers have used more experimental designs to evaluate the impact of compassion meditation in more clinical populations. For example, Feliu-Soler et al. (2017) randomised 32 participants with a diagnosis of Borderline Personality Disorder (BPD) to either a three-week mindfulness group or a three-week compassion/loving
kindness group. The researchers reported that participants in the compassion group showed a greater acceptance of present moment experience than the mindfulness group. The researchers suggest that increased acceptance of present moment experience may arise from the meditation technique's focus on taking a self-supportive stance (e.g. "May I be happy, may I be free of suffering), leading to improved emotional regulation, compared to the mindfulness group. They suggest that this is an important discovery because acceptance of present moment experience can be seen as an antidote to emotional avoidance, which they link to expressions of distress (e.g. self-harm, drug and alcohol use) in this BPD population. This study supports arguments made in previous neuroscientific studies about the potential role for compassion meditation in enhancing emotional regulation (e.g. Lee et al. 2012). However, it should be noted that the compassion intervention went beyond mere Buddhist-derived meditation practices, and included elements such as compassionate letter writing. Nevertheless, the strong emphasis on meditation in this study makes it an interesting addition to this review.

Compassion meditation with adolescents

Some researchers have explored whether compassion meditation may be useful as an intervention in adolescents. Pace et al., (2012) continued their line of work on compassion meditation and stress with 71 teenagers (aged 13-17) in American foster care. The teenagers - who had suffered varying degrees of neglect, physical abuse and/or sexual abuse - attended 12 one-hour sessions of CBCT over six weeks and these were modified, from the adult protocol, to include games and storytelling. Classes began with a short meditation and concluded with a slightly longer guided practice - but not as long as the 30-minute session for adults. The children were also encouraged to practice meditation at home for up to 30 minutes a day with the help of a CD and asked to record those minutes. Sixteen of the participants dropped out leaving 29 in the CBCT group and 26 in the control group. Before and after the intervention, researchers tested saliva for C-reactive protein (CRP). High levels of this protein have been associated with
physical illness but also early childhood stress, depressive symptoms and chronic anxiety (Carpenter, Gawuga, Tyrka, & Price, 2012). Pace et al., (2012) discovered that the more participants meditated the less CRP was found in the saliva. Interestingly, however, the decrease in CRP did not correspond with a fall in self-reported anxiety or depression scores. The researchers concluded that meditation might buffer against the detrimental effects of early life trauma on immune response in adolescents at high risk for poor mental and physical health. They suggest that the reason that CRP decrease did not correlate with emotional wellbeing scores may be that the adolescents are notoriously unreliable reporters of their own internal states (e.g. Kraemer, Measelle, Ablow, Essex, Boyce, & Kupfer, 2003). This study is exciting because it is the first to look at the effect of compassion meditation in a non-adult population. Moreover, it suggests that compassion meditation, with some modifications, is a feasible intervention for adolescents, even those with difficult backgrounds. It is noteworthy that the CRP decrease was correlated specifically with minutes spent meditating, indicating that practice, rather than a variable such as group dynamics, was responsible for the decrease.

In a related study (Reddy et al., 2013) reported separately, frequency of compassion meditation practice in adolescents in the same foster care system was associated with increased hopefulness and a trend decrease in anxiety. Of particular interest were the qualitative findings, which suggested that participants found meditation useful for dealing with stressful situations and for regulating emotion, particularly anger. For example, one girl reported: “My brother got me mad at home. He spilled oxide powder on my shoes and my mum’s shoes and blamed it on me. I went and did meditation and it calmed me down.” Moreover, adolescents reported enjoying the meditation and said they would recommend it to a friend. Indeed, 30 of the original 70 participants took up the offer of continued training after the end of the course. Also noteworthy is the observation that frequency of practice in the last three weeks of training is associated with decreases in self-reported anxiety and hopefulness scores. The authors point out
that this might suggest that children only begin to really benefit from meditation after they have fully understood the underpinning concepts and ideas. It raises the possibility that courses should be longer, or more intense, than for adults.

**Could compassion meditation benefit younger children?**

Having reviewed some of the most compelling research on compassion meditation, this review now considers the potential for introducing such meditations in pre-adolescent children. Developmental theory suggests that human brains are exquisitely vulnerable to the environment in early year, but also that plasticity is retained, to some degree, throughout life (Schore, 2005; Mikulincer & Shaver, 2007; Pascual-Leone et al., 2005). Bowlby (1982) argued that early developmental processes are best understood in terms of an interaction between genes and the environment. In particular, the degree to which a caregiver is attuned to an infant’s emotional needs – the attachment bond - has a profound impact on the child’s capacity to deal with stress, form relationships in later life and regulate emotions. Schore (2005) argued that inadequate caregiving could result in serious alterations in the biochemistry of the immature brain, affecting the maturation of the amygdala and anterior cingulate limbic circuits. Poorly regulated systems predispose children to stress-related difficulties, such as anxiety, depression and post-traumatic stress disorder (Schore, 2005). Schore (2005) points to the importance of the neurohormone oxytocin in facilitating healthy attachment and, by consequence, emotional regulation. Gilbert (2009) expands on this idea highlighting the role of oxytocin in the “soothing and safeness system” - one of three types of emotional system governing human behaviour (the others are threat/protection and drive/reward). Gilbert (2009) suggests that oxytocin is linked to feelings of affiliation and feeling soothed and calmed within relationships (Depue & Morrone-Strupinsky, 2005) and reduced sensitivity in fear circuits of the amygdala (Kirsch et al., 2005). He adds that the soothing system may come to be dominated by the threat system in children who suffer early life trauma, disrupting oxytocin.
Recently, work by Mikulincer & Shaver (2007) suggests that it may be possible to modify troublesome attachment styles, and related behaviours. This has coincided with an increasing emphasis on early intervention strategies to prevent self-destructive early behaviour from damaging social relationships and mental health (Greenberg, Domitrovich, & Bumbarger, 2001). In one fascinating study Mikulincer, Shaver, Gillath, & Nitzberg (2005) asked volunteers to observe a “fellow student” – a decoy - in another room who was being instructed to pet a live tarantula. Beforehand, volunteers were subliminally primed with either the name of someone they considered an attachment figure or the names of non-attachment figures. When the student with the spider feigned distress and refused to take part any longer, volunteers were asked whether they would help. The researchers observed that, when not exposed to attachment primes, those who had avoidant attachment styles showed little distress and refused to help. Meanwhile, those who were anxiously attached showed more personal distress, but also refused to help. However, when participants were exposed to attachment primes, both avoidant and anxiously attached individuals offered to help and showed more compassion, and less distress. The researchers concluded that it might be possible to alter attachment-related behaviour by enhancing a sense of emotional security.

Against this theoretical backdrop, the evidence presented in the reviewed studies on compassion meditation appears to hold promise for children. It raises the possibility that compassion meditation may target precisely the neural systems (e.g. circuits involving the amygdala and anterior cingulate gyrus) damaged by early childhood trauma and responsible for emotional regulation and mood (e.g. Leiberg et al., 2011; Reddy et al., 2013). Research indicates that compassion meditation may increase emotional engagement with the feelings of others while at the same time reducing personal distress and enhancing emotional regulation (e.g. Desbordes et al., 2012; Lee et al., 2012; Feliu-Soler et al., 2017). This could clearly have important implications for how high risk children function socially. If Leung and colleagues (2013) are right that compassion meditation increases volume in regions associated with stress-related
disorders then might it be possible that practice may begin a neural healing process for attachment-related trauma? Also, given the damaging role of early trauma on stress-related physical health in children (Schore, 2005) the evidence from neuroendocrine studies is also encouraging. Practice of compassion meditation has been associated with reduced levels of physiological markers for stress, such as cortisol and CRP in adults (Danucalov et al., 2013; Pace et al., 2009) and adolescents (Pace et al., 2012). These findings are corroborated by qualitative reports where meditators have described feeling better able to deal with stressful situations and being more connected to others (Reddy et al., 2013; Leiberg, 2011).

Given the tendency depressed children to isolate and withdraw (Leon, Kendall, & Garber, 1980) the behavioural evidence indicating an increased propensity to empathise and engage with others is also exciting (Mascaro et al., 2013; Leiberg et al., 2011). This behavioural tendency towards social connection may further be reflected in a shift from right to left pre-frontal brain activation (Barnhofer et al., 2010). Also, if the tentative hypothesis that compassion meditation may enhance empathy and emotional regulation by influencing the oxytocin system is correct (Mascaro et al., 2012) then assertions by Schore (2005) and Gilbert (2009) relating to the importance of this neurohormone in child development take on extra significance. It raises the possibility that compassion meditation could rebalance disrupted brain chemistry in children. Finally, recent attachment theory (Mikulincer & Shaver, 2007) suggests that maladaptive attachment styles can be altered, at least temporarily, by simple priming exercises. This leaves one wondering what might be achieved with techniques which have been shown to have an enduring effect on feelings of security, such as compassion meditation (Leiberg et al., 2011).

All of this leaves one very important practical consideration; is it possible to get a young child to sit down quietly for long enough to do meditation? Evidence from two systematic reviews on mindfulness meditation in children (Burke 2009; Harnett & Dawe, 2012) suggests the answer is yes and, moreover, that children enjoy it and benefit
psychologically. Napoli, Krech and Holley (2005) reported that 12 mindfulness meditation sessions, lasting 45 mutes each, with 225 high anxiety children, aged between five and eight, reduced anxiety and ADHD behaviours. Meanwhile, Joyce et al. (2010) reported that mindfulness reduced depression in children aged between 10 and 13-years-old. Biegel, Brown, Shapiro, and Schubert (2009) demonstrated that an eight-week mindfulness course for four to 18-year-olds reduced symptoms of anxiety and depression, and increased self-esteem and sleep quality. Similarly, a more recent study (Flook, Goldberg, Pinger, & Davidson, 2015) randomised 68 nursery school children in America (average age 4) to a 12-week mindfulness-based "Kindness Curriculum (KC)" or a control group. The former consisted of some basic mindfulness meditation practices, with a shared emphasis on kindness practices, stressing empathy, gratitude and sharing. Researchers reported that children in the intervention group showed greater improvements in learning and demonstrated more pro-social behaviour than those in the control group.

Further support for the feasibility of compassion meditation in younger age groups comes from the reported success of Social Emotional Learning (SEL) programmes, which aim to teach children core social and emotional skills, including self-awareness, empathic response and relationship skills. In a meta-analysis of 207 SEL interventions (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011) combined effect sizes represented an 11% improvement in academic performance, a 25% improvement in social and emotional skills and a 10% decrease in classroom misbehaviour, anxiety and depression. Moreover, the effect was generally maintained for at least six months after the intervention. Given the emphasis in compassion meditation on generating feelings during practice (Hoffman, Grossman, & Hinton, 2011), it could be argued that compassion meditation is a way for children to embody the ideas which are taught in SEL classes.

While there are no controlled studies on compassion meditation and children, one pilot study (Ozawa-de Silva & Dodson-Lavelle, 2011), has explored the feasibility of using a
specific compassion-based protocol in an elementary school for children aged five to eight in America. Researchers developed Cognitive-Based Compassion Training for Children, an eight to 10 week course where twice-weekly classes started with a short meditation and included stories, games and role-play. Children were not asked to practice between classes. Initially, it was discovered that children seemed unwilling to keep their eyes shut for more than a few seconds during meditation. However, children did appear to engage with the process as time went on and – with games and play - demonstrated a remarkable understanding of conceptual issues. For example, they recognised the connection between emotional states and behaviour and came to grasp the idea of equanimity; cultivating impartiality towards others. Furthermore, children said they had enjoyed the meditations and teachers reported that classrooms were “positively affected” at least five months after the training. The careful calibration of compassion meditation techniques to developmental needs of children resonates with previous observations (Pace et al., 2012; Reddy et al., 2013) which emphasised the importance of simplifying important concepts rooted in Buddhist thought. For example, to explain the concept of equanimity – teenagers in the study by Reddy and colleagues (2013) were asked to imagine hypothetical situations about friends, strangers and enemies, before placing a mark on a length of tape on the floor with ‘empathy’ and ‘no empathy at all’ at opposite ends. Also, boredom was relieved in teenagers by incorporating a physically active form of meditation, such as yoga. Ozawa-de Silva & Dodson-Lavelle (2011) conclude that much more research is needed in this area, including trials to evaluate the impact of compassion meditation on emotional well-being and social connection.

Conclusion

As NHS mental health budgets grow increasingly tight, the emphasis is shifting towards the development of preventative strategies and early intervention (Bell, 2011). In a major review, Greenberg, Domitrovich, & Bumbarger (2001) concluded that various early psychological interventions might limit the damage caused by early trauma by
improving social-cognitive and emotional regulation skills, enabling children to soothe themselves when angry, form friendships and resolve conflicts. By cultivating these skills at a young age, children are less likely to develop entrenched, maladaptive habits. The authors conclude that high-risk children, predisposed to mental illness by early childhood trauma, are best protected with long-term, disorder unspecific interventions beginning in primary school years. The Buddhist conviction that meditation is a skill, which can, and should, be cultivated over a lifetime suggests that compassion meditation may be a non-pathologising, long-term intervention par excellence. The evidence from the various adult, adolescent and child studies considered above, underpinned by developmental theory, neuroscience and Buddhist contemplative psychology, provides a compelling argument to conduct more research into the potential of compassion meditation as a psychological intervention for pre-adolescent children. Its effects (in adults) appear to be related to, but dissociable from mindfulness meditation and may have a pronounced impact on emotional regulation. Further evidence might explore how compassion meditation interacts with attachment styles, in a similar vein to the experiments by Milkulincer & Shaver (2007). Other research might seek to investigate whether compassion meditation improves wellbeing in disadvantaged children, or whether it reduces anti-social behaviour, such as bullying. Use could be made of the ZPG maze game which Leiberg and colleagues (2011) say is particularly appropriate for children. Another line of research might be to explore the effect of compassion meditation in children who show deficits in empathy. Poor empathy skills have been documented in children diagnosed with autism (Yirmiya, Sigman, Kasar, & Mundy, 1992) and researchers have recently demonstrated success in reducing deficits with behavioural techniques (Schrandt, 2009). Future research should build on the previous findings with adults and teenagers while, where possible, improving research designs, which have previously limited interpretation. The paucity of qualitative research is noted and is another area for exploration. A phenomenological investigation might look at how individuals (potentially children) experience compassion meditation. Interventions and research should also be guided by evidence in adults.
(Mascaro et al. 2012; Barnhofer et al., 2011) which may indicate that those who are damaged by early trauma could be precisely those who find it most difficult to engage with compassion meditation. They may need sensitive encouragement from teachers or psychologists who are aware of the science.
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Appendix 1. *Child Development* – Journal Notes for Contributors

Child Development publishes empirical, theoretical, review, applied, and policy articles reporting research on child development. Published by the interdisciplinary Society for Research in Child Development (SRCD), the journal welcomes relevant submissions from all disciplines. Further information is available at http://www.srcd.org/cd.html.

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Essays describe original concepts, methods, trends, applications, and theories; these may also be accompanied by solicited commentaries.

Child Development and…are articles that provide readers with tutorials about some new concept or academic specialty pertinent to research in child development. These papers should review the major definitions, methods, and findings of the concept or specialty and discuss past or potential links to child development.

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Project 2. Does participation in the programme of Alcoholics Anonymous predict self-compassion, shame and wellbeing?

Supervised by Dr Michele Birtel

Word count: 9588

For submission to *Journal for Studies on Alcohol and Drugs*

See Appendix 2 for Journal Notes to Contributors
Abstract

Background: More than two million people across the world attend Alcoholics Anonymous (Vaillant, 2006). Yet, research into AA and its impact on psychological health is limited in quantity and scope. A critical feature in AA’s own theoretical literature is that shame in members is reduced as individuals attend meetings, share difficulties with mentors (known as “sponsors”), and gradually work their way through a series of designated steps (known as the 12-Step programme), aimed at processing painful experience from the past, and fostering healthier behaviours. However, this aspect of emotional recovery has been overlooked, with most research focusing exclusively on abstinence-related outcomes.

Objectives and methodology: This study addresses this important gap by using a cross-sectional, correlational methodology to test a psychological model which proposes that participation in AA’s programme reduces shame, by enhancing self-compassion, a relatively new construct in Western psychology. In addition, associations between the AA programme and the construct of wellbeing are tested.

Results: Regression analyses found that progressing through the 12 Steps positively predicted self-compassion and negatively predicted shame as hypothesized. The effect of the 12 Steps on shame was fully mediated by self-compassion, also as hypothesized. Those with AA sponsors who helped them “see their defects” had higher wellbeing than those without sponsors.

Discussion: These original findings are discussed within a psychological framework, which understands self-compassion as an antidote to shame, and against the backdrop of AA’s own theoretical literature. It is argued that the implications of these findings extend beyond the AA programme, and are of interest to clinicians working with all individuals experiencing alcohol-related difficulties.

Key words: self-compassion, Alcoholics Anonymous, alcohol, shame, addiction, wellbeing
Introduction

Background

Alcohol has been used to help human beings relax, socialise, dance and sing. But it has also been linked with immense personal suffering and is a huge burden to health systems. A recent report highlighted 1,008,850 alcohol-related UK hospital admissions and 6,490 deaths, costing the NHS £2.8bn (Alcohol Concern, 2016). Consumption has been associated with crime, unemployment and suicide and various indices of psychological distress, including anxiety, depression (Kelly, et al., 2010).

Alcoholics Anonymous

Individuals who experience problems with alcohol have several options for support, including individual therapy and so-called recovery programmes (Nutt, 2012). One of the most popular programmes is Alcoholics Anonymous (Room & Greenfield, 1993). The organisation emerged from a religio-spiritual tradition in 1935 and caters for millions of individuals in 180 countries (Room & Greenfield, 1993). AA suggests an abstinence-based approach, which is rooted in a disease model of alcoholism. Members are urged to attend AA meetings and identify with the stories of fellow alcoholics1 who share their “experience, strength and hope” (Wilson, 1939, p. 562). The only requirement for membership is a “desire to stop drinking” (Wilson, 1939, p. 562 ). Key to the programme

1 From a counselling psychology perspective, reductionist terms such as “alcoholic”, “addiction” and “treatment” are problematic as they suggest definable entities that exist as ontological givens, when these categories are ideologically driven and historically-derived social constructions (for a discussion, see Klaue, 1999). I use them within this text with reservations and for convenience only, as deconstructing them is beyond the scope of this paper. Further reflections are made, however, in a reflexivity section in Appendix 1.
are the “12 Steps” of recovery, set out in the eponymous book of Alcoholics Anonymous - also known by members as the “Big Book” - written by the organisation’s co-founder Bill Wilson (Wilson, 1939). Part 1 contains an outline of the programme, including a description of the 12 Steps (Table 1), while Part 2 contains subjective accounts of addiction and recovery from early members.

Crucially, AA’s theoretical framework sees recovery as a programme of “action”, where members systematically complete tasks set out in the 12 Steps to gain emotional sobriety. Emotional sobriety is marked by a mature attitude towards the self and others, leading to “easy, happy, and good living” (Wilson, 1939, p. 72). According to AA, mental health is improved gradually but depends on steadily moving through each Step - from 1 to 12, bringing increased relief from emotional pain.

Diminished shame is seen as one important emotional consequence of working through the Steps (Wilson, 1939), with case studies in Part 2 of the Big Book mentioning the emotion 28 times, and describing a process of self-acceptance. For example, a 70-year-old man states: “I am free from shame and regret, free to learn and grow and work. I have left that lonely, frightening, painful express train through hell.” (Wilson, 1939, p. 535). Within the AA community, it is understood that abstinence can be achieved without the psychological benefits of working through the Steps, living as a dry drunk, who is “restless, irritable and discontent” (Wilson, 1939, p. 35). The emphasis here, then, is that meaningful recovery is not simply a matter of stopping drinking, but requires active engagement in the programme of AA.
**Figure 1: The 12 Steps of Alcoholics Anonymous**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>We admitted we were powerless over alcohol - that our lives had become unmanageable.</td>
</tr>
<tr>
<td>2.</td>
<td>Came to believe that a Power greater than ourselves could restore us to sanity.</td>
</tr>
<tr>
<td>3.</td>
<td>Made a decision to turn our will and our lives over to the care of God as we understood Him.</td>
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<tr>
<td>4.</td>
<td>Made a searching and fearless moral inventory of ourselves.</td>
</tr>
<tr>
<td>5.</td>
<td>Admitted to God, to ourselves and to another human being the exact nature of our wrongs.</td>
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<tr>
<td>6.</td>
<td>Were entirely ready to have God remove all these defects of character.</td>
</tr>
<tr>
<td>7.</td>
<td>Humbly asked Him to remove our shortcomings.</td>
</tr>
<tr>
<td>8.</td>
<td>Made a list of all persons we had harmed, and became willing to make amends to them all.</td>
</tr>
<tr>
<td>9.</td>
<td>Made direct amends to such people wherever possible, except when to do so would injure them or others.</td>
</tr>
<tr>
<td>10.</td>
<td>Continued to take personal inventory and when we were wrong promptly admitted it.</td>
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<tr>
<td>11.</td>
<td>Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.</td>
</tr>
<tr>
<td>12.</td>
<td>Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.</td>
</tr>
</tbody>
</table>

As well as the 12 Steps, the AA programme encourages members to be active in other ways. For example, members are encouraged to get a sponsor, a more senior AA member, who guides them through the tasks set out in programme. For example, one important sponsor task is to support sponsees through the process of Steps 4-7. In Step
4, sponsees write lists of long-standing resentments and recall their own destructive patterns of behaviour, often linked to alcohol. In Step 5, sponsees read out these lists to their sponsors with a view to better understanding their own past behavior, processing resentments and learning to forgive others and themselves (Wilson, 1939). AA members are also encouraged to cultivate gratitude each day, guided by an assumption that grateful members will not relapse (Coats, 2006). Recently, with the increasing popularity of mindfulness practice (Brown & Ryan, 2003), more and more AA members are emphasising the *meditation* aspect of Step 11, bringing together aspects of Buddhist psychology with the 12-step programme (Littlejohn, 2009).

**Relevance to counselling psychology (CoP)**

At first blush, the values and philosophy of Alcoholics Anonymous appear almost antithetic to the humanistic underpinnings of counselling psychology (Medina, 2013). AA calls for self-surrender to a “higher power”, while CoP promotes a strengthening of the self. One speaks a language of wellbeing and inter-subjectivity, the other of disease and essentialism. This inconsistency may be reflected in the dearth of research on AA in the profession’s peer-reviewed journal, the Counselling Psychology Review.

Yet such an apparent contradiction in values and outlook should not erect a barrier between CoP profession and AA; rather it invites engagement with the field’s emphasis on diversity and “the limitless array of client perspectives that we encounter in all aspects of our working lives” (Kasket & Gil-Rodriguez, 2011, p. 22). McAteer (2010) further argues that it is necessary to assume a very critical, open and curious position in relation to our own assumptions and perspectives on the world - something the topic of AA insists that we do. AA is often considered insular, secretive and organised by its own set of socio-cultural norms (Vaillant, 2009). This study will hopefully provide a valuable reference point for counselling psychologists working with an increasing number of AA members seeking *outside help* from professionals (Vaillant, 2009).
Extant Literature

*Is Alcoholics Anonymous effective?*

Empirical research into AA has been limited by difficulty in accessing the target population, since most meetings are closed to non-members (Kelly, Stout, Magill, Tonigan, & Pagano, 2010b). Reviews of the available literature, however, consistently converge on the finding that AA is, at a minimum, helpful as a means to achieving abstinence (Kelly & Yeterian, 2008). The largest clinical trial examining AA was Project MATCH (Mattson, 1993), involving 1726 participants who were randomly assigned to three treatment groups; cognitive-behavioral therapy (CBT), motivational enhancement therapy (MET) and AA, and measured longitudinally on two outcome measures - days abstinent and average drinking per drinking day. The researchers reported that the 12-Step condition was at least as effective as established comparison treatments.

This study is typical of many others, which focus on abstinence as an outcome measure (e.g. Morgenstern, Labouvie, & Frey, 1997). It says very little about whether participants engaged in the active part of the action programme (e.g. working through the 12 Steps, sponsorship), or the emotional health of participants. Furthermore, there is a strong emphasis in this abstinence-focused literature on *cost-savings* and *compliance with alcohol treatment* (Mattson, 1993), which sounds ethical alarm bells from a CoP perspective. Vaillant (2009) highlights a strong need for research investigating how AA might impact the subjective experience of individuals, beyond only abstinence.

*Alcohol use and shame*

One emotion explored in the broad context of addiction is shame (Meehan, O’Connor, Berry, Weiss, & Acampora, 1996). Gilbert and Proctor (2006) point out that there is no commonly agreed definition of shame but suggests it is characterised by two components, which are often fused together. The first relates to evaluations of the self
as inadequate, flawed or bad. The second relates to a sense that one’s personal characteristics are viewed as unattractive and rejectable in the minds of others. Shame is thus characterized by harsh self-judgment, wanting to isolate from others and hostile responses to one’s own emotional pain (Gilbert, 2017). Neff (2016) usefully distinguishes shame from guilt by suggesting that the former results from seeing oneself as a bad or inadequate person, while the latter is related to self-perceived bad behaviour. Gilbert and Proctor (2006) suggest that individuals can become prone to shame for various reasons including experiences of trauma or parental rejection. The emotion is considered particularly corrosive for psychological health and has been linked to anxiety, depression and suicide in multiple studies (see Kim, Thibodeau, & Jorgensen, 2011, for a review).

Evidence suggests that individuals who use alcohol destructively are dispositionally prone to shame (Dearing, Stuewig, & Tangney, 2005; Meehan, O’Connor, Berry, Weiss, Morrison & Acampora, 1996) and are likely to have experienced adverse childhood experiences, including parental neglect and/or trauma (Anda et al., 2002). For example, new arrivals at an alcohol treatment centre were more prone to shame than a control sample (O’Connor, Berry, Inaba, Weiss, & Morrison, 1994), and within a population of 600 college students and prison inmates, proneness to shame was significantly correlated to drug and alcohol problems (Dearing, Stuewig, & Tangney, 2005). Theoretically, alcohol is seen as offering a means of temporarily dealing with painful feelings of shame because the substance alters cognition, inhibiting self-awareness - a pre-requisite for shame (Randles & Tracy, 2013; Gilbert & Proctor, 2006). However, such a way of dealing with shame often introduces a vicious cycle, where heavy drinking can lead to destructive or humiliating behavior and rejection by other people. This behavior and rejection is evaluated by individuals as evidence confirming their sense of being an essentially bad and rejectable person, increasing shame - and leading to more drinking (Randles & Tracy, 2013).
Recently, a couple of studies have looked more specifically at shame within an AA context. For example, one study used a longitudinal design to follow 105 participants over four months in early recovery. They were initially videotaped as they recounted earlier drinking stories and then re-interviewed four months later. The researchers reported that participants who demonstrated non-verbal displays of shame - for example, slumped shoulders - while recounting drinking stories were more likely to start drinking again (Randles & Tracy, 2013). Behavioural displays of shame also predicted subsequent declines in physical and mental health. The authors concluded that shame about addiction may be a cause of problematic drinking and health declines in those in alcohol recovery. The longitudinal design provides compelling evidence for the damaging impact of shame in AA members. However, the authors acknowledge that further investigations are needed to explore what factors, or interventions, might be useful to mitigate the impact of shame in this population. Furthermore, while a number of potentially confounding variables were controlled for (e.g., prior alcohol dependence, trait affect, demographics), there were no attempts to control for ingredients which AA considers critical for healthy recovery (e.g. working through the Steps etc.). The findings thus invite more research into the patterning of relationship between shame and participation in the AA programme.

One qualitative investigation (Randa, 2010) has explored the relationship between different aspects of the AA programme and shame, using interpretative phenomenological analysis (IPA). This study looked at the changing experience of shame in recovery as described by 13 AA participants, with varying lengths of sobriety. The epistemological approach enabled the researcher to explore the relationship between shame and the AA steps in more depth. The author describes a “generalised pattern” of decreasing shame as individuals progress through the Steps, concluding that meetings attendance and working through the Steps foster self-acceptance, self-awareness, and improved relationships. The accounts in this study resonate with those in AA’s Big Book (Wilson, 1939), where the emotion is mentioned 28 times, mostly in the case studies.
Overall, the quantitative and qualitative research reviewed above, as well as the narrative accounts from the Big Book, indicate that shame is an important construct to consider in AA populations, but more empirical evidence is required to support and flesh out this very limited literature. For example, what psychological constructs might explain any reductions in shame?

**Conceptual framework: Self-compassion as an antidote to shame**

The qualities described in Randa’s IPA study - self-acceptance, identifying with others and awareness - evoke an important psychological construct - that of self-compassion (Neff, 2003a; Gilbert & Proctor, 2006), which underpins this research. The construct of self-compassion has been prominent in Buddhist philosophy for centuries, but has only recently been considered in Western psychology (Neff, 2003b). Neff describes self-compassion as an openness to one’s own suffering and a desire to alleviate it by cultivating a non-judgmental and kind attitude to the self, which recognizes that emotional pain, failures and inadequacies are part of a broader human experience. While self-esteem often relies on positive assessments of personal achievements and comparisons to others, self-compassion emphasizes self-acceptance and an understanding that life is difficult. Importantly, researchers (Neff, 2016; Gilbert, 2017) have developed a psychological framework, which explains how cultivating self-compassion provides an antidote to distress, in particular shame.

Theoretically, Neff (2003b) suggests how enhancing self-compassion reduces shame by cultivating three psychological components - self-kindness, an understanding of common humanity, and mindfulness. She proposes that self-kindness implies offering warmth and unconditional acceptance to the self, rather than being harshly judgmental, as those prone to shame tend to be. Cultivating a sense of common humanity means recognizing that humans are imperfect and that all people make mistakes and have significant life challenges. By keeping in mind that imperfection is part of life, and by identifying with shared human fallibilities, the pain of shame is reduced because one
feels less isolated (Neff, 2016). Finally, the cultivation of mindfulness of emotional pain, means individuals do not over-identify with and ruminate about painful thoughts and feelings about the self, as happens when people feel shame. Instead, cultivating mindfulness allows individuals to hold such thoughts and feelings in balanced awareness, responding with warmth and understanding (Neff, 2003b). Neff (2016) points out that being self-compassionate does not give individuals carte blanche to behave destructively or to feel self-pitiful. Rather, having compassion for oneself often means reducing harmful behaviors to which one is attached, and motivating the self to engage in whatever actions are necessary - even if challenging or painful - so as to shift shame and enhance wellbeing (Neff, 2003b). Gilbert and Proctor (2006) add to this framework by emphasising neurobiological research which suggests that shame is one of the most potent elicitors of cortisol-induced stress responses (Dickerson & Kemeny, 2004). They suggest that cultivating self-compassion stimulates soothing systems in the brain, involving oxytocin and opiates (Depue & Morrone-Strupinsky, 2005), which counteract the arousing effects of cortisol.

It is suggested that certain practices can cultivate a capacity for self-compassion, and combat shame. For example, meditation exercises have been shown to enhance self-compassion in many studies (e.g. Gilbert and Proctor, 2006; Neff, 2016; Gilbert, 2017), as does writing kindly about shameful events and using compassionate imagery (Neff & Germer, 2013; Gilbert and Proctor, 2006). Purposely reflecting about how one’s shame-inducing inadequacies are part of being human, sharing shame-inducing experiences with an empathic other, and changing and making amends for harmful behaviours can also enhance self-compassion (Neff, 2003b; Bates, 2005; Neff, 2016; Gilbert, 2017). Self-compassion research also suggests that cultivating empathy circuits in the brain, which may have been damaged through childhood neglect or trauma, can enhance self-compassion. Evidence suggests that the tendency to respond to suffering with caring concern is a general process applied to both oneself and others, so that other-focused concern and self-compassion actually go hand in hand (Longe et al., 2010; Gilbert, 2017).
In this way, activities which encourage mindful perspective taking and empathy for another, such as cultivating forgiveness for others or making amends for wrongdoing, have been positively associated with self-compassion (Neff & Pommier, 2013; Lewis, Parra, & Cohen, 2015; Gilbert, 2017; Neff, 2016).

The importance of self-compassion as a psychological construct and its theoretical links to shame is emphasised by a modest but growing body of empirical research. For example, the inverse relationship between shame and self-compassion has been widely reported in correlational studies (e.g. Barnard & Curry, 2011). An important earlier pilot study by Gilbert and Proctor (2006) supported the theoretical conviction that self-compassion may act as an antidote to shame. This study had a small sample of two men and four women who were in secondary NHS care for long-term and complex difficulties, and who identified as having high shame. They attended 12 weekly two-hour group sessions of Compassionate Mind Training, which included exercises such as mindfulness meditation and writing down and sharing painful experiences. At the end of the training, participants reported significant drops on shame-related measures. These findings have been supported in more recent studies, with larger samples (e.g. Kelly, Carter, & Borairi, 2014).

**Self-compassion and alcohol use**

There is very limited research looking at self-compassion and problematic alcohol use, an omission that this investigation seeks to address. The most informative is a longitudinal study (Brooks, Kay-Lambkin, Bowman, & Childs, 2012) which followed 77 individuals at an alcohol treatment centre in the US and reported that self-compassion levels (Neff, 2003a) were lower at outset than national average scores. After 15 weeks of treatment, self-compassion levels had risen significantly, but were still below average. The lower than average self-compassion scores suggest that this construct may be a meaningful one to consider for individuals with alcohol-related difficulties. However, despite having a longitudinal design, the findings relating to treatment are difficult to
interpret because participants were subject to a wide range of psychosocial interventions, including different models of therapy, as well as being encouraged to attend AA. This meant that it was impossible to evaluate what enhanced self-compassion for participants. This study supports a small handful of correlational studies linking self-compassion to alcohol use in student populations (e.g. Rendon, 2006).

**Could the AA programme enhance self-compassion and reduce shame?**

Based on the conceptual framework above (Neff, 2016; Gilbert, 2017), there are strong theoretical reasons to believe that participation in the AA programme will enhance self-compassion, and thus reduce shame. Working through the steps offers the opportunity for this process by encouraging members to share painful experiences and relinquish resentments with an empathic sponsor (e.g. Step 4-5), commit to less harmful behaviours (e.g. Steps 6-7), repair for past transgressions (Step 9) and cultivate more empathy while helping others (e.g. Steps 8, 9 and 12). In Step 10, this process of writing and processing experience is encouraged on a daily basis to keep shame at bay, while in Step 11, members are encouraged to meditate. Meetings attendance offers members the chance to identify with the painful and shame-inducing stories of others, helping them to see that their perceived inadequacies are part of a wider human condition and that they are not bad people. Self-compassion and shame may also be connected to sponsorship style. Given what we know about self-compassion (e.g. Neff, 2003b), it is likely that an empathic sponsor who encourages self-forgiveness and acceptance will be more associated with self-compassion than one who moralizes and points out mistakes. Research suggests that there are differences in mentorship styles. For example, some sponsors are known to emphasize what AA literature describes as “defects of character” (Wilson, 1939), while others have less pathologising approaches (Vaillant, 2009). Theoretically, AA proposes that all of these processes provide a systematic method of progressively shifting shame (Wilson, 1939).
Alcoholics Anonymous and wellbeing

While the main focus of this work was to investigate AA in the context of shame and self-compassion, it was felt that such rare access to this population warranted an exploration of other important variable - wellbeing - which could also be impacted by aspects of the programme. Wellbeing is generally considered a multi-dimensional construct spanning different areas of an individual's life including mood, relationship satisfaction and hopes for the future (Diener, 2009), and there are compelling reasons to suggest it will be positively associated with elements of the AA programme. Theoretically, AA proposes that working through the programme, progressively increase contentedness, and by the time Step 9 is reached, members are promised “a new happiness”. Among other things, enhanced wellbeing is linked by AA to the cultivation of gratitude (Wilson, 1939), and this corresponds to the empirical literature on these constructs (Wood, Froh, & Geraghty, 2010). Likewise, mindfulness meditation has been consistently linked to wellbeing (e.g. Shapiro, 2009), therefore those who engage with Step 11 may experience greater wellbeing. Also, having a sponsor who provides support in stressful situations is likely to increase wellbeing, given evidence linking the empathic support of significant others and mood (Brannan, Biswas-Diener, Mohr, Mortazavi, & Stein, 2013; Moyers & Miller, 2013). The process of going through certain Steps related to forgiving others may also positively promote wellbeing, given evidence that harboring resentments increases the production of stress-related hormones, such as cortisol (Berry & Worthington, 2001) whilst self-forgiveness is positively associated with wellbeing (Worthington et al., 2007). Furthermore, there is evidence to show that helping others - in accordance with Step 12 - increases wellbeing (Schwartz & Sendor, 1999). These theoretical links are supported by longitudinal investigations, which demonstrate that frequency of AA meetings is related to improved mood. For example, Kelly and colleagues (2010b) followed 1706 AA members for 15 months, and reported that the more meetings individuals attended, the lower their depression scores. This
that compassion, whereby variances process gradually that increases in wellbeing. Given the corrosive impact of shame generally (Kim, Thibodeau, & Jorgensen, 2011) and the reported importance of shame for individuals with alcohol-related difficulties (Randles & Tracy, 2013; Randa, 2010) further research is needed.

Understanding more about how AA impacts on mental health and potential mechanisms of psychological change would not only be helpful for clinicians working with individuals who are members of the organisation, but could also support therapists working with other individuals with alcohol and addiction difficulties, who do not wish to go to AA. Indeed, many millions of people with alcohol-related problems are put off the organization because of its requirement of abstinence and its religious associations (Vaillant, 2009).

Given the empirical data and theoretical frameworks, it is reasonable to hypothesise that as one works through the programme and attends more meetings, shame will gradually diminish and self-compassion increase. A mediational model is thus proposed whereby the AA programme reduces shame by enhancing self-compassion. Abstinence is controlled for in a bid to demarcate changes in outcome variables that occur in association with the AA programme, and those that would occur simply from the process of not drinking. Given the strong relationship between mindfulness and self-compassion, frequency of meditation practice (encouraged in Step 11), and noted variances in sponsorship styles, these variables are included separately. The prediction that AA participation, in particular the cultivation of gratitude, will be associated with increases in wellbeing is also tested. The independent variables are: number of 12 steps

Present research

To date, there has been no quantitative research specifying the relationship between ingredients of the AA programme (e.g. working through the 12 Steps) and both constructs of self-compassion and shame. Given the corrosive impact of shame generally (Kim, Thibodeau, & Jorgensen, 2011) and the reported importance of shame for individuals with alcohol-related difficulties (Randles & Tracy, 2013; Randa, 2010) further research is needed.
completed, meetings attended, frequency of meditation, frequency of gratitude lists, and attitude of sponsor (whether forgiving or defect-focused). The following hypotheses are made:

**Hypothesis 1 (H1):** Steps completed and frequency of meetings will negatively predict shame, while controlling for abstinence.

**Hypothesis 2 (H2):** Steps completed, frequency of meditation and meetings attended will positively predict levels of self-compassion, while controlling for abstinence.

**Hypothesis 3 (H3):** Participants whose sponsor have a forgiving attitude will be more self-compassionate, have less shame and higher wellbeing than those with defect-focused sponsors.

**Hypothesis 4 (H4):** The effect of the 12 Steps and meetings on shame will be mediated by self-compassion.

**Hypothesis 5 (H5):** Steps completed, and frequency of meetings, meditation and gratitude lists will positively predict wellbeing, while controlling for abstinence.

**Method**

**Pilot Study**

The potentially distressing nature of the questionnaire, along with an ethical commitment to working collaboratively (Shillito-Clarke, 2010), led the researcher to conduct a short pilot study with a small sample of participants. This was done with full university ethics approval. Three AA members completed the questionnaire in the presence of one researcher and were then asked: **How did you feel after completing the questionnaire? Is there anything you would change?** More details of the pilot study and responses are contained in Appendix 4.
Main study

i) Participants and design

112 participants were recruited from AA meetings in the UK and internet forums - 59 females and 53 males between the ages of 25 and 70 ($M = 47.52$, $SD = 10.75$). There were 65 white British, 41 white other, one Asian and five other mixed background. None of the participants received reimbursements. The study employed a cross-sectional, correlational design to test specific predictions relating to the AA programme and measures of shame, self-compassion and wellbeing.

ii) Reflection on design

The correlational design is consistent with the research aim - to test predictions relating to patterns of relationships between specific psychological constructs. It can, however, be seen as a departure from the researcher’s own epistemological position, which values more in depth qualitative explorations of lived experience. However, as Kasket points out (2011), a counselling psychologist researcher must be guided by the methodology best suited to answer the research question and personal worldviews do not preclude them from benefiting from a piece of work that does not demonstrate that stance (Kasket & Gil-Rodriguez, 2011). Indeed, embracing epistemological pluralism in research is consistent with CoP’s emphasis on considering multiple research perspectives to further psychological understanding. Further reflections on the research process are made in Appendix 1.

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2 A power calculation (Soper, 2015) indicated that 97 participants would be needed to detect a medium-sized relationship, maintaining a power of 80%, with a maximum of six predictor variables.
iii) Procedure

Participants were recruited from AA meetings in the UK and online recovery forums by the researcher, an AA member for eight years. Permission was sought from meetings before attending. All participants chose to complete the study at home and were sent an information sheet and the questionnaire by email. The questionnaire included a debrief form, with relevant phone numbers in case of distress. Those recruited from forums responded to a poster on the relevant site and followed the same procedure. Data were collated automatically in Google Forms.

iv) Ethics

The study was approved by the University of Surrey’s Faculty of Arts & Human Sciences Ethics Committee (FAHS EC) and conducted in accordance with ethical guidelines established by the British Psychological Society (BPS) and Health and Care Professions Council (HCPC). The BPS sets out four core principles for ethical human research - respect for the autonomy and dignity of persons; scientific value; social responsibility; maximising benefit and minimising harm. All participants gave informed consent, were told they could withdraw at any point, and were assured confidentiality.

Power, autonomy and boundaries

The existing power imbalance between researcher and vulnerable participant was exacerbated by the primary researcher’s involvement with AA populations. There was a risk that newcomers to AA, anxious and keen to “fit in”, would feel compelled to comply with research requests. Schillito-Clarke describes how dual roles “may call into play subtle and not always conscious forces” (p523). Moreover, the researcher’s presence at the meeting risked putting newcomers off attending, perhaps eliciting fears that anonymity could be compromised. The researcher therefore sought to minimise the risk of harm by adopting a specific approach to recruitment. First, recruitment began at the end of the meeting so that newcomers’ opportunity to benefit from proceedings was
not jeopardised. This also allowed the researcher more time to explain the study, stressing that it was not part of normal procedure, and assuring members that he was deeply cognizant of anonymity and its pride of place within the organization. Second, the researcher did not pro-actively approach members in person. Instead, he was given a few seconds to introduce the study and clarify that he was at the meeting in the role of researcher. He then stood at the back at the end of the meeting. While this approach increased the risk of self-selection bias (discussed in limitations), it seemed, on balance, the correct ethical decision. Finally, in an effort to make participants feel less like subjects and more like co-researchers (see Berger and Malkinson 2000), the researcher agreed to disseminate and discuss the results with participants who express an interest.

**Impact of questionnaires**

Another important matter was the potentially distressing impact of the questionnaires. Research indicates that mental health service users find long lists of negatively worded items in mood scales upsetting (Crawford, Robatham and Thana 2011). Moreover, evidence from mood induction studies has shown that negative wording can induce low affect in abstinent individuals, leading to an increased subjective desire to drink (see for example, Cooney, Mark and Morse, 1997). Of particular concern, therefore, was the strong focus on negatively worded items in the shame scale, particularly since all participants responded remotely. Hence, the decision to conduct the pilot study. It was also decided to order the questionnaire sheets so that they ended with the entirely positively worded Wellbeing questionnaire, since mood induction works both ways (Ruys & Stapel, 2008). Finally, every effort was made to enable participants to communicate potential distress to either the lead researcher or his supervisor and debrief sheets included numbers for the AA hotline and the Samaritans.

**v) Measures**

*Self-compassion:* Self-Compassion was assessed using the 26 item Self-compassion Scale (Neff, 2003a), with responses ranging from 1 (almost never) to 5 (almost always). It has
six subscales self-kindness, self-judgment, common humanity, isolation, mindfulness and over-identification. These can be examined separately, or else a total self-compassion score calculated. Scores below 2.5 are considered low, between 2.5 and 3.5 moderate and between 3.5 and 5 high (Neff & Germer, 2013) (Cronbach’s $\alpha$ = .89).

**Shame:** Shame was measured using the 30-item Internalized Shame Scale (Cook, 1988), initially among individuals suffering with alcohol addiction. It is comprised of 24 negatively worded items and six positively worded items, taken from the Rosenberg Self-Esteem Scale (Rosenberg, 1965). Participants respond on a five-point Likert scale ranging from Never to Almost always. The shame score is obtained by excluding the self-esteem items and summing the remaining items. Scores over 50 indicate clinical levels of shame, and over 60 extreme levels (Cronbach’s $\alpha$ = .89).

**Wellbeing:** Wellbeing was measured using the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) (Tennant et al., 2007). This has 14 positively worded items, with five response categories ranging from 1 (None of the Time) to 5 (All of the Time). The statements cover both feeling and functioning, for example, “I’ve been feeling optimistic about the future” and “I’ve been feeling close to other people”. It measures mental wellbeing (as opposed to mental illness or disorder), something considered particularly relevant from a counselling psychology perspective. Scores are summed (Cronbach’s $\alpha$ = .94).

**Steps completed:** The number of the 12 Steps completed was assessed by asking participants “How many of the 12 Steps of AA Recovery have you completed?” with the option to tick boxes from 0-12.

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3 Cook (1989) maintains that the self-esteem subscale is not designed to be an independent measure of self-esteem but rather to further corroborate scores on the shame scale. As such, the current study does not include the self-esteem subscale in the analyses.
Meetings attended: Participants were asked, “On average how many AA meetings do you get to a week?” They selected from: this is my first meeting; less than 1; 1; 2; 3; or more than 3.

Meditation practice: Participants were asked, “How often do you meditate as part of your AA programme?” with the option to select: never; sometimes; often; nearly every day.

Gratitude lists: Participants were asked, “How often do you complete a gratitude list as part of your AA programme?” with the option to select; never; sometimes; often; nearly every day.

Abstinence: Participants were asked “When was the last time you drank alcohol?” with the option to select: Less than a month ago; 1-6 months; 7-12 months; 13-24 months; 2-5 years; more than 5 years.

Results

Pilot study

Written responses to the pilot study are contained in Appendix 4. Visual observations of respondents and analysis of their responses revealed no obvious signs of significant distress.

Main Analysis

Table 1 presents the means and standard deviations for all of the study variables. Hierarchical multiple regression was performed to test H2, that various aspects of the AA programme (Steps, gratitude, meditation and meetings) would predict levels of self-compassion, after controlling for abstinence and gender. The results are summarised in
Table 2\textsuperscript{4}. Preliminary analyses indicated violations of the assumption of normality and therefore a robust regression method was employed, using bootstrapping to generate confidence intervals and significance tests of the model parameters. In the first step, two predictors were entered; gender and abstinence. In this model, abstinence was a significant predictor of self-compassion ($\beta = .37, p < .001$), but gender was not significant ($\beta = .37, p = .417$). This model was statistically significant, $F(2, 95) = 8.02; p < .001$ and explained 14\% of variance in self-compassion (Table 2). After entry of the 12 Steps, meditation and meetings, the total variance explained by the model as a whole was 22\%, $F(6, 91) = 4.26, p < .001$. This represents a medium to large effect size (Selya, Rose, Dierker, Hedeker, & Mermelstein, 2012), Cohen’s $f^2 = .28$\textsuperscript{5}. In this model, abstinence was no longer a predictor of self-compassion ($\beta = -.02, p = .928$), while the 12 Steps completed was a significant predictor ($\beta = .46, p = .008$). Self-compassion was not predicted by meditation ($\beta = .09, p = .407$) or meetings attended ($\beta = .02, p = .818$).

\textsuperscript{4} This format of table for reporting regression is recommended for clarity by Field (2013), p. 352.

\textsuperscript{5} Cohen’s $f^2$ is recommended for hierarchical multiple regression, where .02 represents a small effect, .15 a medium effect and .35 a large effect (Selya, Rose, Dierker, 2012).
Table 1. Means, standard deviations and bivariate correlations for all variables

<table>
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<tr>
<th>Variables</th>
<th>M</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
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<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>2. Self Comp</td>
<td>3.15</td>
<td>0.77</td>
<td>-.77**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. Wellbeing</td>
<td>49.70</td>
<td>10.04</td>
<td>-.62**</td>
<td>.52**</td>
<td>-</td>
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<td>4. 12 Steps</td>
<td>9.98</td>
<td>3.65</td>
<td>-.40**</td>
<td>.45**</td>
<td>.12</td>
<td>-</td>
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<tr>
<td>5. Gratitude</td>
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<td>1.00</td>
<td>-.11</td>
<td>.17</td>
<td>.15</td>
<td>.30**</td>
<td>-</td>
<td></td>
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<tr>
<td>6. Meditation</td>
<td>2.78</td>
<td>1.10</td>
<td>-.14</td>
<td>.21*</td>
<td>.02</td>
<td>.30**</td>
<td>.34**</td>
<td>-</td>
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<tr>
<td>7. Abstinence</td>
<td>4.75</td>
<td>1.74</td>
<td>-.30**</td>
<td>.34**</td>
<td>.17</td>
<td>.84**</td>
<td>.28**</td>
<td>.23*</td>
<td>-</td>
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<tr>
<td>8. Meetings</td>
<td>4.53</td>
<td>1.32</td>
<td>.03</td>
<td>-.06</td>
<td>.09</td>
<td>-.15</td>
<td>.05</td>
<td>.03</td>
<td>-.20*</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>10. Gender</td>
<td>0.47</td>
<td>0.5</td>
<td>-.04</td>
<td>.12</td>
<td>.12</td>
<td>.05</td>
<td>.12</td>
<td>-.16</td>
<td>-.04</td>
<td>.12</td>
<td>-</td>
</tr>
</tbody>
</table>
Table 2. Linear model predictors of self-compassion, with 95% bias corrected and accelerated confidence intervals reported in parentheses (confidence intervals and standard errors are based on 1000 bootstrap samples)

<table>
<thead>
<tr>
<th></th>
<th>$R^2$</th>
<th>$\Delta R^2$</th>
<th>$b$</th>
<th>SE B</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abstinence</td>
<td>.11</td>
<td>(-1.51, 0.38)</td>
<td>.14</td>
<td>.07</td>
<td></td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td>.22</td>
<td>.07</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.12</td>
<td>(-0.15, 0.37)</td>
<td>.15</td>
<td>.08</td>
<td></td>
</tr>
<tr>
<td>Abstinence</td>
<td>-.01</td>
<td>(-0.19, 0.16)</td>
<td>.10</td>
<td>-.02</td>
<td></td>
</tr>
<tr>
<td>12 Steps</td>
<td>.10</td>
<td>(0.01, 0.18)</td>
<td>.04</td>
<td>.46**</td>
<td></td>
</tr>
<tr>
<td>Meditation</td>
<td>.06</td>
<td>(0.09, 0.24)</td>
<td>.08</td>
<td>.09</td>
<td></td>
</tr>
<tr>
<td>Meetings</td>
<td>.01</td>
<td>(-0.11, 0.15)</td>
<td>.06</td>
<td>.02</td>
<td></td>
</tr>
</tbody>
</table>

**Notes.** *****$p<.001$, **$p<.01$, *$p<.05$**

Similar analyses (using bootstrapping) were repeated to see if aspects of the AA programme would predict the dependent variables, wellbeing ($H5$) and shame ($H1$). For shame, gender and abstinence were added in the first step, and 12 Steps and meetings were added in the second step. In the first model, abstinence was a significant predictor of shame ($\beta = -.39$, $p < .01$), but gender was not significant ($\beta = -.03$, $p = .749$). This model was statistically significant, $F(2, 96) = 8.46$; $p < .001$ and explained 15% of variance in shame. After entry of the 12 Steps and Meetings, the total variance explained by the model as a whole was 20%, $F(4, 94) = 5.83$, $p < .001$. This represents a medium sized effect, Cohen’s $f^2 = .20$. In this model, abstinence was no longer a predictor of shame ($\beta = -.08$, $p = .703$), while the 12 Steps was a marginally significant
predictor (β = .38, p = .065) of shame. Shame was not predicted by meetings (β = .07, p = .540). The analysis was repeated for wellbeing. None of the IVs hypothesized to predict wellbeing (12 Steps, meditation, gratitude or meetings) were significant.

Mediation analysis

To test whether self-compassion functioned as a mediator between Steps completed and shame (H4) the bootstrapping procedures outlined in Preacher and Hayes (2008) were used. The major problem of the Sobel test (Baron & Kenny, 1986) is that it needs the assumption of normality of the sampling distribution of the indirect effect. However, small or finite samples are rarely normally distributed. Thus, bootstrapping, a nonparametric resampling procedure, is advised over the Sobel test since it makes no assumptions about the shape of the sampling distribution of the indirect effect (Preacher & Hayes, 2008). A mediation analysis was computed to assess whether the effect of completing Steps on shame was mediated by levels of self-compassion, while controlling for gender and abstinence. The 12 Steps predicted shame (β = -2.04, p = .024). The 12 Steps also predicted the mediator, self-compassion (b = .10, t = 2.85, p = .005). The path between self-compassion and shame while controlling for the predictor was significant (β = -17.61, t = -9.33, p < .001). When the mediator was controlled, the relationship between 12 Steps and shame became non-significant (β = -2.85, t = -0.426, p = .67). Since zero was excluded from the 95% bias-corrected confidence interval (BC CI) obtained by bootstrapping of 1,000 subsamples (ranging from -3.34 to -.585), the indirect effect was significant, p < .05. Therefore, in line with predictions, the effect of the 12 Steps on shame was mediated by self-compassion and this represents a large effect, $\kappa^2 = .35$, 95% BCa CI [.238, .474]. The results of this analysis are summarised in Model 1 below.
Model 1: Indirect effects on shame

![Diagram of the model with regression coefficients]

Notes: ***p<.001, **p<.01, *p<.05. Covariates effects have been omitted, 95% CI Bias Corrected Interval is depicted for the indirect effect

Sponsorship style and wellbeing, self-compassion and shame

Analysis of variance was conducted to see whether levels of self-compassion, wellbeing and shame varied depending on sponsorship attitude (H3). The only significant effect was of sponsor type on wellbeing, F(3, 106) = 2.89, p = .039. Post hoc comparisons were conducted using the Hochberg G2 Test, as this test is advised when group sizes are unequal (Field, 2013). These comparisons indicated that the only significant difference in groups was between those whose sponsors who helped them see their defects (M = 52.83, SD = 10.8) and those without sponsors (M = 44.56, SD = 6.62). These results are illustrated in Figure 2.
Figure 2. Mean wellbeing scores for participants with different types of sponsors

Discussion

Results indicated that shame was negatively predicted, at a marginal level, by the number of Steps completed, when controlling for abstinence. However, contrary to expectations, meetings attendance did not predict shame. Hypothesis 1 was thus partially supported. Steps completed positively predicted self-compassion, even when controlling for abstinence. However, contrary to predictions, meetings and meditation practice did not predict self-compassion. Hypothesis 2 was thus also partially supported. Hypothesis 3 - that AA members with a sponsor who encouraged self-forgiveness would be higher in self-compassion and wellbeing and lower in shame than those without sponsors or those with sponsors who focused on defects - was not supported. In fact, while no significant differences between groups were found for self-compassion and shame, participants with defect-focused sponsors had the highest levels of wellbeing. The prediction that levels of shame would be mediated by self-compassion was
supporting, in line with Hypothesis 4. The results failed to support Hypothesis 5 - that meditation frequency, gratitude frequency, frequency of meetings and working through the 12 Steps would predict wellbeing. These findings are discussed in relation to previous research before implications for CoP practice are considered. A number of limitations are discussed.

**AA programme and shame**

The finding that shame decreased as participants progressed through the 12 Steps is consistent with previous qualitative research (Randa, 2010) and narrative accounts within AA (Wilson, 1939). Yet, this study provides the first evidence that shame decreases as members move through the programme. Generally, the finding illuminates previous accounts which suggests that shame is an important emotion for those with alcohol-related difficulties (e.g. Dearing, Stuewig, & Tangney, 2005; Meehan, O’Connor, Berry, Weiss, Morrison & Acampora, 1996). The fact that the number of meetings participants went to was not associated with shame is intriguing and raises the possibility that reductions in this emotion occur by steadily working through each Step, processing experiences, rather than simply showing up at meetings.

**AA programme and self-compassion**

Results provide the first evidence that working through AA’s 12 Steps is associated with enhanced self-compassion. This is consistent with research that participation in alcohol treatment, generally, is associated with higher self-compassion (Brooks, et al., 2012), as well as the phenomenological investigation linking a steady progression through the Steps with a gradual increase in self-acceptance (Randa, 2010).

This finding is also consistent with theoretical links made in the introduction between ingredients of the programme and conceptualisations of self-compassion (Neff, 2003; Gilbert & Proctor, 2006), whereby self-compassion is enhanced through identifying with others, writing down and sharing painful experiences, relinquishing resentments,
helping others and taking action to change harmful behavior (e.g. Neff, 2016; Gilbert, 2017). The finding supports AA’s theoretical contention that the process of change is incremental and related to action.

Unexpectedly, self-compassion was not predicted by frequency of meditation or meetings attended. One explanation for the non-significant finding relating to meditation may be that the practice was too vaguely defined in the questionnaire. Most previous research evaluating effects of meditation on self-compassion have evaluated specific forms of practice, such as mindfulness of breath (e.g. Kuyken et al., 2010) or self-compassion meditations (Neff & Germer, 2013). Although there has been much integration of AA with mindfulness approaches (Littlejohn, 2009), meditation for some in AA may have a more religious flavour, in line with Step 11’s encouragement to “improve our conscious contact with God” (Wilson, 1939, p. 59). Future research on this topic should thus specify more clearly in questionnaires between different forms of meditation.

The number of meetings attended also did not predict self-compassion, as was the case with shame. This finding strengthens the possibility that changes in self-to-self relating result from a gradual process of actively sharing and processing experience, while working through the tasks contained in the steps, rather than simply attending meetings, or reliance on any one aspect of the programme.

Sponsorship, wellbeing, shame and self-compassion

Contrary to predictions participants who had sponsors who were deemed to help them forgive themselves were not higher in self-compassion or wellbeing or lower in shame, than those without sponsors, or with sponsors who drew attention to “defects of character” or self-centredness. Indeed, the only significant difference between groups was between those that had defect-focused sponsors and those without sponsors, with the former having significantly higher levels of wellbeing. There is a similar pattern (at a trend level), in relation to self-compassion, with defect-focused sponsors having the
highest levels and those without sponsors the lowest. This appears counter-intuitive, but it raises an intriguing possibility.

It is difficult to see how sponsors who focus on defects of character could elicit anything other than a shameful sense of self for the sponsee (see Le, Ingvarson, and Page, 1995, for an interesting critique of the Steps, on this score). One interpretation however may rest in the psychological distinction between shame and guilt and how this plays out in the relationship between sponsee and sponsor. Lewis (1971) conceptualized guilt as a painful focus on a wrong action while shame is related to a direct negative reflection on one’s self-worth. According to Lewis (1971), guilt spurs reparative behavior while shame elicits hiding, escape and self-loathing. There is evidence to suggest that while shame is damaging, guilt may motivate people towards reparation or change (Baumeister, Stillwell, & Heatherton, 1995) and is related to empathy and self-esteem (Kim, et al., 2011). Indeed, as mentioned above, Neff (2016) suggests that self-compassion requires a commitment to change harmful behaviours.

While shame-proneness is positively associated with alcohol problems (Randles & Tracy, 2013), guilt-proneness is negatively related to consumption (e.g. Meehan et al., 1996). Against this conceptual distinction, it may be that what defect-focused sponsors facilitate is not harsh judgment of the self, eliciting shame, but accountability for past and current behavior, eliciting guilt, which boosts positive emotions (Kim, et al., 2011). This idea is supported by the fact that what the steps actually encourage members to do is make a list of past actions, with a view to rectifying them and making amends. It may therefore be that sponsors who were considered more defect-focused by participants actually helped them focus more sharply on destructive past behavior, facilitating reparative guilt, with a positive impact on mood.

**AA programme and wellbeing**

Surprisingly, no part of the AA programme, other than sponsorship, predicted wellbeing. The fact that meetings did not predict wellbeing is inconsistent with previous research
(Kelly, at al., 2010b) indicating attendance was associated with reduced depression. One possible interpretation for this inconsistency is that those who go to more meetings are lonelier than those who do not, or have more time on their hands due to unemployment or sickness, factors which have been shown to have an adverse impact on wellbeing (e.g. Vinamki, et al., 1993; VanderWeele & Hawkley, 2012). This would be consistent with some of the case studies in the Big Book.

The finding that working through the 12 Steps did not predict wellbeing is surprising given the various theoretical links proposed above and other-focused attention (Schwartz et al., 1999). One interpretation of this relates to what is known in AA circles as the “pink cloud” and has been described as the “unexpected feeling of extraordinary well-being that often follows the stress of detoxification” (Baumohl, 1989 p. 288). In other words, it may be that the very act of sobering up and finding hope in AA provide participants with a lift out of their previous despair. In this way, AA newcomers may respond positively to questions on the wellbeing scale (Tennant et al., 2007), such as item 1 “I’ve been feeling optimistic”. This idea is consistent with evidence linking wellbeing to novel experience and dopaminergic pathways in the brain (Buchanan & Bardi, 2010). Indeed, there is some support in the data, at a trend level, for this idea. For example, the mean scores of those in the first six months of recovery are higher ($M = 51.50, n = 8$) than for those at 7-12 months ($M = 46.67, n = 6$) or 13-24 months ($M = 45.50, n = 6$), before rising again between two to five years ($M = 55.47, n = 17$). More longitudinal research is needed to investigate this possibility further.

The absence of effect for gratitude lists on wellbeing is also surprising given the abundance of evidence linking these two constructs (Wood, et al., 2010). Again, one explanation may be that the question assessing this measure was not specific enough. In the review on gratitude’s effects on wellbeing (Wood, Froh and Gerraty, 2010), all 12 studies focused on measures of gratitude that involved writing gratitude down, be it in journals or as a part of letter writing. It may be that for those in this AA sample, the notion of doing a gratitude list was broader and included completing only mental lists,
which may not have same impact. This would be consistent with accounts in the study by Randa (2010) and AA literature.

The overall lack of support for a positive relationship between any part of the AA programme (other than sponsorship), and wellbeing could also be the result of design limitations. The within-subjects design introduces the risk of carryover effects - the potential for the responses on one scale to be influenced by previous scales (Tourangeau & Rasinski, 2000). In this case, it is possible that the moods of participants were influenced by previous scales, in particular the negatively worded shame scale (Cook, 1989). Carryover effects are shown to be especially pronounced when respondents are asked about attitudes and beliefs that are emotionally relevant to them, as is reasonable to assume would be the case in this study. Indeed, there was some evidence from the pilot study that participants felt sad or especially reflective after the questionnaire (see Appendix 4). It is difficult to see how this could be satisfactorily resolved using multiple measures, and researchers particularly interested in wellbeing and AA, might choose to be more focused in their approach.

**Mediation model: Working the Steps reduces shame by enhancing self-compassion**

A defining feature of this study is support for a mediation model, which proposes that progressively working through the 12 Steps reduces shame by enhancing self-compassion. This original finding is consistent with theoretical accounts in AA literature suggesting that steadily advancing through the programme reduces shame and fosters self-acceptance. It is also consistent with previous evidence indicating negative associations between shame and self-compassion in general populations (Barnard & Curry, 2011), as well as intervention studies indicating that self-compassion reduces shame in shame-prone individuals (e.g. Gilbert & Procter, 2006). Theoretical, clinical and political implications of this model form the main focus of the section below, before limitations are considered and future research suggested.
The mediation model is interesting because it draws together two theoretical frameworks - AA’s account of how shame is lifted by progressively working through the 12 Steps, and a conceptual map which sees shame reduced by cultivating self-compassion. The model suggests that cultivating self-compassion may be a critical ingredient for those in AA recovery and that it is achieved, not by simply turning up to meetings, or stopping drinking, but rather by steadily working through a series of steps, which facilitates the processing of painful shame-inducing experience.

Clinically, this framework raises a number of implications. First, the research provides a point of reference for therapists who are working with more and more AA members hoping to enhance mental health by combining their programmes with therapy (Coats, 2006). Recognising that clients from this population appear to be especially prone to the corrosive impact of shame (e.g. Randles & Tracy, 2014) and understanding how cultivating self-compassion may alleviate it could help to shape clinical interventions when working with this population. For example, counselling psychologists may wish to integrate compassion-based techniques into their approaches, such as Gilbert’s compassion-focused-therapy (CFT) model (Gilbert, 2017). Given the lack of support for meditation and gratitude with self-compassion or wellbeing in this study, therapists might discuss with members how they could adapt these AA-related practices in ways that are more in line with the evidence, for example, writing down gratitude lists or practicing mindfulness of breath meditation.

The findings could prove equally useful for clinicians working with the many clients with alcohol-related difficulties, who are unsure about whether to go to AA. The study provides some context for therapists to hold in mind when exploring the pros and cons of attending AA. When clients decide they do not wish to go to AA, as many do, the value of introducing self-compassionate approaches may be especially important, given evidence suggesting this population has lower than average self-compassion scores,
Generally (Brooks, Kay-Lambkin, Bowman, & Childs, 2012). Moreover, it may be that more secular programmes of recovery - for example, the CBT-based SMART Recovery programme, could look to integrate self-compassionate exercises into protocols. These are currently lacking. Furthermore, given that actively working through the 12 steps appeared to enhance self-compassion, clinicians may seek to extract elements of this programme into interventions. For example, the emphasis on writing down painful material in AA indicates that self-compassionate letter writing may be a particularly useful intervention. Also, given AA’s emphasis on changing and facing harmful behaviours (and the links Neff, 2016, makes between committed change and self-compassion), clinicians working in a CBT way, might emphasise the behavioural focus of this therapeutic approach.

Politically, the research challenges the wisdom of punishing individuals who are caught in a self-defeating battle with shame, alcohol or drugs. Instead, it loudens the call for a more restorative and compassionate justice approach to this population. In June of 2015, the The Division of Counselling Psychology Social Justice Network was launched and such research may prove helpful to those interested in this area. Psychologists working with individuals who are in prison after committing crimes related to alcohol might also seek to reduce shame by introducing self-compassion exercises.

**Limitations and future research**

This research has several significant limitations, some of which have already been discussed above. Perhaps the most obvious is the cross-sectional, correlational design, which limits causal interpretations. It may be, for example, that individuals with higher self-compassion at the outset are more likely to tolerate the hardships involved in processing experience as they progress through the Steps. These limitations could be reduced by adopting more longitudinal methods, which were not possible in the present research, because of time constraints. An even tighter method would be to randomly allocate participants at an alcohol intervention service to different groups, including a
no treatment group, and test for changes to self-compassion and shame. However, given what we know about the benefits of at least some form of treatment (eg. Kelly, Stout, Magill, Tonigan, & Pagano, 2010a), it is ethically questionable (certainly from a CoP perspective) to allocate vulnerable participants, with a high risk of relapse (Randles & Tracy, 2013), to a control group. For an interesting discussion on the ethics of comparison groups see Areán and Alvidrez (2002). A third possibility would be to conduct a more phenomenological investigation exploring the experience of self-compassion in a smaller sample, to gain a more nuanced picture of how this construct impacts on lives.

A related design problem is the potential for self-selection bias in these results. The majority of those who took part in the study chose to respond to a post in one of several internet forums. It may be that participants' decision to take part was correlated with traits measured in this study. For example motivation itself has been negatively associated with shame (Breines & Chen, 2012).

Attempts were made to account for the fact that the sample was heavily skewed towards those that had completed all of the 12 steps (robust method of regression and analysis of variance were used), but future research should aim to increase the number of participants at the lower end of the 12 step scale. One way to do this would be to target meetings that are run specifically for AA newcomers. These can usually be found in larger towns and cities. Another epistemological limitation of this study is that it relied on self-report measures. These were filled out at home meaning there was less control over possible distractions. Indeed, Randles and Tracy (2013) propose that shame is a particularly difficult emotion to assess. They suggest that the painfulness of experiencing shame combined with its associated tendencies of hiding and escape may lead those who are shame-prone to avoid acknowledging those feelings in a self-report measure. Furthermore, it has been demonstrated that shame is often experienced at an implicit level, making it difficult for individuals to consciously report it (Mikulincer & Shaver, 2005). In light of this evidence, future studies might seek to use physiological or
implicit measures, or, as discussed above, choose to investigate these phenomena, using qualitative methods.

Finally, these findings are limited by the overwhelmingly Caucasian sample. There is evidence to suggest that levels of self-compassion and shame vary in different cultural contexts (Neff, Pisitsungkagarn, & Hsieh, 2008). Future studies might thus seek to include participants of different ethnicities. Given that AA is a global organization it should be possible to target forums in different countries.

Conclusion

The findings propose a psychological model which suggests how progressing through the tasks contained in AA’s programme of recovery reduces shame by enhancing self-compassion. For clinicians, it suggests that enhancing self-compassion in clients who are experiencing difficulties with alcohol may be an important focus. This might be particularly significant for the many clients who do not attend AA. Punishing individuals who commit crimes related to their alcohol consumption, without addressing issues of shame and self-compassion, is likely to be unhelpful. Future research is needed to address the design limitations of this research, and longitudinal studies are encouraged to tighten directionality.
References


Appendix 1.

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Each manuscript must be in English, in 12-point Times New Roman font, with everything double-spaced (including references) and 1" margins. The following sections should be included in the order listed: (a) Title Page, (b) Abstract, (c) Introduction, (d) Method, (e) Results, (f) Discussion, (g) Acknowledgments, (h) References, (i) Tables, (j) Captions for Figures, and (k) Figures.

Please note: JSAD has specific policies regarding use of the term abuse. See the link at the top of this page for more information. Regarding the term binge, authors should include an operational definition for the term as well as an in-text citation and corresponding reference in the list for the source of the definition.

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Abstract Page: Abstracts should be 250 or fewer words and must include the following information under the these four headings: (a) Objective: the background and purpose of the study (in a complete, grammatical sentence); (b) Method: the study design, setting, participants (including manner of sample selection, number and gender of participants) and interventions; (c) Results: details of major findings; and (d) Conclusions: main inferences drawn from results and potential application of findings.

Introduction: This section, which should begin a new page, should acquaint the reader with the background of the study and should contain a clear statement of the goals of the investigation or the hypotheses that the study was designed to test.

Method: For all research containing human subjects, the first paragraph of the method section should provide detail about human subjects review and institutional review board approval. The methods should be described in sufficient detail to allow the reader to judge their accuracy, reproducibility, and reliability. New methods or procedures and modifications of previously published methods should be described in sufficient detail to permit replication of the study. Commonly used methods require only a citation of the original source.
**Results:** The experimental data should be described succinctly but completely in text without redundancy between figures and tables or discrepancy between text and tables. Graphic and tabular displays are preferred to discursive narrative. Sufficient data must be provided to allow readers to judge the variability and reliability of the results. Average values must be accompanied by standard errors or standard deviations (e.g., $M = 21.5, SD = 0.95$). Statistical analysis of the data should be explained early so that the interested but nonexpert reader can interpret the findings. The results of statistical tests should be accompanied by degrees of freedom, for example, $t(27) = 2.12, p = .05, F(3, 27) = 6.51, p = .0$. **For the presentation of statistics in the text, use American Psychological Association (APA) style** (Publication Manual of the APA, Sixth Edition, Second Printing). For further guidance on the appropriate presentation of results, authors should consult Carpenter, J. A. (1996) Between acceptance and publication. A sampling of some common problems. *Journal of Studies on Alcohol and Drugs*, 57, 341–343.

**Discussion:** The discussion of the experimental findings and their interpretation should be brief and focused. Alternative interpretations and/or limitations in the procedures should be explained. Avoid repetition of material in the introduction and detailed repetition of the experimental findings. Speculative discussion should be limited and directly relevant to the results obtained.

**Acknowledgments:** Acknowledgments made to individuals should be as brief as possible.

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Three or more authors: . . . (Jefferson et al., 1998) . . .

Authors' names in the text (first and all subsequent citations):
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Multiple works by the same first author: If two or more references in the list have the same first author, have three or more authors, and were published in the same year (e.g., an article by Arthur, Cleveland, and Harrison published in 1988 and a second article published by Arthur,
McKinley, and Hayes also in 1988), the first article would become "1988a" and the second would become "1988b" in the reference list. On the first and all subsequent in-text citations, Arthur, Cleveland, and Harrison should be cited "Arthur et al., 1988a," and Arthur, McKinley, and Hayes should be cited "Arthur et al., 1988b."

Reference list: JSAD publishes all reference lists in APA style (Publication Manual of the APA, Sixth Edition, Second Printing). In the following, we present a brief sample of a reference list entry for a journal article and a book chapter. Please consult the Publication Manual of the APA for additional details about styling reference lists. More information and tutorials are also available at: www.apastyle.org. EndNote Users: Authors who use EndNote can download JSAD’s reference style directly from EndNote’s website via this link: http://endnote.com/styles/J%20Studies%20Alcohol%20Drugs.ens

Journal Articles

Book Chapters

Tables: Each table should be typewritten on a separate page and should be numbered consecutively with Arabic numerals. Each table must have a concise descriptive heading and should be constructed as simply as possible: Preferably use only tabs and text typed directly in the word processing document, or use Word’s table function. Tables must be intelligible without reference to the text (e.g., in the footnotes, define all abbreviations used in the table). Footnotes to tables should be referred to by italicized lowercase superscript letters (\textsuperscript{a,b,c} etc.) and should appear beneath the table involved, not on a separate page of the manuscript. Do not use any functions or tools that format footnotes, but instead set footnotes in plain type below the table.

Figures Captions: These should be numbered consecutively in Arabic numerals and should appear on a separate page of the manuscript. Captions should explain the figures in sufficient detail so that repeated reference to the text is unnecessary. Abbreviations in the captions should conform to those in the text.

Figures: Copies of all figures should be embedded within the word processing file at the end of the manuscript, if possible. However, authors may submit figures as separate files. Figures will be
photo-reproduced and thus must be supplied fully camera-ready. Figures preferably should be black and white only, with black and white hatching or design used in the place of gray or color. (If a figure requires grayscale and cannot be altered to contain black and white only, create a file of the figure in .tif format with 300 dpi. If a file requires color, create a high-resolution CMYK .eps file with 300 dpi.) Authors will be charged a fee for the use of color. Symbols, numbers, and letters should be supplied in 11–14 point boldface (2.5–3.5 mm); all borders, rules, and lines should also be printed in boldface. The title of each figure should appear in the caption rather than on the figure itself.

**Supplemental material:** Authors should be judicious in their use of tables, figures, and appendices. Any tables, figures, or appendices that are excessive in length or that would expand a journal article beyond standard length may be included as online-only supplemental material. If deemed necessary by the peer reviewers or editor, such files would be included with the journal article online upon publication. When authors submit manuscripts, any supplemental material should be included at the end of the manuscript (after tables, figure captions, and figures) so that the supplemental material may be easily accessed by peer reviewers. Please denote supplemental tables and figures with letters (e.g., Supplemental Table A, Supplemental Figure A) to distinguish them from the numbered tables that will appear within the article itself. NOTE: Supplemental material is not copy edited or typeset.

**Abbreviations, Symbols, and Nomenclature:** Blood alcohol concentration (BAC) should be expressed in percent for whole blood and in mg/dl for plasma. Whether whole blood or plasma was used should be indicated. The forensic standard for BAC (e.g., driving while intoxicated = .08%) is measured in whole blood and is 85% of BAC measured in plasma (118 mg/dl).

Alcohol dose should be expressed in g/kg to facilitate comparisons across preparations and species.

Alcohol used in in-vitro studies should be expressed in mM.

Standard abbreviations for the route of alcohol administration are as follows: IG, intragastric; IP, intraperitoneal; IV, intravenous; PO, orally.

Nonstandard abbreviations, symbols, or acronyms not easily understood by the general scientific reader should be avoided. In general, abbreviations should be avoided in text except for standard units of mass, concentration, time, length, volume, and temperature; routes of drug administration; standard error; and standard deviation.
Drugs: Generic names should be used in the text, tables, and figures. Trade names may be mentioned in parenthesis in the first text reference to the drug but should not appear in titles, figures, or tables. When a trade name is used, it should be capitalized; generic or chemical names are not capitalized. The form of drug used in calculations of doses (e.g., base or salt) should be indicated.

Ethical Assurances: Studies involving human subjects should explicitly indicate that informed consent was given for participation in the research.

Studies involving animals should indicate that care and maintenance were conducted in accordance with National Academy of Sciences-National Research Council (NAS-NRC) guidelines. The type and dose of anesthetic agent used in surgical procedures should be specified.

Pagination: Each manuscript page should be numbered consecutively in the upper right-hand corner, and the last name of the first author should appear next to the page number in the header. Other than the Introduction, sections do not need to begin on a new page.

PROOFS AND REPRINTS

Galley proofs will be sent to the corresponding author and should be returned within 72 hours.

*Please do not hesitate to contact the Managing Editor's Office if you have any questions or comments about these*
Appendix 2. Ethics approval

Faculty of Arts and Human Sciences
Ethics Committee

Chair’s Action

Proposal Ref: 1104-PSY-15
Name of Student/Trainee: DAMIEN PEARSE
Title of Project: Is participation in the programme of alcoholics anonymous positively associated with self-compassion and reduced internalised shame
Supervisor: Dr Michele Birtel
Date of submission: 03 MARCH 2015
Date of confirmation email: 26TH MARCH 2015

The above Research Project has been submitted to the FAHS Ethics Committee and has received a favourable ethical opinion from the Faculty of Arts and Human Sciences Ethics Committee with minor conditions. Confirmation has been received that the conditions stipulated after ethical review have now been addressed and compliance with these conditions has been documented.

The final list of documents reviewed by the Committee is as follows:

Protocol Cover sheet
Summary of the project
Detailed protocol for the project
Participant Information sheet
Consent Form

This documentation should be retained by the student/trainee in case this project is audited by the Faculty Ethics Committee.

Signed and Dated:  
Professor Bertram Opitz  
Chair

Please note: If there are any significant changes to your proposal which require further scrutiny, please contact the Faculty Ethics Committee before proceeding with your Project.
Appendix 3. Responses on questionnaire from pilot study

Responses on questionnaire from pilot study. Three participants were asked to complete the full questionnaire in the presence of the researcher. They were then asked to write down answers to two questions:
1) How did you feel after completing the questionnaire?
2) Is there anything you would change about the questionnaire?

Participant 1 (more than five years sobriety)

How did you feel after completing the questionnaire?

“I felt quite tired but ok generally. Some of the questions brought back memories of early recovery and made me realise just how far I have come.”

Is there anything you would change about the questionnaire?

“I felt that the questionnaire was quite long and some of the questions seemed rather repetitive. I would have preferred a shorter questionnaire.”

Participant 2 (between 1-5 years sobriety)

How did you feel after completing the questionnaire?

“It made me feel like I don’t like myself very much! I’m not sure what the questions were getting at but I think that I must hate myself more than I thought. I came away feeling ok, but a little sad.”

Is there anything you would change about the questionnaire?

“No.”

Participant 3 (under one year sober)

How did you feel after completing the questionnaire?

“Felt fine. I thought the questionnaire was interesting and it made me reflect on my feelings towards myself. I see a therapist most weeks and this will be food for thought.”

Is there anything you would change about the questionnaire?

“I thought that some of the questions were quite similar, but I suppose that’s the nature of it. It was quite difficult to focus at times, because the questions were similar so it needed some concentration. Overall though, I had no concerns. Good luck!”
Appendix 4. Participant Information Sheet

26/01/15

Participant Information Sheet

Experiences with Alcoholics Anonymous and Personal Attitudes and Beliefs

Introduction

I am a member of Alcoholics Anonymous and also a doctoral student at the University of Surrey. I would like to invite you to take part in a research project. Before you decide you need to understand why the research is being done and what it will involve for you. Please take the time to read the following information carefully.

What is the purpose of the study?

You are being asked to take part in a research study that examines your experiences in the Alcoholics Anonymous programme as well as attitudes and beliefs about yourself.

Why have I been invited to take part in the study?

Because you are a member of Alcoholics Anonymous.

Do I have to take part?

No, you do not have to participate. There will be no adverse consequences in terms of your AA membership. If you decide to participate, you can withdraw at any time without giving a reason.

What will my involvement require?

In this study you will be asked to complete one questionnaire about your participation in AA and some of your attitudes and beliefs about yourself. You can complete the questionnaire now, take it away and return to me in person or by email or I can send you an electronic copy for you to complete. The questionnaire should take no longer than 20 minutes to complete. No expenses will be paid for taking part.

What will I have to do?

If you would like to take part please complete an informed consent form and then read and complete a questionnaire.

What are the possible disadvantages or risks of taking part?

There are no known benefits or risks for you in this study. However, if you feel distressed at any point during the study, you can stop without explanation. There are some helpline numbers at the bottom of this information sheet if you feel you need support. You can also contact the researchers, listed below.
What are the possible benefits of taking part?

It is unlikely that you will benefit directly but it is hoped that this research will lead to establish a clearer understanding of the impact of AA on its members. It is hoped this research will improve the quality of addiction treatment.

What happens when the research study stops?

After the study has been completed, you will be debriefed and made aware of the full research aims. If you want to find out about the final results of this study, you should contact me on d.pearse@surrey.ac.uk and I will arrange to give you a copy of the final study.

What if there is a problem?

My supervisor Dr Michele Birtel will be glad to answer your questions about this study at any time. You may contact her at m.birtel@surrey.ac.uk.

Will my taking part in the study be kept confidential?

Your participation in this study will be completely anonymous. All information collected will be coded and stored according to an allocated participant number to ensure confidentiality. All data files will be treated with the utmost confidentiality. No individual will be named or identified in any report or possible publication arising from this study. Data will be handled in accordance with the Data Protection Act 1998 and stored for 10 years in a secure place.

Contact details of researcher and supervisor.

My contact details are d.pearse@surrey.ac.uk. My supervisor is Dr Michele Birtel and she can be contacted on m.birtel@surrey.ac.uk.

Who is organising and funding the research?

The research is not being funded by any organisation.

Who has reviewed the project?

The study has been reviewed and received a Favourable Ethical Opinion (FEO) from the University of Surrey Faculty of Arts and Human Sciences Ethics Committee.

Helpline Numbers

Alcoholics Anonymous National Helpline: 0845 7697555
Samaritans: 08457 90 90 90.

Thank you for taking the time to read this Information Sheet.
Appendix 5. Participant Consent Form

Consent Form

- I, the undersigned, voluntarily agree to take part in the study on the experience of Alcoholics Anonymous and personal attitudes and beliefs.

- I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been advised about any discomfort and possible ill-effects on my health and well-being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

- I agree to comply with any instruction given to me during the study and to co-operate fully with the investigators. I shall inform them immediately if I suffer any deterioration of any kind in my health or well-being, or experience any unexpected or unusual symptoms.

- I consent to the use of my personal data, as outlined in the accompanying information sheet, being used for this study and other research. I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).

- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

- I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of volunteer (BLOCK CAPITALS) .................................................................

Signed ......................................................................................................................

Date .........................................................................................................................

Name of researcher/person taking consent .................................................................

(BLOCK CAPITALS)

Signed ......................................................................................................................

Date .........................................................................................................................
Appendix 6. AA experiences questionnaire

1

Study: Experiences with Alcoholics Anonymous and Personal Attitudes and Beliefs

The following questions relate to your participation in Alcoholics Anonymous. Please read each statement carefully and tick the appropriate box.

How long have you been attending AA?
○ Less than a month ago
○ 1-6 months ago
○ 7-12 months ago
○ 13-24 months ago
○ 2-3 years ago
○ More than 5 years ago

When was the last time you drank alcohol?
○ Less than a month ago
○ 1-6 months ago
○ 7-12 months ago
○ 13-24 months ago
○ 2-3 years ago
○ More than 5 years ago

On average how many AA meetings do you get to a week?
○ This is my first meeting
○ Less than once a week
○ Once a week
○ Twice a week
○ 3 times a week
○ More than 3 times a week

How many of the 12 steps of AA recovery have you completed?

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</table>

Are you currently in the process of writing your Step 4 inventory?
○ Yes
○ No

How often do you complete a gratitude list as part of your AA programme?
○ Never
○ Sometimes
○ Often
○ Nearly every day
How often do you meditate as part of your AA programme?
○ Never
○ Sometimes
○ Often
○ Nearly every day

Which description which most applies to your AA sponsor
○ I do not have a sponsor
○ My sponsor reminds me I'm self-centred
○ My sponsor helps me see my defects
○ My sponsor helps me to forgive myself
Appendix 7. Shame questionnaire

The following questions relate to how you feel about yourself. Please circle the appropriate answer.

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Almost Always</th>
</tr>
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</table>
Appendix 8. Self-compassion questionnaire

The following questions explore how you typically act towards yourself in difficult times. Please circle the appropriate answer.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Almost Never</th>
<th></th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I’m disapproving and judgmental about my flaws and inadequacies.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2.</td>
<td>When I’m feeling down I tend to obsess and fixate on everything that’s wrong.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3.</td>
<td>When things are going badly for me, I see the difficulties as part of life that everyone goes through.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>4.</td>
<td>When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5.</td>
<td>I try to be loving towards myself when I feel emotional pain.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>6.</td>
<td>When I fail at something important to me I become consumed by feelings of inadequacy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>7.</td>
<td>When I’m down and out, I remind myself that there are lots of people in the world feeling like I am.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>8.</td>
<td>When times are really difficult, I tend to be tough on myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9.</td>
<td>When something upsets me I try to keep my emotions in balance.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>10.</td>
<td>When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11.</td>
<td>I’m intolerant and impatient towards those aspects of my personality I don’t like.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>12.</td>
<td>When I’m going through a very hard time, I give myself the caring and tenderness I need.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13.</td>
<td>When I’m feeling down, I tend to feel like most other people are probably happier than I am.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14.</td>
<td>When something painful happens I try to take a balanced view of the situation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15.</td>
<td>I try to see my failings as part of the human condition.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16.</td>
<td>When I see aspects of myself that I don’t like, I get down on myself.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>17. When I fail at something important to me I try to keep things in perspective.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. When I'm really struggling I tend to feel like other people must be having an easier time of it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. I'm kind to myself when I'm experiencing suffering.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. When something upsets me I get carried away with my feelings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22. When I'm feeling down I try to approach my feelings with curiosity and openness.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23. I'm tolerant of my own flaws and inadequacies</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24. When something painful happens I tend to blow the incident out of proportion.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>25. When I fail at something that's important to me, I tend to feel alone in my failure.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>26. I try to be understanding and patient towards those aspects of my personality I don't like.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</table>
Appendix 9. Wellbeing questionnaire

*Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 weeks*

<table>
<thead>
<tr>
<th>STATEMENTS</th>
<th>None of the time</th>
<th>Rarely</th>
<th>Some of the time</th>
<th>Often</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>I’ve been feeling optimistic about the future</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I’ve been feeling useful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I’ve been feeling relaxed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>I’ve been feeling interested in other people</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I’ve had energy to spare</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<tr>
<td>I’ve been dealing with problems well</td>
<td>1</td>
<td>2</td>
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<tr>
<td>I’ve been thinking clearly</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
</tr>
<tr>
<td>I’ve been feeling good about myself</td>
<td>1</td>
<td>2</td>
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<tr>
<td>I’ve been feeling close to other people</td>
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<tr>
<td>I’ve been feeling confident</td>
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<td>I’ve been able to make up my own mind about things</td>
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<td>5</td>
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<tr>
<td>I’ve been feeling loved</td>
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</tr>
<tr>
<td>I’ve been interested in new things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I’ve been feeling cheerful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix 10. Demographics

Finally, please answer a few questions about yourself.

Please write down your personal code here. We ask for this code only so that we can identify your responses in the event that you would like us to remove them from the summary of results. Please note that your participant code will not be associated with your name and surname. In fact, you are the only person who will be able to identify your questionnaire on the basis of this code. Please write down the last three letters of your mother’s maiden name and your month of birth, e.g. [LIK-09]:

Personal code: __ __ __ __

What is your gender? ☐ Male ☐ Female

What is your age? ______________

What is your ethnic group? Choose one option that best describes your ethnic group or background.

White

☐ White – British
☐ White – Irish
☐ White – Gypsy or Irish Traveller
☐ Other White, please specify: __________________________

Mixed / Multiple ethnic groups

☐ Mixed White and Black Caribbean
☐ Mixed White and Black African
☐ Mixed White and Asian
☐ Other mixed background, please specify: __________________________

Asian / Asian British

☐ Asian – Indian
☐ Asian – Pakistani
☐ Asian – Bangladeshi
☐ Asian – Chinese
☐ Other Asian, please specify: __________________________

Black / African / Caribbean / Black British

☐ Black – African
☐ Black - Caribbean
☐ Other Black, please specify: __________________________

What is your religion? Please choose one option:

☐ No religion
☐ Jewish
☐ Muslim
☐ Christian
☐ Sikh
☐ Buddhist
☐ Other religion, please specify: __________________________

What is your faith? Please choose one option:

☐ Hindu
☐ Other faith, please specify: __________________________

Thank you very much for participating in this survey.

Your help is greatly appreciated. ☐
Appendix 11. Poster

ARE YOU IN AA?
Will you take part in some research into addiction?
Click here to take part

I am in AA recovery and also a doctoral researcher at the University of Surrey in the UK. I am conducting research into AA and personal attitudes and beliefs. I believe that by taking part in this research you will contribute to a better understanding of AA and addiction treatment.
Project 3. How do heterosexual Generation X males experience internet pornography? An interpretative phenomenological analysis

Supervised by Dr Ben Rumble

Word count: 10,978

For submission to Journal of Men’s Health

See Appendix 11 for Journal Notes to Contributors
Abstract

Internet pornography has attracted research attention, but most studies have focused on a generation of young individuals who have grown up with the web. The lived experience of older males has been overlooked, despite regular consumption and suggestions that attitudes and beliefs about sex vary between generations and across lifespan. This report presents findings from a qualitative study with eight self-identified heterosexual males who belong to a demographic defined as Generation X - born between 1961 and 1981. Interviews were subjected to interpretative phenomenological analysis, to provide an in-depth analysis of how this sample of males experienced the medium. Three main themes are reported; 1) Self and internet pornography, 2) Internet pornography and intimate relationships, 3) Making peace with internet pornography. A compelling feature was how participants understood experience in the context of their ages, background and developmental aspirations. Unlike the qualitative accounts of younger individuals, they did not typically see consumption as socially acceptable, reporting feelings of shame, and relationship difficulties. Theoretically, these experiences are illuminated by considering how psychological frameworks of ageing, masculinity and cognitive dissonance interact. Clinical implications are discussed.

Key words: Pornography, internet, porn, sex, cyber, web, masculinity, Generation X
Introduction

Background

Consumption of internet pornography (IP) is widespread. A survey of 2,000 Britons suggested more than half of adults use it (Opinium, 2014). This poll suggests consumption spans age groups - 56% of 16-24-year-olds use it, compared to 74% of 25-34-year-olds, 59% of 35-54-year-olds and 38% of individuals over 65. The same survey revealed variances across gender and sexuality; 76% of males used it, compared to 36% of women, and 54% of those identifying as heterosexual\(^6\), compared with 88% of those identifying as gay. IP consumption also spans nationalities. The UK, Pakistan and Jamaica all feature in a top 10 of countries searching for “free porn” in 2017, according to Google Trends. Engagement with IP has been attributed to the "Triple-A Engine" effect of Accessibility, Affordability, and Anonymity - millions who may not have consumed pornography before the internet are drawn to the vast quantity of free content (Cooper, Delmonico, & Burg, 2000). Pornography is defined as content containing the explicit description or display of sexual material, intended to stimulate sexual excitement (Weiner, Simpson, & Profitt, 1993). IP is thus such material available on the internet.

Rationale for this study

The present study explores IP experience of heterosexual males from a generational cohort known as Generation X. This cohort was born between the early 1960s and early 1980s and, unlike recent generations (e.g. Millennials - born up until the turn of the century), did not grow up with internet (Miller, 2012). So why research this cohort?

\(^{6}\) For convenience, males who identify as heterosexual or gay are referred to as "heterosexual males" or “gay males”. The researcher recognises that this term is problematic because sexuality is socially constructed and does not represent an ontological given.
Males were chosen over females because of a desire to contribute to a previously under-researched, but growing body of psychological literature, focusing on male mental health (Wright & Bae, 2016). This literature is often situated within frameworks of masculinity, suggesting males are especially vulnerable to psychological distress because they are less likely to access support, due to sociocultural masculine ideals of being strong and self-reliant (Strofford, Halford, & Owen, 2016). Males are also known to use IP more than females and for different reasons (Peter & Valkenburg, 2011c), with constructivist and evolutionary theories of masculinity advanced for why this may be (MacKinnon, 1989; Malamuth, 1996; Buss & Schmitt, 1993; Wright & Bae, 2016). These are discussed where appropriate later. One rationale, therefore, was to maintain a homogenous group, in line with IPA’s epistemological stance. Similarly, heterosexual males are known to use IP in different ways to gay males. Gay males use sites more frequently and often for chatting sexually explicitly with others (Træen, Nilsen, & Stigum, 2006). One suggested reason for differences is that the anonymity of the internet enables marginalised groups to express sexual preferences without fear of stigmatisation (Tikkanen & Ross, 2003).

There are several reasons for focusing on Generation X males, in particular. First, as the literature review below reveals, the vast majority of research focuses on younger adult males, or adolescents. This has led masculinity scholars (e.g. Wright & Bae, 2016; Robbins, Wester, & McKea, 2016) to call for additional research into the pornography experiences of older males. Also, the focus on a generational cohort recognises that sexual attitudes and behaviour are likely to change over time and may influence IP experience (Wright & Bae, 2016). Theories of normalisation suggest that Millennials experience life differently from their parents (Pennay & Measham, 2016). Generation X males grew up without the internet in a more sexually conservative environment (Twenge, Sherman, & Wells, 2014) and may therefore experience IP differently to their younger counterparts. Given proposed socio-cultural influences on sexual experience, as well as biological factors (Robbins, Wester, & McKea, 2016), it may also be that
Generation X males experience the medium differently to older males, who use IP less (Opinium, 2014). From a therapeutic perspective, the experiences of Generation X males are of particular interest given strong associations between this demographic and psychological distress (Samaritans, 2017). In terms of ethnicity, evidence is mixed (Hald & Malamuth, 2008; Kvalem et al., 2014; Mulya & Hald, 2014, Miller, Hald, & Kidd, 2017). This research does not narrow the focus to one nationality or spiritual tradition.

**Extant literature**

**Quantitative research**

There is a remarkable diversity of findings from considerable quantitative research into heterosexual male consumption of IP. On the one hand, a large bulk of evidence points to IP’s deleterious impact on behaviours, attitudes and mood, while on the other, recent research suggests IP enhances sex lives and sexual knowledge. The vast majority of this quantitative literature focuses on heterosexual males, under the age of 35.

The largest body of research is conceptualised by pathology and addiction, reporting on males with “online sexual problems” (Cooper, Galbreath, & Becker, 2004) or “online sexual compulsivity” (Cooper et al., 1999). Some research indicates IP use may alter reward circuits in the adolescent brain, causing addiction (Owens et al., 2012). The focus on addiction has led to distinctions between discrete categories of IP user. For example, after surveying more than 9,000 individuals, Cooper and colleagues (2000) propose three categories: recreational, compulsive, and at-risk. They suggest that recreational users - the majority of respondents - use IP for fewer than a couple of hours per week, and it has a limited impact on well-being. More frequent use, however, has serious consequences for work, relationships and mental health.

While categorisation appears to offer a pragmatic way to conceptualise consumption for the purposes of addiction treatment, such an approach cannot help but neglect the nuances of pornography experience, especially for the majority of individuals who fall
into the so-called recreational category. Moreover, while age is usually considered as an independent variable in the majority of studies, it is a not primary focus of investigation, apart from in the neurobiological studies of adolescents. Overall, the experience of older males is overlooked.

Emerging from this literature, recent correlational research has investigated IP and different indices of emotional or relational distress. Again, the large majority of participants are under 35. Pornography was associated with loneliness and depression in a survey of mostly young adult, heterosexual males from the US (Yoder, Virden & Amin, 2005), and guilt and shame in US teenagers (Vaisey & Smith, 2008). A rare study with an older sample (559 male and females from the US, typically aged between 35-54) demonstrated IP use was associated with depression and poorer life quality (Weaver et al., 2011). Most research on the impact of IP on relationships has focused on young heterosexual couples and generally concludes that consumption diminishes sexual satisfaction, reducing sexual attraction to partners, and leads to infidelity and marital break-up (Albright, 2008; Drake, 1994; Manning, 2006; Doran & Price, 2014; Ferron et al., 2017). While these studies suggest strong associations between distress and IP use the correlational designs make interpretations difficult. For example, in the case of loneliness (Yoder, Virden & Amin, 2005), it is difficult to interpret whether individuals become more lonely because they watch IP alone, or whether lonely individuals watch more IP. The subjective experience of IP use is better suited to phenomenological methods, where the nuances of consumption can be explored idiographically with in-depth interviews.

This epistemological rationale for alternative research designs is strengthened by a growing body of correlational evidence indicating that the impact of IP on wellbeing is not clearcut for males. This research (e.g. Miller, Hald, & Kidd, 2017; Rissel et al., 2017; Mulya & Hald, 2014) suggests IP has a more positive impact on the lives of males, than previously suggested - and hints at the importance of age-related demographics. For example, more than 300 heterosexual men, aged 18 to 73, of different nationalities,
rated the impact of pornography on sexual relationships, “life in general”, sexual knowledge and attitude to other genders, along both positive and negative dimensions. Overall, participants perceived consumption to have a more positive than negative effect. Intriguingly, older men reported fewer negative consequences than younger participants, a finding mirrored by Rissel et al. (2017). Miller and colleagues (2017) explain this age-related finding by evoking masculinity frameworks which theorise that males generally suffer distress because consumption creates unrealistic sexual relationship expectations and masculine ideals for performance. Older men may be less vulnerable to this because their real-world experience helps them see that pornography paints an inaccurate picture of sex or masculinity, the authors suggest.

Qualitative research

There is a paucity of qualitative research on the topic of IP and heterosexual males. This is a significant omission given the potential for qualitative methods to distentangle the inconsistencies above. Moreover, while the handful of qualitative studies begins to contextualise IP experience within generational cohorts, all focus on young adults, again overlooking older male experience. Overall, the research that exists paints a positive picture of pornography use among young heterosexual males, suggesting that for recent generational cohorts, pornography has become normalised, in accordance with theoretical frameworks signposted in the introduction (Pennay & Measham, 2016; Wright & Bae, 2016). One study (Hare et al., 2014) analysed the IP experience of 12 young heterosexual Canadians (male and female, under the age of 21), using a constructivist grounded theory approach. This inductive approach enabled researchers to unpack how individuals from a specific generational cohort made sense of their use, within the context of relationships and their socio-cultural environment. Participants reported that pornography helped relieve stress, increased self-acceptance and had a benign influence on offline relationships. Importantly, both males and females reported being able to share their experiences with peers, without feeling ashamed. Similarly, a thematic analysis by Löfgren-Mårtenson and Månsson (2010), reported that for
51 Swedish heterosexual male and female adolescents, IP was used as a form of social intercourse. The authors observe that the cultural script on pornography appears to have changed across generations - from being regarded as shameful and morally reprehensible to socially accepted.

Summary of literature

In sum, the reviewed literature paints a complex and inconsistent picture of pornography use among heterosexual males, characterised by distress and addiction on the one hand, and more positive experiences on the other. The vast bulk of this literature is focused on males under the age of 35, and is correlational, making interpretation difficult and highlighting a need for more qualitative investigations. Recent quantitative and qualitative research suggests that generational factors may influence how males experience pornography. Some quantitative research suggests older males may be impacted less negatively than their younger counterparts, while qualitative research suggests young males are normalised to pornography, using it as a form of social discourse. There are presently no qualitative investigations focusing on the experiences of Generation X males.

Research question

Given the absence of an in-depth exploration of Generation X males’ use of IP, a phenomenological approach, with an idiographic focus, is used with a relatively small sample to answer the broad research question: How do Generation X males experience internet pornography use?

Methodology

Theoretical framework

A phenomenological framework (IPA) (Smith, Flowers, & Larkin, 2009) is used to understand different properties and meanings of pornography experience for
Generation X males. Epistemologically, this approach aims to provide a rich, in-depth account of lived experience of participants. Phenomenology, as conceived in IPA, is both idiographic and hermeneutic.

**Idiography**

IPA is idiographic, in that it is primarily concerned with the particular, in contrast to the nomothetic focus of mainstream psychology, which makes claims at a group level, establishing generalised laws of human behaviour (Smith, Flowers, & Larkin, 2009). It is only through the painstaking analysis of the lived experience of individual cases that “we can do justice to the complexity of human psychology itself” (p.38). It is also idiographic through its commitment to exploring how particular phenomena, in this case the experience of watching pornography, have been understood from the perspective of particular people in a particular context in this case a generational cohort of males. Generalisations are not necessarily eschewed; this report involves a detailed examination of data from participants, exploring convergences and divergences (Smith, Flowers, & Larkin, 2009) across cases and highlighting emerging patterns of meaning. However, such generalisations are developed cautiously and remain grounded in the particular lived experience of a participant.

**Hermeneutics**

IPA unapologetically embraces a hermeneutic version of phenomenology (Smith, Flowers, & Larkin, 2009), in the sense that analysis of an experience always involves a level of interpretation. An interpretative stance is adopted as the researcher tries to get closer to how each participant experiences pornography, uncovering meaning that may be latent. It is in fact a "double hermeneutic", in that the researcher is trying to make sense of - interpret - experience as described by the participants, who themselves are trying to make sense of their own experience. Both researcher and participant may come to this sense-making task with pre-conceptions that risks blurring access to the phenomenon itself. In this light, the task is to both 1) assume the role of "detective"
(Smith, Flowers, & Larkin, 2009), engaging with the participants' account interpretatively to shine as much light on the phenomenon as possible, 2) bracket one's own pre-conceptions so that these interpretations always remain grounded in the participants' account. To strike this balance the researcher kept a research diary, with a sharp focus on self-reflection (see Appendix 2).

Why choose IPA over other qualitative approaches?

In the introduction, the epistemological advantages of a phenomenological approach over quantitative methodologies are set out, but why choose IPA over other qualitative approaches? Smith (2004) suggests that deciding which qualitative approach to take is not so much choosing a "tool for the job", as may be the case in quantitative method analysis, but rather a question of identifying “what the job is” (p43). In other words, the main reason for choosing IPA over other qualitative approaches is because it is consistent with the epistemological position of the research question. In deciding to use IPA, the researcher reflected on other potential approaches to the question. For example, a grounded theory approach was considered, but dismissed, because it arguably seeks to generate a more theoretical-level account of a particular phenomenon. Given that IP experience of this demographic has not been explored in qualitative research before, the divide between analysis and building a theoretical framework felt too wide. Instead, the focus in this study is an in-depth analysis of the lived experience of a relatively small number of participants, with an emphasis on convergences and divergences between accounts. Had the research question been more theoretically-inclined, for example, “What factors influence male experience of pornography?”, a grounded theory approach may have been appropriate.

Participants

Participants were eight men - aged between 35 and 55 - who all identified as heterosexual and viewed pornography. Smith (2004) points out that for a professional doctorate a sample of four to 10 participants is appropriate. Eight participants struck a
good balance for ensuring an appropriate level of analytical depth and criticality, while maximising opportunities for publication. Participants were anonymised in the report. Table 1, below, provides demographic details.

Table 1. Participant demographics

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Relationship</th>
<th>Ethnicity</th>
<th>Children</th>
<th>Profession</th>
<th>Sexuality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bryan</td>
<td>47</td>
<td>Co-habiting</td>
<td>White/British</td>
<td>No</td>
<td>Media</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Tony</td>
<td>42</td>
<td>Married</td>
<td>White/British</td>
<td>Yes</td>
<td>Teaching</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Peter</td>
<td>43</td>
<td>Separated</td>
<td>White/British</td>
<td>No</td>
<td>Teaching</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Steven</td>
<td>48</td>
<td>Co-habiting</td>
<td>White/British</td>
<td>No</td>
<td>Lecturer</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Ralph</td>
<td>50</td>
<td>Single</td>
<td>White/British</td>
<td>No</td>
<td>Tradesman</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Warren</td>
<td>49</td>
<td>Single</td>
<td>White/British</td>
<td>No</td>
<td>Media</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Paul</td>
<td>47</td>
<td>Married</td>
<td>White/British</td>
<td>Yes</td>
<td>Technology</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Seth</td>
<td>44</td>
<td>Single</td>
<td>White/British</td>
<td>No</td>
<td>Media</td>
<td>Heterosexual</td>
</tr>
</tbody>
</table>

Procedure

Recruitment

Given the sensitive nature of the topic, a “pragmatic” approach to recruitment was adopted, observing that, as Smith and Osborne (2008), state, the sample “will in part be defined by who is prepared to be included in it”. Five participants were recruited through posters on social media sites (such as Facebook) and at the University of Surrey. An additional three were recruited by approaching acquaintances. No financial incentive
was offered. Ethical and methodological issues arising from this approach are outlined below.

**Inclusion and exclusion criteria**

Participants were included if they currently consumed IP, identified as heterosexual males and were born between 1961-1981. Participants were not restricted to those who have accessed support for pornography use, hoping to capture a range of experiences.

**Interviews**

Interviews were semi-structured (see Appendix 6 for schedule). Given that this was the researcher’s first IPA, the semi-structured interview made him feel less anxious, which in turn made participants more comfortable and able to share their experience. Before interviews, the researcher checked participants were comfortable and emphasized that they could take a break at any point, or terminate the interview if they changed their minds. The schedule moved from a practical question, towards areas which were potentially more sensitive, so that participants were eased into the interview (Smith & Osborne, 2008). Interviews typically lasted between 60 and 75 minutes.

**Analytic strategy**

The interviews were analysed using IPA. As outlined above, this approach is both interpretative and phenomenological in that it views the analytic outcome as resulting from an interaction between participants’ accounts and the researcher’s frameworks of meaning. Interviews were recorded and transcribed verbatim. Transcripts were read several times resulting in initial notes being made in the margins, commenting on descriptive, linguistic and conceptual perspectives. The notes included initial interpretations and made connections between different parts of the interviews. The notes in the first interview were condensed into themes, and checked again against the data. Connected themes were then clustered to form the first list of superordinate themes, which were emailed to the researcher’s supervisor who checked for coherence.
The theming process was repeated for the remaining transcripts. All of the themes and superordinate themes were then considered together by printing them out and laying them on an office floor. New connections and clusters were formed until a master list of themes was created, again corroborated in supervision.

Validity and quality

Yardley (2000) suggests four principles for evaluating the validity and quality of qualitative research. These are sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. Sensitivity to context can be demonstrated in several ways, including choice of analysis, sensitivity to power dynamics during interviews and self-reflection. Commitment and rigour requires a commitment to investing significant resources - in particular, time and skill - to ensuring high standards of data collection and analysis. Transparency refers mainly to the write-up of the study and how clearly each stage of the research is described and presented (Smith, Flowers, & Larkin, 2009). Finally, the ultimate test of validity and quality rests on whether this report tells the reader something that is useful and important, relating to the research question posed (Smith, Flowers, & Larkin, 2009). The extent to which these criteria are met is evaluated in the Discussion.

Ethics

Ethical approval was obtained from the Faculty of Health and Medical Sciences. Several matters were especially pertinent to the ethical guidelines of the BPS (BPS, 2010) and the HCPC (HCPC, 2012). In particular, it was vital to minimize any potential distress arising from the sensitivity of the topic. This was achieved by paying careful consideration to ethical principles including transparency, consent, confidentiality, and debriefing (BPS, 2010).
**Transparency**

It was made clear how data was to be analysed, stored and the potential for publication. This helped participants feel some control over the research process, an important principle for sexual research (Riley & Scott, 1999).

**Consent**

Given that participants may disclose sensitive material, which they may later regret, it was agreed they could retrospectively withdraw consent after debriefing. In the event, no-one asked for any retractions.

**Confidentiality**

Where there was an existing relationship with a participant, careful boundaries were established at the outset. It was made clear that the interviewer was there as a researcher and that material would not be discussed outside of this domain.

**Debriefing**

During interview the researcher’s clinical skills were used to monitor for distress. After interview, sources of support were signposted, including The Samaritans, which were also marked on the participant information sheet (Appendix 3). Needless to say, the researcher drew on his humanistic training as a counselling psychologist to ensure that participants did not feel judged or devalued.

**Analysis**

Analysis revealed four overarching themes, three of which are presented here. The three are 1) Self and internet pornography 2) Internet pornography and intimate relationships, and 3) Making peace with internet pornography. The fourth theme related to controlling pornography but this theme was a more common motif in the addiction literature. In line with Smith (2004), it was decided to focus on the themes with enabled
the richest possible analytical account, and which formed the most compelling and original narrative. To do justice to the richness of accounts, and to provide a more comprehensive audit trail for the reader to evaluate analysis, additional quotes are provided in support of each theme in Appendix 1, immediately after the references.

1) Self and internet pornography

All participants describe an impact on their sense of self, relating to their pornography-watching. Accounts are characterised by feelings of guilt, regret, disappointment and shame, as well as a sense of aloneness. A powerful thread of this theme is the relation between age and upbringing on pornography experience. There are four sub-themes; 1) regretful self, 2) solitary self, 3) ageing self, and 4) animalistic self.

i) Regretful self: “Oh no, did I do that? I really don’t want to do that”

Participants typically report that a fleeting feeling of pleasure from the masturbation experience is almost immediately replaced by a sense of regret, characterised by disappointment in the self, guilt, or disgust.

Tony says: “I think there's a chemical, a very instantaneous chemical shift. So that there's almost a release of tension, and whatever chemical is being released - but then that gets replaced quite quickly with a kind of profound sense of the, with the lowness.”

Tony’s reference to an “instantaneous chemical shift and use of “profound” to describe his “lowness”, illustrates how quickly and significantly his mood changes over a matter of moments.

In the same vein, Warren says: “There was a slight feeling of, I suppose, disappointment in myself, slight disgust - just a hollowish sort of feeling”.

Interestingly, accounts typically illustrate a difficulty in evaluating the significance of negative experience.
For example, Bryan describes pornography as a “very disposable, transient experience”, adding: “Well, it's kind of instantly forgotten isn't it? But I think there's a kind of trace element of it that remains.”

Later, he says: “You have a self-image of who you are, where you're at in life, what your values are, how you want to treat people, how you want people to treat you, and you fundamentally break all of that by indulging in that behaviour. And I'm keen to stress that it's not a strong feeling of shame. It's something that passes within moments, but within that moment you get 'oh no, did I do that? I really don't want to do that'.”

Similarly, Peter, a teacher, says: “Yeah, I don't know if I feel that guilty anymore [long pause] because I'm not really hurting anybody but myself [long pause] well, I'm not even hurting myself, I can't be immoral [pause].”

Yet, shortly afterwards, he says: “Yeah even at work, if I’ve played with myself the night before, it does crop up on my mind that I’ve done it (...) I’ve done something that I, I know I shouldn’t have.”

For Bryan, then, there is a strong contradiction between something “instantly forgotten” and the impact on facets of his “self-image”, spanning development (“where you’re at in life”), values and relationships. His “trace element” metaphor sheds light on this; in chemistry, trace elements are by definition both tiny - 100 parts per million - but at the same time play a critical role in the functioning of an organism. In other words, while the impact of pornography is difficult to see, Bryan recognises it may have profound and enduring implications for him.

\[ ii) \textit{Solitary self: “A pretty tragic image”} \]

Participants typically see their pornography experience as a very solitary one, often characterised by secrecy and shame. Tony and Seth describe it as a “dirty secret”, Ralph as “clandestine”. 
Describing it as a “solitary thing and a secret thing”, Tony says: “I wouldn’t openly tell people and I wouldn’t necessarily kind of joke about it.”

Also explaining feelings of shame, Bryan says: “And there's also the fact that there you are masturbating in front of a screen on your own - which is a pretty tragic image.”

Bryan’s "tragic image" underscores the solitary nature of pornography watching as he sees it, and his sense that such behaviour is socially inept.

Shame is heightened in Bryan, and others, by a sense of the solitary pornography-watching self being watched and judged by others.

He says: "There's the admission or the awareness of everyone in your life knowing that you were watching that kind of stuff.”

He elaborates: “It's like going on a South-Eastern train with those sliding doors on the toilets, those huge sliding doors, and it's like taking a dump, and that door suddenly opening to an entire carriage...”

Bryan’s toilet analogy is a graphic illustration of how he sees his pornography experience as something very private, and potentially humiliating.

Seth also highlights a sense of aloneness: “You feel like you're the only person in the world that has done it. It's like this dirty little secret that you're guilty of, that no-one else is. Only you. And there's a part of you that thinks people will say 'he watches internet porn, he's a pervert'.

Seth expands upon this theme with concerns about what others would think of the specific content he was watching, another common concern for participants.

“You worry and think 'what if someone were to check my browsing history?' You just wouldn't want anyone to know, even if you stop and think 'well, probably nine out of ten people, if not ten out of ten, have done this'.”
Common concerns about the specifics of “browsing histories” indicate that the sense of isolation is heightened for participants because they imagine being judged for their very personal pornography preferences.

This is further illustrated by Bryan, when he says: “I think in any area of sexuality your private peccadilloes and idiosyncrasies, you not only wouldn't want your partner to know but probably even your friends and colleagues to know. Everyone has a dark indulgence I think somewhere, and certainly the titles of the films that you're watching bring home - sound a lot worse than the content that you're watching. Well, not sound a lot worse because they are! They describe the content that you’re watching, but they, yeah, they're not something that you'd want to share at a dinner party (laughs).”

Bryan’s self-contradiction and choice of language may highlight a difficulty in reconciling his personal pornography choices with an acceptable sense of self. “Peccadilloes”, “idiosyncrasies” and “indulgence” are all words that downplay the significance of these pornography choices when compared to other descriptions of pornography use as “appalling”.

iii) Ageing self: “I’m looking at girls who could actually be my daughter”

The depiction of a solitary self can be understood alongside participants’ understanding of ageing and pornography use. For example, Seth links his sense of aloneness with past experience of porn.

“When I was a kid and you'd see these old guys going in the shops and buying the magazines and you’d see the shopkeepers thinking 'oh, I know what he's going to be doing now when he goes home’ (...) So there was always this dirty little sordid element to it.”

By linking current experience to childhood memories of pornography, Seth reveals how he, like others, makes sense of the phenomenon within the context of his age and generation.
Throughout accounts there is a recurring motif of the stereotypical “dirty old man in a Mac” who read magazines while participants were growing up.

Ralph says: “Well, it's just that little man in the mac. Porno magazines in the bushes - my first impressions of pornography, you know? That ghost still hangs around.”

Ralph’s evocation of a ghost, draws together the sense of being “watched over”, as others have described, with memories from the past. Yet, his use of the rather casual “still hangs around” suggests a less intimidating presence, more of a nuisance. This can be understood within the context of Ralph's overall account, which is characterised by a greater acceptance of pornography in his life (see below).

Seth links the “dirty old man” motif to another common thread - efforts by participants to make sense of the age gap between themselves and those appearing in porn clips.

He says: “It could be a fear that I might be heading into 'dirty old man' territory- your next thought is 'she's young enough to be my daughter'... and that's a bad feeling.”

Describing feeling uneasy, Bryan says: “This general awareness that if you’re looking at a 20-year-old girl (...) then you at the age of 47... that's appalling, really bad. Because when you were 27 she wasn't even born, and when you were 28 she was a baby.”

References to “daughters” and “babies” indicate a difficulty in reconciling a duty of care for the younger generation, while at the same time using them as objects of sexual gratification.

Bryan excuses his younger self, but says such matters are harder to ignore as you get older.

“So the naivety and the exploration drives you in your early life and you don't think about these things, and then later in life you do - you become aware of them.”
Most participants reflect on an awareness that their experience of pornography is likely to differ from that of younger generations.

Warren says: “I did a course recently and some of the young people, I used to listen to them, and quite a few of them would actually film themselves having sex and actually show it - pass it around, you know; 'this is her giving me a blow-job and this is her doing this' and I was actually quite flabbergasted by it. With an older generation you're not gonna have it, you're not gonna hear 'oh, this is me shagging my wife' (...) I also noticed there didn't seem to be any embarrassment, it was normal, and I think am I carrying around something from a dark age where porn was something to be discovered in the woods.”

“Flabbergasted” emphasises the significant shift he sees in attitudes towards pornography across generations. Moreover, his use of the pejorative "dark age" suggests that he sees his generation’s conceptualisation of pornography as outdated.

Seth further illustrates the extent to which he feels pornography is normalized for the younger generation, when he says: "I think the younger generation coming up now treat it like it's nothing. A lot of them might possibly regard it like they would drinking a can of cola or eating a bar of chocolate."

A related thread is how participants connect pornography with their personal development or life stage trajectories.

Describing previous attempts to reduce his pornography use at the age of 43, Bryan says: “I became aware of certain behaviours and traits within me that had become stuck (...) that I had become a kind of ossified version of my kind of experience."

He describes concerns that what he initially saw as “behaviours” or “traits” had become a more fixed part of his identity, hardening like bone.
Bryan reduces his pornography use after beginning a romantic relationship, but he uses the metaphor of a Snakes and Ladders game to explain how he returns to watching.

"Well, it's that Snakes and Ladders thing. You've come so far and been so productive emotionally, that you think of that old cliché that you've let yourself down and you've let others down. It's generally that feeling of going all the way back to the beginning and having, kind of, base behaviours that aren't acceptable that you've reverted to (...) you're just like 'oh shit, I've got to start again. And work my way back up the ladders'."

Bryan’s sense of going “back to the beginning” suggests he sees watching pornography as a regressive move for his personal development. The metaphor also introduces another common feature of accounts - the sense that pornography use is beyond his control, here dependent on the roll of a dice. At a third level, the metaphor can be interpreted as an illustration of how, like others, Bryan makes sense of his experience within a framework of morality. The snakes in the metaphor, together with the "base behaviours", and the “going all the way back to the beginning” evoke the biblical story of Adam and Eve. It resonates with other excerpts from his interview where he describes the "forbidden side" of pornography and the sexual experience as "a very small bite-sized chunk", evoking the prohibited apple in the Garden of Eden.

*iv) Animalistic self: “The animal’s kind of won over the higher self”*

Peter’s reference to a “true self” brings to focus another feature of accounts; an awareness of how pornography highlights a tension between competing selves, often defined as “bestial” or “animal” on the one hand, and “spiritual” or “higher” on the other.

Describing moments when he feels “compelled” to watch pornography, Tony says: “I think it feels like the animal’s kind of won over the higher self. Your lower kind of self has won out. And I think that can create a real sense of (...) sadness, grief and regret.”
Again, Tony’s use of grief” suggests something is permanently lost. Later he sheds light on this when he describes being confronted about pornography by his partner.

“It's like you're breaking down a kind of a bit of a myth (...) you're basically admitting to yourself that you’re not this ideal, idealised human, that maybe they want you to be. There's a gulf between who they want you to be and who you actually are.”

By referring to “who (...) they want you to be”, Tony suggests that he sees his idealised self as co-constructed with his partner. Moreover, his use of “myth” implies that he sees this idealistic self as a fiction, and perhaps the “grief” he expresses is the loss of this ideal.

Tony’s sense of constructing an ideal self in relation to others resonates with an excerpt from Bryan.

“If you had a CCTV camera on you the whole time (...) you'd like to think that everything you do in your life could be filmed and broadcast to the world and everyone would be like 'yeah, he lives his life well'.”

Both Bryan and Tony highlight the extent to which pornography causes them to reflect on matters of deep existential significance, including relationship, identity and what it means to live one’s “life well”.

For some, evidence of an “animalistic self” is manifested in the “sexualisation” of women after pornography use.

Peter says: “If I'm walking to work and if I see a pretty girl then I immediately think of them naked or having sexual positions (...) I can be doing a lot more notable things with my mind than continually thinking of undressing women in the streets.”

Meanwhile, after describing the “animalistic self”, Tony says: “One of the ways I try to kind of diminish thoughts about porn is to try and really break down the glamorisation
of it in my head. So that when I'm looking at women I try and remember that they've got menstrual cycles - whether they take shits in the morning.”

Tony’s imagining of “menstrual cycles” and women defecating, graphically demonstrates the considerable anguish he feels at his sexualisation of women.

2) Internet pornography and intimate relationships

All participants try to make sense of pornography and conventional romantic and sexual relationships. Experiences are often characterised by emotional accounts of secrecy, feelings of betrayal and regrets about lost intimacy, and sometimes interconnect with the sub-theme of age. There are three sub-themes of 1) starting a relationship 2) secrecy and betrayal, and 3) intimacy with partner.

i) Starting a relationship: “She’s nothing like that one from Swedish nymphos”

Participants typically describe how pornography impacts finding a partner. Referring to a period before his current relationship, Bryan says: “If you continue to watch pornography you will continue to go round in this cycle of having highly visual, highly sexual relationships with multiple women. And I was fundamentally sick of that.”

He reports being influenced by his peer group.

“(I was) seeing templates of relationships of my friends that had really worked and wanting that - and then at the same time realising in the background what a heinous or pernicious thing pornography actually was.”

Bryan’s use of “heinous” contrasts with other assertions pornography is an “innocent past-time”, again highlighting contradictions in evaluation of pornography. “Pernicious”, meanwhile, resonates with the subtle impact conveyed by his earlier “trace element” metaphor, suggesting these “elements” have the power to organise his relational world.

Furthermore, he directly attributes the beginning of his current relationship with a period of pornography abstention.
Bryan: “I gave up pornography when I was still not in a relationship and very, very quickly I met my current partner. And I think there is a causal link between the two.”

He continues: “That's the energy that you're radiating (...) It's what you hold in your heart and the communication that's coming from your heart. I don't believe in fate but I think that's what delivered me to my partner and my partner to me. It's that readiness for something.”

Bryan’s use of “very quickly” and “causal link”, as well as associations with “heart” communications, imply he views abstention as having both a transformational and profound impact on his openness to relationships. The “radiating energy” contrasts sharply with the “ossifying” experience of pornography use, elsewhere.

Warren, meanwhile, reflects on two pornography-related obstacles to beginning a relationship. Like others, he reports that repeated exposure to young, attractive females in clips raises his standards to unrealistic levels.

“I think it's subconscious, but it raises your standards in a delusional way. You see other possible partners around and you think 'oh yeah, but she's nothing like that one from 'Swedish Nymphos'. If she took her clothes off she wouldn't look anything like that porn model I was looking at yesterday (...) I mean, most guys in their 30s, 40s or 50s are never gonna sleep with an 18-year-old.”

By referencing “guys in their 30s, 40s or 50s”, Warren implies he sees the “delusional” raising of standards as connected to his age. His reference to the “subconscious” resonates with Bryan’s emphasis on pornography’s subtle impact on experience.

Warren also explains how pornography provides a convenient way to avoid the awkwardness of having to go out and meet real women.

“It's like you could be in a bar with someone whom you have nothing in common with, you're pretending to like each other - in order to have some sort of sex. Now, I think
ahead ... I think through the whole scenario. I think ‘well, that would involve having to
talk to them, you probably wouldn't get on great’, and then what would I do? Would I
take them back to mine ... have I tidied up my flat? Would I go back to theirs... have they
got some sort of weird partner in the background? And I think a lot of that is to do with
internet porn - it's immediate, it's convenient (...) if some sort of encounter comes along
that might involve some sort of sex, it almost feels like too much hard work to go
through with it.”

He adds: “It [pornography] almost makes you lazy; there's so much there that you can
almost get enough from it - it ticks all those boxes that you can't get in real life.”

The detail in Warren’s bar scenario suggests he is not simply reflecting on reasons for
staying at home, but recalling a familiar decision-making process, implying a relatively
prominent role in his intrapsychic experience. Like others, Warren invokes laziness as a
motivator for pornography-watching. His suggestion that there is “so much there that
you can almost get enough from it” is revealingly ambiguous. On the one hand, it might
suggest that the vast choice of pornography enables him to customise his experience to
such an extent that he feels it “ticks all the boxes” of a conventional sexual relationship.
Yet, by qualifying his comment with “almost”, he suggests he is aware that something is
lacking. Later, he sheds light on this with an existential reflection.

“It's just that you're not next to a snoring person, or a real person you can touch; it's just
an image on a screen and it's over now and I feel 'well, what was the point of that?'. I
think that disappoints a human being.”

Elsewhere, he says: “You're left with that guilt and a deflated feeling.”

In this way, Warren contrasts his enthusiastic rationale for not going out, with the
“disappointing” consequence of his choice. His desire to avoid the “hard work” of a real
encounter appears to backfire as he is left feeling “deflated” - implying pornography is
seen as energy-conserving, but also energy-sapping.
Peter also links pornography with starting a relationship. Referring to meeting other women, after his marital-break-up, he says: “That energy I get from that [not using] is carried forth, like there is something hanging between my legs again.”

His reference to “something hanging between my legs again”, implies an emasculating impact of pornography, while abstention energises his quest to meet a new partner.

Paul recognises that, for him, pornography is not a viable alternative to real encounters.

“These days I’d rather drink a few cocktails with a beautiful stranger (...) my tastes have changed and I have become more interested in real people again.

ii) Secrecy and betrayal: “I’d broken some spell by doing it”

Participants typically try to keep their pornography-watching a secret from partners, seeing it as a form of betrayal.

Referring to his estranged wife, Peter says: “I’d sneak off when she was asleep, and (...) use my phone in the bathroom....”

Unusually, Steven does not keep use from his partner.

“...she goes 'are you coming to bed' and I'm, 'oh, sorry darling, I'm just having a wank so I can sleep - it's been a stressful day'. Now she's not worried by that (...) and that's what I love about our relationship.”

He contrasts intimacy with his partner with the functionality of pornography.

“I just want to be with someone I love, to cuddle (...) two souls meeting, so that's my real life. Then if I need to go to sleep quickly, flipping open the phone, finding an erotic picture and knocking one out is just what you do.”
Interestingly, despite such open-ness Steven says he would be more reticent about revealing his actual browsing history to his partner, perhaps re-emphasising the earlier tension between the universality of pornography and very personal choices.

Like others, Peter describes his secretive viewing during his marriage as a form of betrayal.

“If she'd known, I don’t think she would have been happy and that’s why I didn’t tell her (...) it was like a mini-affair.”

Later, referring to pornography, he says: “...I feel a bit lonely and it’s quite nice to have a sort of semi relationship with someone (...) have some female company in a sense.”

Peter’s reference to a “semi-relationship” and “female company” clarifies why he sees viewing as a “mini-affair”, implying he feels a level of relational engagement with characters in clips. Elsewhere he describes an almost symbiotic pleasure transaction with those on the screen, especially while watching “amateurs”.

“When it's amateur it's also a choice thing for them and it may turn them on too, to be filmed.”

Peter’s relational engagement with pornography contrasts sharply with Seth’s experience.

“They're there thinking they look all erotic and I'm thinking 'hmm, look at your face', so it does seem to have a certain sense of ridiculousness. It doesn't fill a sexual void in my life.”

Seth’s “look at your face” implies ridicule and his apparent lack of connection to characters may point to why, unlike Peter, he does not see pornography as comparing to real relationships.

Peter goes on to connect his pornography use with a real affair, and the end of the marriage.
“It was a contributing factor to us splitting up I think, because [...] I would have made a much bigger deal of not having sex with her, had I not had porn (...) It was definitely a stepping stone to me having an affair.”

The “stepping stone” in the metaphor can be interpreted as representing a convenient way for Peter to pass over difficult conversations about their sex life, and symbolises the “mini-affair”, which, when conceded, bridges the gap to a real affair.

Bryan also relates pornography watching in his current relationship with betrayal.

“There was a feeling that I'd broken some kind of sanctity between me and my partner, almost like being unfaithful - I'd broken some spell by doing it…”

Using the analogy of a fictional one-night stand, he goes on: “…something is broken as a result. You will never come back from that fully. And I guess pornography is a mild version of that.”

Bryan’s use of “sanctity” and “broken a spell” suggest that by watching pornography he has blighted an implicit and unspoken understanding of profound significance. He again encapsulates the subtle (“mild”) but enduring (“never come back from”) flavour of pornography experience for him, this time in relation to his relationship, and that fact that it can “break a spell”, suggests he sees it as a powerful force.

**iii) Intimacy with partner: “I’m almost using her as a kind of physical form”**

Participants typically report that pornography impacts desire for their partner and intrudes on sexual intimacy.

Peter says: “It did feel slightly like I was being unfaithful to her by looking at other girls and then my urge for wanting her would then be diminished…”

Tony expands by describing how pornographic images impact intimacy.
“I'd like to be appreciating her and I'd like to be in the moment (...) having a very loving, intimate, experience with her. Invariably, what happens is (...) in order to ejaculate [...] I go into an image kind of world, where I'm not particularly present (...) I'm almost using her as a kind of physical form. Like to, to kind of project my own experiences, own things on her.”

Sometimes, Tony senses his partner picks up on his distraction: “I think [...] she can feel I'm not being present, and she says as much.”

The emotional impact of reflecting on “not being present” and repercussions for his partner were movingly emphasised when I observed Tony had become quite tearful7. His distress can be interpreted as reflecting an acute dissonance between his aspirations for how he wants to be in the relationship and a reality influenced by pornography. For Tony, the contrast is stark; a deep yearning for connection, alongside the depersonalisation of his partner to the extent that she is reduced to a “physical form” to gratify his pornography fantasies.

Despite this, Tony also points to positives that emerge from talking about the experience.

“...they're tense, tense conversations but I feel we're better off having had them and that we're better off for having gone through those kind of challenges.”

3) Making peace with internet pornography use

All participants report ways they make peace with pornography use. A recurring thread is how participants see male evolution as a way to accept pornography watching. Four sub-themes are 1) Treat and reward 2) comparing to others 3) sharing experience 4) evolution.

7 I reflect ethically on this in Appendix 1
i) Treat and reward: “It's like finding an extra bar of chocolate at the back of the fridge”

Most participants refer to pornography as a treat, reward, or sleep aid.

Ralph says: “I'm nearly always in bed and I think 'excellent! I can have a wank!' It's a treat - it's like finding an extra bar of chocolate at the back of the fridge.”

Paul, one of two fathers, says: “…there's lots of things, as you expand over middle age - the range of things that are private and just for me, I see that as a consequence of ageing, little things I like to do (...) I feel as if I've worked quite hard, spent time and money bringing up kids, and being a good husband, and it goes hand in hand with having a bit more leisure time…”

By linking pornography use to “middle age” and “ageing” in a positive way, unlike others, Paul illustrates how pornography experience is always contextualised within life stories. For Paul, the fact that he has devoted “time and money” to his family helps to justify use.

Some compare pornography use to addictions.

Ralph, a recovering addict, says: “It's a wee gift to myself that I can have without having to sell all my furniture or all my jewellery.”

By suggesting he does not have to sell his possessions, Ralph, like others, implies that he sees pornography as a relatively benign form of addiction. While this and other excerpts imply participants make sense of pornography in the context of what they see as more harmful addictions, they may equally shed light on why some find it difficult to give up.

ii) Comparing to others: “I don't wear a gag or start chewing on an orange”

Another way participants understand pornography viewing is by comparing themselves to others.
Bryan says: “The concept of sitting through a whole porn movie is just beyond me - like an hour of watching people have sex just seems utter, utter nonsense to me. But clearly that's how some people use it. But for me it's like two minutes. In and out – done.”

Ralph says: “I just watch it and have a wank - I don't stick my thumb up my arse or wear a gag or start chewing on an orange, you know what I mean?”

These excerpts can be interpreted as participants making efforts to see pornography use as relatively functional when compared to others.

*iii) Sharing experience: “It's nothing weird and everyone is doing it”*

Occasionally, participants report on the benefits of sharing pornography experience with others.

As above, Tony describes feeling “better” for talking about pornography with his partner and Steven says being able to share such material is part of “what I love about our relationship”.

Paul, meanwhile, talks to two female friends.

“I don't feel I'm in any way unique, I suppose [...] I've got two female friends who talk about it a lot (...) what they've enjoyed, how they've enjoyed it and the role it has played (...) it just further increases your sense that it's nothing weird and everyone is doing it.”

Paul’s reference to not feeling “in any way unique”, challenges other accounts (recall Seth’s “You feel like you're the only person in the world that has done it”), and implies that sharing the experience begins to normalise it for him.

*iv) Evolution: ‘We're apes, just developed apes”*

A final sub-theme is how participants make sense of pornography in the light of evolution and biology.
Steven compares evolutionary theory to religion, describing the latter as “patent bollox”.

Expanding, he says: “It [pornography] meets a psychological need that men have. And a physical need due to their evolution. That's why monkeys in zoos walk around wanking all the time. You know, when you take your niece and nephew to the zoo and they ask 'what's that chimp doing?' And that's all we're doing. We're apes, just developed apes (...) I used to think sometimes 'this is evil, this is bad' when there is no good and bad... only thinking makes it so, as Shakespeare said.”

He adds: “I wouldn't be doing this interview if I didn't understand the mechanics behind the thought processes (...) I'd probably still feel really ashamed.”

Tony adds: “It's that reptilian mind (...) I try very hard not to beat myself up. Because I think (...) I'm dealing with a stage of evolution (...) I have these drives. They feel animalistic (...) They almost override another part of me which would be more rational, more logical, more loving (...) I don't really have much choice in the matter unfortunately.”

Meanwhile, justifying his arousal to teen pornography, Warren says: “I think that's quite a male thing (...) it's like the idea of the virgin, it's just such a very sexual, tantalising thing.”

The richness and verbal fluency of Steven’s analogy suggests he has reflected previously on this area in some depth. The significance of this evolutionary understanding is highlighted by his assertion that he would not have done the interview without it. Moreover, by comparing himself to a “wanking” monkey, while also quoting Shakespeare, he reveals a desire to demonstrate that his sexually driven animal side is balanced by more sophisticated qualities.

Steven’s capacity to reconcile his sexual drives with his identity resonates with Ralph’s description of what he does after masturbation to pornography.
“I probably put on some spiritual talk to get myself to sleep. I'm caught between that yin and the yang (...) It's not that I feel guilty and need to be cleansed; my guilt is marginal.”

Ralph’s reference to the Chinese dualities of “yin and yang” and assertion his guilt is “marginal” suggest he sees that sexual desire and spirituality can be complementary.

Support for this interpretation comes later when he says: “Sex is primal. You want to sweat, you want to twist, you want to lose yourself - that's what it is. That's why it's close to what we're trying to attain spiritually; actually the connection of oneness.”

Discussion

Three overarching themes are reported; 1) self and IP, 2) IP and intimate relationships, and 3) making peace with IP. Here, I consider these findings in relation to the extant literature, arguing that IP experience for this cohort might best be contextualised with reference to theories of masculinity and ageing, and alongside frameworks of cognitive dissonance.

Extant literature

The findings converge with correlational evidence, linking IP use in heterosexual males with shame and secrecy (e.g. Vaisey & Smith, 2008; Cooper, Delmonico, & Burg, 2000), and relationship difficulties, including diminished sexual desire for partners, feelings of betrayal and marital breakdown (e.g. Albright, 2008; Manning, 2006; Ferron et al., 2017). However, since this sample typically saw themselves as relatively light users of IP, yet reported varying degrees of existential and relational tension, this data challenges the epistemological wisdom of categorising consumers into discrete groups (e.g. Cooper et al., 1999), where so-called “recreational users” are seen as impervious to intrapersonal and interpersonal distress. It is likely that correlational studies failed to capture the nuances of experience for lighter users, an interpretation supported by the difficulty present participants had in assessing the impact of IP. It may be that, without an opportunity for deeper reflection, participants would have underplayed the influence
on their lives.

The data is also incongruent with evidence IP has a benign impact on older males (Miller, Hald, & Kidd, 2017; Rissel et al., 2017). Instead, accounts resonate with constructivist and evolutionary theories of masculinity and pornography, which link consumption with distress. For example, describing the “Centrefold Syndrome”, Brooks (1995) argues pornography socialises males to believe that masculinity is endorsed through sexual conquest, that it is normal for men to reduce women to sexual objects and that voyeurism is natural and inevitable. He contends this view of masculinity has negative repercussions for men’s relationships with females - as objectification, voyeurism and unrealistic sexual expectations prevent them forming meaningful connections. Clearly, this chimes with present accounts. For example, Tony's poignant description of intrusive objectifying thoughts during sex with his partner and his bid to diminish such objectification by imagining females “taking shits”, Peter “undressing women in the streets” and Warren’s fruitless search for “Swedish nymphos”. Meanwhile, Warren’s bar-room analogy, evaluating vicarious IP relationships, and Peter’s “semi-relationships” with those in clips, call to mind some evolutionary perspectives on masculinity (e.g. Buss & Schmitt, 1993) which stress males are adapted to maximise short-term-mating with minimal personal investment - and that pornography facilitates this vicariously. Warren's overall dissatisfaction with such encounters suggests he recognises at some level that such a strategy fails in its central biological mission - to procreate - while also denying him the opportunity to form meaningful connections. The inconsistency with previous questionnaire studies relating to older males could again be accounted for by design limitations. Interestingly, while responses in the study by Miller and colleagues (2017) were, overall, more positive than negative, many males described "a very small negative effect" on lives. This recalls some present descriptions, for example Bryan’s "trace element" idea. While "a very small negative effect" is reduced to a statistic in a correlational study, an idiographic focus enables such nuances to be unpacked; Bryan's metaphor suggesting a subtle but
profound impact on his life.

A defining feature of this study is how stories diverge from younger males in previous qualitative investigations (Löfgren-Mårtenson & Månsson, 2010; Hare et al., 2014). Unlike, their Millennial counterparts, who describe IP as a form of social discourse, these Generation X males typically emphasise “solitary” and ”clandestine” experience, characterised by secrecy from partners and peers, and fears of being labelled “a pervert”. Theoretically, these differences may be illuminated by considering how the “Centrefold Syndrome” (Brooks, 1995) could interact with conceptualisations of normalisation, and prominent theories of lifespan development, to heighten tensions for older males. Normalisation theories suggest attitudes and beliefs vary between generations; what is considered sub-cultural and immoral in one, becomes unremarkable and acceptable in the next (Pennay & Measham, 2016). One manifestation are “sexual scripts” (Gagnon & Simon, 1974), where cohorts learn what is sexually acceptable, from social environments and upbringing. In this light, it is perhaps unsurprising that males raised to believe “magazines in bushes” were for “dirty old men” experience IP differently to younger cohorts, where IP is ubiquitous. Warren appears to emphasise the power of sexual scripts when he describes being “flabbergasted” by students sharing pornography on mobiles. Evidence suggests younger males are not immune from aspects of the “Centrefold Syndrome”, such as the objectification of females (e.g. Flood, 2009), but it may be that sociocultural norms means they are less ashamed of it. Tensions felt by Generation X males could be further heightened as masculinity ideals, distorted by IP, clash with psychosocial requirements for successful ageing (Erikson, 1980). For example, the objectification of females “young enough to be my daughter” collide with developmental imperatives during middle adulthood to nurture the generation below. These tensions are also highlighted by struggles to connect to “higher” selves. Similarly, reports of feeling “ossified” and “not progressing” due to IP, resonate with Erikson’s account of “stagnation” when individuals fail to make meaningful connections.
Efforts to make peace with IP evoke the theory of cognitive dissonance (Festinger, 1957), which asserts that individuals strive to reconcile contradictions between their beliefs and behaviours. Interestingly, it appears participants sometimes try to resolve dissonance by consciously legitimising ideas that are central to theories of masculinity and pornography. For example, the deterministic explanations offered by participants for IP use (“Snakes and Ladders”, “wanking apes”, “animalistic self”) support Brooks’ thesis that males see voyeurism as “inevitable”. Interestingly, Miller et al. (2017) raise the possibility that positive responses in their study may have resulted from attempts to resolve dissonance, whereby respondents under-reported negative effects of their pornography consumption in a bid to reduce dissonance between their beliefs (e.g. believing that pornography use adversely impacts one’s life) and their behaviours (frequently using pornography).

Implications for counselling psychology practice

The findings have meaningful implications for clinical practice. These males did not typically see themselves as heavy IP users and struggled to evaluate its impact on their psychological health. Alongside the associated secrecy, men in this demographic, who may be impacted by IP in subtle, yet profound ways, could thus neglect to mention it in therapy. Their failure to raise issues could be reinforced by known difficulties in males to express vulnerability around sexual issues (Robbins, Wester, & McKean, 2016). I would suggest counselling psychologists are particularly well placed to offer support in this area, offering a space for men to explore their lived experience of IP, without fear of being judged or pathologised.

The data also reveals how some participants reduce shame with reference to evolutionary theory. This resonates with Gilbert’s compassion-focused therapy approach and its emphasis on helping clients to understand their “tricky brains” (Gilbert, 2009). Therapists could use this framework to help Generation X males foster self-acceptance for behaviours and beliefs. At the same time, however, understanding how
socially constructed masculinity ideals intertwine with IP use, might enable therapists to challenge the attitudes of clients who are keen to reduce use, but feel doomed to consumption by their genes.

Accounts may also contextualise couple’s work. Tony’s assertion he and his partner were “better off” having spoken about IP use, suggests psychologists could encourage and support such “tense, tense” conversations. Equally, therapists seeing females experiencing relationship difficulties with Generation X partners may also hold these accounts in mind. It could also be worth considering these findings when working with younger populations, contextualizing discussions about the relative costs and benefits of engaging with IP and its potential impact on relationship development and sustainability.

**Limitations**

Despite efforts to homogenise the sample, it could be argued that participants were not an ideal representation of Generation X males. For example, only two of the sample had children. Given how children are known to influence the lives of men (Munch, McPherson, & Smith-Lovin, 1997), this may have influenced the data. Indeed, the experience of one of the fathers was unusual for its sparsity of negative experiences, while the other account was more typical. In the first case, it is possible that a more positive experience reflected a sense of having achieved life stage prescriptions for nurturing (Erikson, 1980), as a result of having children. It should be remembered, however, that achieving a representative sample is not the aim of IPA. Rather, it is to create an in-depth analysis of a small sample, where conclusions are specific to that group. Any move beyond the sample should be undertaken tentatively. While this study’s sample may appear small, it is at the upper end of what is a recommended maximum for IPA (Smith, 2004).
Validity criteria

Overall, validity criteria set out in the methodology section were met. Sensitivity to context was demonstrated by the choice of the idiographic IPA approach itself, while the researcher’s background as a broadsheet journalist and clinical skills facilitated sensitive interviews, evidenced by the rich accounts offered. A self-reflective and ethical stance throughout the process also fulfilled these criteria (see Appendix 2). Commitment and rigour was demonstrated by a willingness to travel extensively to homes and attempts at an even-handed use of extracts. While the latter was largely achieved, some accounts were richer than others were, and may have been marginally over-represented. Additional quotes presented in Appendix 1 aimed to rectify this, and, together with material illustrating the analytic process, met criteria for transparency and coherence. Success in publishing these original and compelling findings should meet criteria for impact.

Future research

A grounded theory investigation could help to flesh out a more theoretical account of IP use in this demographic, using this data and the conceptual suggestions made as a starting point. Such an account might help shape assessments and interventions in the field of male mental health. Other qualitative investigations might focus on females, older males or those identifying as gay, all under-researched domains.

Conclusion

Generation X males typically found it difficult to assess the impact of IP on their lives. However, given space, they offered vivid accounts, describing tensions characterised by shame, feeling stuck, secrecy and relationship issues. They struggled to reconcile their voyeuristic inclinations with a desire to feel more connected and nurturing. Unlike younger counterparts previously, these males struggled to talk about IP with peers, considering it a solitary pursuit. They revealed how they made various attempts to make
peace with consumption, sometimes offering deterministic explanations of male evolution to reconcile tensions.

Conceptually, divergences between this sample of Generation X males and younger counterparts could be illuminated by normalisation theories and considering how distorted pornography-induced masculinity ideals might clash with prescriptions for successful ageing. Dissonance theories may explain efforts to resolve such tensions. These findings could prove particularly helpful for therapists working with this demographic, with couples or with females experiencing relationship difficulties.
References


HCPC Standards of performance, conduct and ethics. London: HCPC.


Smith, J. (2004). Reflecting on the development of interpretive phenomenological analysis and its contribution to qualitative research in psychology, *Qualitative Research in Psychology* 1, 39-54


Appendix 1: Additional quotes

1) Self and internet pornography

**Ageing self:**

Ralph: “If you wanted porn in the past it was a seedy operation (...) A certain subterfuge went on to access it, you know? And that carries over now in the sense that you feel like there’s somebody watching you watching porn.”

Tony: “I think there was a grief, because again, the older you feel, yeah - God, I’m looking at girls who could actually be my daughter.”

Peter: "I’m not going anywhere (...) I’m not making grounds or I’m just repeating the same old - what I’ve done for years and I’m not progressing (...) I’m being weak, so I’m not growing, building myself into where I wanna go."

Peter: "So if I do it, then I feel like I’m back to square one (...) I just feel weakened and less - less my true self after that.”

**Animalistic self:**

Peter: “I do feel that I’m better than that (...) it is a sort of animalistic sort of thing to do and I should be more spiritual.”

2) Internet pornography and intimate relationships

**Secrecy and betrayal:**

Bryan: “Our sex life had clearly withered on the vine a long time ago and that was my kind of guilty secret - watching porn while my partner slept.”

Bryan: “…you wonder if this person is as into it as you are, and feeling very exposed, and
thinking that there's no harm in watching some pornography (...) so it's kind of like levelling the score. So I don't just get sexual gratification from you, I get it from elsewhere.”

3) Making peace with internet pornography

Treat and reward:

Peter: “So, I brush my teeth, have a wank, and then I'll fall asleep.”

Comparing to others:

Steven emphasizes how, while others get “sucked into all kinds of horrendous shit”, he sees pornography experience as “expanding his horizons”.

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Appendix 2. Ethics approval

Proposal Ref: 1224-PSY-16

Names of DAMIEN PEARSE
Student/Trainee:

Title of Project: How do Generation X males experience internet pornography? An interpretative phenomenological analysis

Supervisor: Dr Ben Rumble

Date of submission: 15th November 2016

Date of resubmission: 12th December 2016

The above Research Project has been re-submitted to the Faculty of Health and Medical Sciences Ethics Committee and has received a favourable ethical opinion on the basis described in the protocol and supporting documentation.

The final list of documents reviewed by the Committee is as follows:
Ethics Application Form

Detailed protocol for the project

Participant Information sheet

Consent Form

Risk Assessment (If appropriate)

Insurance Documentation (If appropriate)

All documentation from this project should be retained by the student/trainee in case they are notified and asked to submit their dissertation for an audit.

Signed and Dated: 04/01/2017

Dr Anne Arber, Professor Bertram Opitz

Co-Chairs, Ethics Committee
Appendix 3. Participant information sheet

Experiences of Internet Pornography Study

Introduction

I am a doctoral student at the University of Surrey. I would like to invite you to take part in a research project. Before you decide, you need to understand why the research is being done and what it will involve for you. Please take the time to read the following information carefully. Please pay particular attention to the question of confidentiality. If you have any questions about participating, please raise them with the researcher before the start of the interview.

What is the purpose of the study?

You are being asked to take part in a research study that explores your experiences of internet pornography.

Why have I been invited to take part in the study?

Because you belong to a specific demographic (males born between 1961 and 1981) and because you say you watch internet pornography.

Do I have to take part?

No, you do not have to participate. If you decide to participate, you can withdraw at any time without giving a reason.

What will my involvement require?

In this study I will ask you a number of questions about your experience of watching internet pornography. Your answers will be recorded with a voice recorder so that I can analyse the transcript later. The interview should not normally last longer than one hour. No expenses will be paid for taking part.

What will I have to do?

If you would like to take part please complete an informed consent form and then we can proceed to the interview.
What are the possible disadvantages or risks of taking part?

There are no known benefits or risks for you in this study. However, if you feel distressed at any point during the study, you can stop without explanation. There are some helpline numbers at the bottom of this information sheet if you feel you need support.

What are the possible benefits of taking part?

It is unlikely that you will benefit directly but it is hoped that this research will help to establish a clearer understanding of the experiences associated with watching internet pornography.

What happens when the research study stops?

After the study has been completed, you will be debriefed and made aware of the full research aims. If you want to find out about the final results of this study, you should contact me at d.pearse@surrey.ac.uk and I will arrange to give you a copy of the final study.

What if there is a problem?

My supervisor Dr Ben Rumble will be glad to answer your questions about this study at any time. You may contact him at b.p.rumble@surrey.ac.uk.

Will my taking part in the study be kept confidential?

Your participation in this study will be anonymous and data files will be treated with the utmost confidentiality. However, the researcher reserves the right to disclose information relating to the consumption or distribution of child pornography to the relevant authorities.

Will my interview be seen by the public?

The contents from the interviews in this study may form part of a published report available to the public. However, no individual will be named or identified. Data will be handled in accordance with the Data Protection Act 1998 and stored for 10 years in a secure place.

Contact details of researcher and supervisor.
My contact details are d.pearse@surrey.ac.uk. My supervisor is Dr Ben Rumble and he can be contacted on b.p.rumble@surrey.ac.uk.

Who is organising and funding the research?

The research is not being funded by any organisation.

Who has reviewed the project?

The study has been reviewed and received a Favourable Ethical Opinion (FEO) from the University of Surrey Faculty of Arts and Human Sciences Ethics Committee.

Helpline Numbers:

Samaritans: 08457 90 90 90. Relate (for sex addiction services): 0300 100 1234. Self Help website with information on pornography: http://www.sexaddictionhelp.co.uk/

Thank you for taking the time to read this Information Sheet.
Appendix 4. Consent Form

I the undersigned voluntarily agree to take part in the study on the experience of watching internet pornography.

I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been advised about any discomfort and possible ill-effects on my health and well-being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

I agree to comply with any instruction given to me during the study and to co-operate fully with the investigators. I shall inform them immediately if I suffer any deterioration of any kind in my health or well-being, or experience any unexpected or unusual symptoms.

I consent to my personal data, as outlined in the accompanying information sheet, being used for this study and other research.

I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).

• I understand the limits of the confidentiality agreement. In particular, I recognise that the researcher reserves the right to disclose information relating to child pornography to the relevant authorities.

• I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

• I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.
Name of volunteer (BLOCK CAPITALS) ....................................................

Signed ............................................................................................

Date ............................................................................................... 

Name of researcher/person taking consent ............................................

(BLOCK CAPITALS)

Signed ............................................................................................

Date ...............................................................................................
Do you watch internet pornography?

If so, would you like to take part in a psychology research study exploring the experience of watching internet pornography? I am a doctoral research student at the University of Surrey and I am looking for male participants who would be willing to be interviewed about their experience of watching internet pornography for about one hour. To take part you will need to be male who identifies as heterosexual and aged between 35 and 55. All material used for the research will be anonymised. The project has been reviewed and received a favourable ethical opinion from the Faculty of Health and Medical Sciences Ethics Committee at the University of Surrey.

To volunteer please email d.pearse@surrey.ac.uk
Appendix 6. Semi-structured interview schedule:

1. Please can you tell me how you came to watch internet pornography?
   Prompts: When, where, what was the experience like?

2. Can you tell me what place Internet pornography has in your life at the moment?
   Prompts: How often? When?

3. Can you tell me about a recent time you watched internet pornography?

4) What did this experience mean to you?
Prompts: What was the best thing about this experience? What was the worst thing?
Appendix 7. Example of raw transcript: Bryan (first two pages)

I: Okay. So can you tell me how you came to watch internet pornography?

B: Erm, I first came to watch it by the fact that it was there. So when the, kind of, the internet first started, I would have watched on – I would have got DVDs when it was DVDs. Erm, I never went out and purchased my own DVDs, but just by appropriation from friends, there were – I had, I mean – not even a handful of DVDs but initially started watching on DVDs. Erm, and then with the advent of the internet one of the first things on the internet that there was, was it was a pioneer for pornography. And so it was ease of access to pornography via the internet. So that would have happened around the time of, you know, 95 – 1995, 1996.

I: Okay, yeah. And can you remember where you started watching it?

B: Where as in..? Oh, that would be at home – if you mean physically where. Erm, yeah, then it would have been at home, like in terms of websites. Are you asking about websites as well? It would have begun – I couldn't even remember the names of the websites – but certainly one that was in the mainstream was YouPorn, erm, and so as those kind of pornography aggregators came along, then I think it was via a friend who would have, erm, put me onto that.

I: Okay. And can you remember what that experience was like? When you started watching it?

B: Erm, the first word that comes into my mind is titillating; sort of forbidden. Definitely arousing. Erm, and the feeling of the fact that it was, I guess, forbidden and private but definitely very arousing, like, the viewing of pornography.

I: Can you tell me a little bit more about the forbidden?
B: Sure, yeah. I guess it almost goes back to the visualisation. I think men are very visual when it comes to sex. And I guess what pornography represents is, erm – it's something that is not personal to you, but something that you enjoy in private – an indulgence. And the fact that there's no limit to how much and what style of pornography as you want to watch, and very much the, sort of, the forbidden side of it comes down to the fact that you don't – you wouldn't want anyone – to know that you were watching that if someone could see your internet history. Erm, it's sort of very private.

I: Can you tell me a little bit more about why you wouldn't want people to..? 

B: Shame. Erm, I think in any area of sexuality your private peccadilloes and idiosyncrasies, you not only wouldn't want your partner to know but probably even your friends and colleagues to know. Everyone has a dark indulgence I think somewhere, and certainly the titles of the films that you're watching bring home – sound a lot worse than the content that you're watching. Well, not sound a lot worse because they are! They describe the content that you're watching, but they, yeah, they're not something that you'd want to share at a dinner party (laughs), what it is that you're watching.

I: Okay. Erm, you mentioned shame there. Can you tell me a little bit more about that feeling?

B: Erm, shame as in the point of view that you wouldn't want to own up to or admit to watching. Somehow, and maybe this is just me, but you're being mindful of the perception of other people and what other people may think of you for watching it. There's no deep personal, personal shame either before, during or after, but it's quite clearly something that you wouldn't want to share with your partner or friends, apart from very intimate friends where you feel no judgement.

Erm, but yeah, it's making public your private peccadilloes which you wouldn't want to do, you know? And that's not just related to pornography. There's a part of all of us that
is private and those will be in your actions, your thoughts, your deeds; shadows of ourselves that we don't like to admit to.
Appendix 8: Sample extract of annotated transcript: Bryan

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<td>Downplaying – is this some shame at start of interview?</td>
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Appendix 9. Example of working during thematic analysis
Appendix 10: Proposal to submit to Journal of Men’s Health

Submission process

Manuscripts submitted to JOURNAL OF MEN’S HEALTH should be submitted with the understanding that they have neither been published, nor are under consideration for publication elsewhere, except in the form of an abstract. Prior abstract publication(s) should be described in the form of a footnote to the title. Articles should contain original data concerning the course (prognosis), cause (etiology), diagnosis, treatment, prevention, or economic analysis of a clinical disorder or an intervention to improve the quality of healthcare. Published manuscripts become the sole property of the Journal and will be copyrighted by Mary Ann Liebert, Inc. By submitting a manuscript to the Journal, the author(s) agree(s) to each of these conditions. In addition, the author(s) explicitly assign(s) any copyrighted ownership he/she (they) may have in such manuscript to the Journal.

SUBMISSION PROCESS

Please read all the instructions to authors before submitting.

USE OF ENGLISH LANGUAGE

All submissions must be in English. Appropriate use of the English language is a requirement for review and publication in Journal of Men’s Health. For authors whose native language is not English, we suggest using a service that can aid in the translation and rewriting of material into correct and proper English usage. The Publisher offers this service with a subsidy from the author prior to official submission. It is important to note that employing the use of the Publisher’s service does not guarantee acceptance of any article. Please contact AuthorServices@liebertpub.com for more information.

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PEER REVIEW
All submissions to *Journal of Men’s Health* are subject to peer review. You will be asked for the names and email addresses of potential suggested reviewers familiar with the field. Please ensure preferred reviewers are not from your university or institution with whom you have collaborated. Anyone whom the author does not want to be considered may also be named as a non-preferred reviewer. Ultimately, the final selection of reviewers is at the discretion of the Editor(s).

**AUTHORSHIP**

All authors should be responsible for a significant part of the manuscript. All authors should have taken part in writing, reviewing, and revising the intellectual and technical content of the manuscript. Any author whose name appears on an article assumes responsibility and accountability for the results.

*Accuracy of Authorship (Also see Copyright section)*

It is incumbent upon the submitting author/agent to ensure the accuracy and inclusion of all contributing authors’ names and affiliations upon original submission of the article. Once an article is accepted for publication, changes in authorship while the article is in production – including page proofs – are NOT permitted. Changes in authorship after publication are strictly prohibited.

**CORRESPONDING AUTHOR**

It is the Journal’s policy that a manuscript declares only ONE corresponding author on an article. This designation should be determined at the time of submission. Additions to corresponding authors are not permitted after acceptance or in page proofs.

**Manuscript Preparation**

All manuscripts must be prepared in accordance with the “Recommendations for the Conduct, Reporting, Editing and Publication of Scholarly Work in Medical Journals.”

**WORD and DATA LIMITS**

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Letter to the Editor

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*These limits relate to the text of the manuscript; word limits do NOT include the abstract, figure and/or table legends, acknowledgments, disclosures, or references.

Requirements for text

Prepare all text, double spaced, in Microsoft Word. Do NOT supply a PDF of your manuscript. Provide the order of items as follows:

- Title page
- Abstract
- Text
- Acknowledgments
- Author Disclosure Statement(s)
- References
- Correspondence address
- Legends
- Tables

Requirements for Title Page

The title page of your submission should be prepared in Microsoft Word and MUST be included as part of your main text document (not as a separate file) and should contain the following items:

- The complete title of the article
- All contributing authors’ full names, complete affiliation(s), including department, institution, city, state, country, full postal mailing address(es), and full contact information (telephone, fax, and email address)
- A brief running title of no more than 50 characters, including spaces
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- Between 3–6 keywords to assist in the peer-review process

Requirements for Abstract
The abstract should be prepared in Microsoft Word

Abstract should be no more than 300 words

Abstract should be **structured**, stating the background, methods, results (including the sample size), and conclusions drawn from the study

The use of the first person should be avoided

Do not use proprietary or trade names in the title or abstract

Clearly summarize the results and conclusions of the work

References are not permitted in the abstract

**Text**

In general, the text should be organized under the headings: *Introduction*, *Materials and Methods*, *Results*, *Discussion*, *Conclusion(s)*, *Acknowledgment(s)*, *Author Disclosure Statements*, and *References*. Use only standard abbreviations, which can be found in the AMA's Manual for Authors & Editors or the Council of Biology Editors Style Manual. At first usage, spell out terms and give abbreviations in parentheses. Thereafter, use only abbreviations. It is not necessary to spell out standard units of measure, even at first usage. Use generic names for drugs if possible. If you wish to use a proprietary drug name the first time it appears, use the generic name followed by the proprietary name, manufacturer, and manufacturer’s location in parentheses.

**Acknowledgments.** The author should acknowledge only those people and their institutions that have made significant contributions to the study.

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**References.** References must be prepared double spaced and **numbered consecutively as they are cited in the text using superscript numbers**. Do not include reference numbers in parentheses or brackets. References appearing for the first time in tables and figures must be numbered in sequence with those cited in the text where the table or figure is mentioned. **Use journal abbreviations as provided by Medline.** List all authors when there are six or fewer. When there are more than six authors, list the first three, followed by et al. If references to personal communications or unpublished data are used, they are not to be in the list of references. They should be referred to in the text in parentheses: (Example: F.P. Haseltine, personal communication). Include among the references any articles that have been officially accepted but not yet published; indicate the article title and the journal to which the work was accepted, and add “In Press.”

**Sample references:**


Websites: Please follow this structure for website references, including capitalization and punctuation: List author/organization name (if available). Article title. List website address. Last accessed on (include last date the site was accessed.)

Conference Proceedings: Please follow this structure for Conference Proceeding references, including capitalization and punctuation: List all Authors’ (or) Editors’ names (last name first, followed by first and middle initials). Conference title. Date of conference. Location of conference. City of publisher: Publisher; Year of publication. Complete number of pages in proceedings book.

Correspondence Address. Following the references, provide the name, postal mailing address, and valid email address of the corresponding author. If accepted, this information will be published and made available to the public.

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Tables. Prepare all tables double spaced in one separate Microsoft Word file (do NOT upload PDFs, .tifs, .eps files for tables). Be sure to provide a title for each table. Cite tables in sequence in the text. Explain abbreviations used in the body of the table in footnotes. If a table is being reprinted from a copyrighted publication, appropriate credit must be supplied in a footnote.

Figures. Cite figures consecutively in the manuscript within parentheses: [Example: These keratotic areas can be confused with condyloma (Fig. 2A).]

PREPARATION OF FIGURE FILES

• Figures should be numbered in the order cited in the text.
• Figures should not show the name of a patient or a manufacturer.
• Name figure files using only alphanumeric characters. Do not use symbols, dots, or dashes.
• File names should be formatted with first author’s last name and the figure number. (Ex: SmithFig1)
Do not embed any figures or tables in the main text file.

Do not prepare any figures in Word as they are not workable.

Save figures as either TIFF or EPS files. Avoid submitting JPEG files if possible.

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Publication of color figures is encouraged, but the cost for color printing must be subsidized by the author(s). Contact the Publisher for an estimate. Please consider these costs when preparing your manuscript for submission.

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Please upload individual files of all manuscript material — do NOT upload a single PDF file containing all text, figure, and table files of your article. Once all individual files are uploaded on to Manuscript Central, the system will automatically create a single PDF proof for you and the peer-review process.

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If applicable, it is incumbent upon the author(s) to obtain patient release statements of permission to reproduce any identifiable images of patients. The submitting author should provide written confirmation of this critical information. Acceptable forms of consent statements are emails or letters. The Journal does not provide a generic patient release form.

The written consent must contain specific information about the patient's name, age, and if pertinent, conservatorship – as well as stated permission – granting the Journal the rights to publish the photograph within its pages (which should include the name of the Journal and your article title).

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Patients and Study Participants

All manuscripts must comply with the privacy and confidentiality requirements outlined on the Recommendations for the Conduct, Reporting, Editing and Publication of Scholarly Work in Medical Journals website. For more information, visit www.icmje.org/recommendations/browse/roles-and-responsibilities/protection-of-research-participants.html

When articles include reports of studies on human subjects, state in the Methods section that an appropriate institutional review board or ethics committee approved the study. Authors who do not have formal ethics review committees should follow the principles of the Declaration of Helsinki. In the Methods section, state that informed consent was obtained from subjects (specify written or verbal).

The principal author must state that if animals were used experimentally, permission was obtained from the appropriate committee(s), and that the animals were treated humanely and the standards conformed to those of current ethical animal research practices.
In addition, text and photographs should not reveal any identifying information unless it is essential for scientific purposes (in which case, consent should be obtained). Masking the subjects’ eyes in photographs is often insufficient to protect their identity.

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PROTECTION OF HUMAN SUBJECTS AND ANIMALS IN RESEARCH*

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### Appendix 11: Table of themes and sub-themes

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