

SELF-CRITICAL OR LACKING IN SELF-COMPASSION? DISTINCT CONSTRUCTS  
WITH UNIQUE PREDICTONS FOR SUBJECTIVE WELL-BEING OVER TIME

DAVID T. CHAFE

A THESIS SUMMITTED TO THE FACULTY OF GRADUATE STUDIES IN PARTIAL  
FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS

GRADUATE PROGRAM IN PSYCHOLOGY

YORK UNIVERSITY

TORONTO, ONTARIO

August, 2018

© David Chafe, 2018

## Abstract

Self-compassion has been found to play an important role in mental health and well-being (Korner et al., 2015). In contrast, self-criticism has long been implicated in the vulnerability/maintenance of negative personality traits and various psychopathologies. There are well-known and valid measures of self-criticism (Blatt, D’Afflitti, & Quinlan, 1976), but only one measure of self-compassion, the Self-Compassion Scale (SCS; Neff, 2003b). Recent studies have suggested the 13 negatively valenced items of the SCS appear closer to self-criticism rather than a lack of self-compassion. The objective of this study was to better define self-compassion by comparing the SCS to a valid measure of self-criticism. It was hypothesized that a subset of the SCS’s positive items would be conceptually faithful to the construct of self-compassion. It was also hypothesized that this subscale would show distinct discriminant and construct validity compared to self-criticism when looking at responses to Online Positive Psychology Interventions (OPPIs) in a large sample. This study addresses a gap in the literature by refining the measurement of self-compassion and identifying a briefer scale called the SCS-5.

## TABLE OF CONTENTS

|   |     |
|---|-----|
| Abstract.....   | ii  |
| Table of Contents.....  | iii |
| List of Tables.....   | v   |
| Introduction.....   | 1   |
| Self-Compassion.....  | 1   |
| Self-Criticism.....   | 4   |
| Measurement Issues.....                                       | 7   |
| Overview and Current Study.....                               | 10  |
| Hypotheses.....   | 11  |
| Method.....   | 12  |
| Participants.....   | 12  |
| Measures.....   | 13  |
| Self-Compassion Scale (SCS).....                              | 13  |
| Self-Compassion Scale-5 (SCS-5).....                          | 14  |
| Depressive Experiences Questionnaire (DEQ) .....              | 14  |
| Compassionate, Positive, Negative Affect Scale (C-PANAS)..... | 15  |
| Center for Epidemiological Studies Depression (CES-D).....    | 15  |
| Satisfaction with Life Scale (SWLS).....                      | 15  |
| Steen Happiness Index (SHI).....                              | 16  |
| Results.....  | 16  |
| CES-D – Depression.....                                       | 19  |
| C-PANAS – Compassionate Affect.....                           | 20  |

|                                    |    |
|------------------------------------|----|
| PA – Positive Affect.....          | 20 |
| NA – Negative Affect.....          | 21 |
| SWLS – Satisfaction with Life..... | 21 |
| SHI – Happiness.....               | 22 |
| Discussion.....                    | 22 |
| References.....                    | 33 |

## LIST OF TABLES

|  |    |
|--|----|
| Table 1: All 26 items and six subscales of the full self-compassion scale (Neff, 2003b)..... | 40 |
| Table 2: Correlation matrix and descriptive statistics for all measures.....                 | 41 |
| Table 3: Hierarchical Linear Model Tests of Psychological Well-Being and Psychopathology..   | 42 |

## Self-Critical or Lacking in Self-Compassion? Distinct Constructs with Unique Predictions for Subjective Well-Being Over Time

While empirical research is only recently occurring on the subject of self-compassion, the concept of self-compassion has been long present in many eastern literatures. The positive psychology movement in the west has been present for the past several decades, with a 2000 article by Seligman and Csikszentmihalyi titled “Positive Psychology: An Introduction” which focused on the science of positive subjective experiences as an antithesis to the overwhelmingly skewed focus in psychology on the pathological. A decade prior to this, Stephen R. Covey’s 1989 book, *The 7 Habits of Highly Effective People* focused on being self-aware and promoting a positive focus towards oneself and their goals. Emerging from this nearly 30-year-old idea of positive psychology and self-focus, self-compassion is now more fully arising as a discreet research topic in western empirical psychology. Neff (2003a) is credited with the initial operationalized definition and “empirical” understanding of self-compassion. In her original 2003a article, Neff drew from Buddhist teachings on the more traditional definition of compassion, and adapted this definition to fit self-compassion, stating it “involves being touched by and open to one’s own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one’s suffering and to heal oneself with kindness. Self-compassion also involves offering nonjudgmental understanding to one’s self experiences of pain, inadequacies, and failures, so that one’s experience is seen as part of the larger human experience” (p. 87). Since its introduction into the literature, self-compassion has gained considerable attention from both researchers and clinicians alike.

Self-compassion has been linked to various health benefits and psychological well-being including higher levels of happiness, optimism, satisfaction with life, motivation and

achievement, coping skills, and emotional intelligence (Neff, 2003a; Neff, Hseih, & Dejittthirat, 2005; Neff, Kirkpatrick, & Rude, 2007; Neff, Rude, & Kirkpatrick, 2007). This construct has gained empirical support as an important buffer against anxiety, depression, and many other mental health issues (Korner et al., 2015). Paul Gilbert (2009), in a paper on Compassion Focused Therapy describing the neuroscience, evolutionary, and developmental processes of self-compassion, provides support that through the activation of these different systems, an individual can become motivated, safe, content, soothed, and have an overall sense of increased well-being in both their physical and psychological health. This idea of self-compassion being an important therapeutic factor is also discussed in Tim Desmond's 2015 book, *Self-Compassion in Psychotherapy – What is so redemptive or beneficial about self-compassion?* In his book, Desmond talked about increases in loving, kind, and forgiving attitudes towards the self when self-compassion is increased. López et al. (2015) also mention the importance of self-compassion in therapeutic interventions and assume it to be vital for lasting improvement. A study by Segal, Williams, and Teasdale (2002) showed that when using mindfulness based cognitive therapies, cultivating acceptance and compassion for the self is believed to disrupt maladaptive associative networks that cause individuals' difficulties. This research suggested that fostering a self-compassionate attitude towards the self helps in preventing relapse of various disorders, particularly when using mindfulness-based interventions.

Given these benefits and its alignment with the positive psychology movement (Seligman, Rashid, & Parks, 2006) there has been an increase in interventions that aim to foster self-compassion. A study by Shapira and Mongrain (2010) investigated the effectiveness of Online Positive Psychology Interventions (OPPIs) and found that a self-compassion exercise led to increases in mood up to six-months post intervention when compared to those who wrote

about an early memory in the control condition. This result was found to be particularly significant in individuals who showed a mature level of dependence in their personality structure. This suggests that those who are comfortable expressing their need for others may be primed for compassion and be better able to adopt this stance towards themselves.

Paul Gilbert who has frequently investigated the benefits of fostering self-compassion as a way of combating self-criticism (Gilbert & Irons, 2004), has since developed Compassionate Mind Training (CMT; Gilbert & Proctor, 2006). His team found that patients at a cognitive-behavioural-based day centre for those with chronic difficulties that engaged in 12 weekly two-hour sessions of CMT showed reductions in depression, anxiety, self-criticism, shame, inferiority, and submissive behaviour, while also showing increased abilities to self-soothe and focus on feelings of warmth and self-assurance. This suggests that CMT may be a beneficial addition to other therapies when dealing with highly self-critical clients.

Neff (2003a) describes self-compassion as an alternative way to conceptualize having a healthy attitude towards the self. This idea of a healthy self-view is, in itself, not new. Psychologists such as Seligman, a key proponent of the positive psychology movement, described the concept of self-respect (Seligman 1995). Famous psychologist Albert Bandura described self-efficacy in the early 1990's. Deci and Ryan (1995) discuss the importance of the concept of self-esteem. I will argue that self-compassion, although similar to these aforementioned concepts, deviates in theoretically important ways.

Consistent with this distinction, Neff and Beretvas (2013) investigated the role of self-compassion vs. self-esteem in romantic relationships. They found that self-esteem showed overlap with narcissism and was more often associated with self-focus and self-absorption, leading to difficulties in acting in a caring and loving way towards a partner. Ultimately self-



esteem does not seem to be associated with strong, healthy relationships. In contrast, self-compassionate individuals were shown to display more positive relationship behaviour, to have higher relationship satisfaction, and to have higher overall levels of relational well-being.

### **Self-Criticism**

Another construct with a long history in the literature on vulnerability to depression is self-criticism (Blatt, Quinlan, Pilkonis, & Shea, 1995; Blatt, Zuroff, Bondi, Sanislow, & Pilkonis 1998; Gilbert & Proctor, 2006; Mongrain & Leather, 2006; Shahar, 2015; Zuroff, Mongrain, & Santor, 2004). Sidney Blatt, from an object relations perspective described the self-critical individual as one who tends to set very high, often unachievable standards for themselves and tends to have a harsh and unforgiving self-evaluative style in the face of real or perceived failure. These individuals often strive for perfection, work hard, are highly competitive, and place high demands on themselves. Even when these individuals achieve a great deal, it is often “not good enough.” Not living up to these high standards leads such individuals to feeling unworthy, inferior, shameful, and guilty (Blatt, D’Afflitti, & Quinlan, 1976; Blatt & Zuroff, 1992). Self-criticism is thought to represent a developmental failure in realizing an essentially resilient, positive sense of self that is forgiving towards perceived failure.

Shahar (2015) writes that self-criticism is marked by an intense and persistent relationship with the self, characterized by two attributes: (1) an uncompromising demand for high standards in performance, and; (2) that performance is often accompanied by an expression of hostility and derogation toward the self when excessively high standards are – inevitably – not met (pp. 5). The psychologically detrimental aspects of self-criticism involve self-directed hostility and “self-slamming” for the having made “mistakes or failed.” It is this joint process

that likely contributes to cyclical self-criticism seen in harsh self-critics who seldom achieve an attitude of compassion towards the self.

There is considerable evidence linking self-criticism to depression (Blatt, D’Afflitti, & Quinlan, 1976), and convincing evidence suggests self-criticism is a vulnerability marker for depression as well as other types of psychopathologies (Gilbert & Proctor, 2006; Mongrain & Leather, 2006; Shahar, 2015; Zuroff, Mongrain, & Santor, 2004). Self-criticism has implications for functioning in a wide variety of spheres and may put individuals at risk for psychopathology through disturbed relationships (see Zuroff, Santor, & Mongrain, 2004) and negative life events (Mongrain & Zuroff, 1994) that self-criticism plays a role in. Self-criticism is also associated with increased relapse rates in several disorders, even after achieving some relief. For some disorders like depression, self-criticism is associated with an increased lifetime risk (Gilbert & Irons, 2006; Murphy et al., 2002; Zuroff, Santor, & Mongrain, 2005).

Gilbert and Proctor (2006) describe how shame may be a key component of both vulnerability to, and perpetuation of, self-criticism. They define shame as having two major components. *External shame*, is characterized by others viewing the individual in negative ways that make that individual vulnerable to being rejected. This may contribute to the self-critical individual’s general sense of belonging to an unsafe social world. In contrast to this, *internal shame* is defined as self-directed feelings of inadequacy, devaluation, and self-criticism. There appears to be a mutually reciprocal relationship between self-criticism and shame, with those high on shame-proneness having higher levels of self-criticism, and those higher in self-criticism having higher shame-proneness (Gilbert & Miles, 2000). In line with this, it has been shown that self-criticism and low self-esteem put individuals at risk for drops in mood, which increase self-critical thoughts, and further perpetuate drops in mood that can lead to depression (Gilbert &

Proctor, 2006). Interpersonally, those who are self-critical also tend to self-disclose less and display colder, more distant behaviour. This may result in interpersonal problems (Zuroff & Fitzpatrick, 1995) which also may further perpetuate this cycle of self-criticism and subsequent drops in mood.

In addition to the difficulties that self-criticism causes both interpersonally and psychologically, self-critical individuals may also suffer from poorer outcomes in therapy. Two studies by Blatt et al. (1995, 1998) looked at self-criticism (referred to as perfectionism) and dependency (need for approval) across four different treatment modalities. They found that in each of the treatments, self-critical participants had poorer outcomes compared to dependent participants. Pre-treatment levels of self-criticism also predicted negative outcomes on posttreatment measures of depression. A study by Luyten et al. (2007) supported this and found that self-criticism was strongly related to major depressive episodes, the severity of depression, and was predictive of specific depressive symptoms such as expressed feelings of failure, self-hate, guilt, and loss of interest in others.

Despite the various mental health implications of both self-compassion and self-criticism, the main tool used to measure self-compassion, the Self-Compassion Scale (SCS) by Neff (2003b) has received considerable criticism in the literature. Emerging empirical work (e.g. Brenner, Heath, Vogel, & Crede, 2017; Coroiu et al., 2018; López, Sanderman, Ranchor, & Schroevers, 2018; López et al., 2015; Montero-Marín et al., 2016; Muris et al., 2018; Muris & Petrocchi, 2017) claim the measure taps the constructs of both self-compassion and self-criticism, leading to both theoretical and psychometric concerns. The current work aims to distinguish the constructs and provide an empirical alternative to the measurement of self-compassion.

## Measurement Issues

Neff (2003a) has operationalized self-compassion as being comprised of: 1) self-kindness vs. self-judgement, 2) a sense of common humanity vs. feelings of isolation, and 3) mindfulness vs. over-identification. Briefly, self-kindness refers to being warm and understanding towards ourselves in the face of our suffering, failure, and feelings of inadequacy, rather than being punitive and cold towards the self (self-judgment). Common humanity is simply recognizing that we are all human, and the human condition is imperfect, and that we are not alone and isolated, but rather part of this imperfect human condition with the rest of the world. Lastly, mindfulness involves seeing painful thoughts and emotions for what they are, without suppressing or avoiding them. This helps us identify when we are in pain and suffering, which allows us to comfort ourselves rather than over-identifying with these painful thoughts and feelings as ego-centric (Neff, 2003b). This idea of “looking inward” and attending to those feelings is coherent with the gestalt idea of “contact” originally described in Perls, Heferline, and Goodman (1951). The idea of acceptance also has a long history in Buddhism, and the intertwining of Buddhism and psychology (Epstein, 1995; Molino, 1998) led to alternative ways of understanding well-being, including the development and implementation of mindfulness-based stress reduction programs (Kabat-Zinn, Massion, Kristeller & Peterson, 1992). However, Neff in her 2003a and 2003b articles was the first to operationalize self-compassion in this way and to create a scale to measure it.

Out of this initial study seeking to operationalize the construct of self-compassion came the creation of the Self-Compassion Scale (SCS; Neff, 2003b). The SCS consists of 26 items contributing to six previously mentioned factors (each a pole of Neff’s three dimensions): self-kindness vs. self-judgement, common humanity vs. feelings of isolation, and mindfulness vs.

over-identification. Her items result in 13 positive and 13 negative items believed to represent one higher-order factor of self-compassion, and her SCS scale has been the principal instrument used in the research on self-compassion (Armstrong III et al., 2016; Gilbert, 2017; Korner et al., 2015; López et al., 2015; Montero-Marín et al., 2016). Despite its popularity, controversy about the SCS persists both on conceptual and empirical grounds, in particular, in relation to the factor structure of the SCS and what the subscales may actually represent.

After reviewing the initial validation of the SCS, a study by Armstrong III et al. (2016) revisited the SCS's factor structure. Through performing both an exploratory (EFA) and confirmatory factor analysis (CFA) they found that the 26 items of the SCS are best represented as two factors, one consisting of all the positive items, and the other consisting of all the negative items. A bifactor analysis provided further support that a single order factor in the SCS was not evident, finding that the negative factor was more closely related to measures of self-criticism than was the positive factor, an assumption explored further in the current study. Armstrong III et al. (2016) also suggested that researchers may benefit from reducing the scale to avoid contaminating the measurement of self-compassion with items that may better measure self-criticism. This would restrict a measurement of self-compassion to the positive items of the SCS.

Similar conclusions were reached by López et al. (2015) who also looked at the psychometric properties of the SCS. This study used a large community sample of 1643 participants while conducting an EFA and CFA, while also investigating correlations among the SCS with measures of self-criticism and other measures of psychological functioning. The results confirmed a two-factor solution representing the SCS's positive and negative items providing the best fit of the data. In their correlation analysis, they also found the negative items correlated more strongly to negative affect, depressive symptoms, perceived stress, rumination,

and neuroticism while the positive items related more strongly to positive affect. The authors proposed that the positive and negative items of the SCS tap different constructs and concluded that the full 26 item version of the SCS is not a valid measure of a unitary construct. The importance of differentiating between self-compassion and self-criticism both theoretically and empirically using the SCS was again also emphasized (López et al., 2015).

Montero-Marín et al. (2016) drew from the previously mentioned López et al. (2015) study aiming to further evaluate and compare the proposed factor structure of the SCS. Going further than previous findings, this study suggested that the negative items of this scale actually represent self-criticism, rather than the absence of self-compassion. This is consistent with the previous evidence reviewed concluding the SCS may tap different constructs which diverge with respect to the overall measurement of self-compassion.

In contrast to the SCS, several widely studied and reliable measures of self-criticism have shown good construct and predictive validity (Blatt, D’Afflitti, & Quinlan, 1976; Gilbert, Clarke, Hemlep, Miles, & Irons, 2004). These have been shown to relate in theoretically predictable ways to psychological distress, including depression and negative affect. The best-known measure and the one utilized in the current study is the self-criticism factor of the Depressive Experiences Questionnaire (DEQ; Blatt, D’Afflitti, & Quinlan, 1976). This DEQ factor includes items such as “I often find that I don’t live up to my own standards or ideals” and “There is a considerable gap between how I am now and how I want to be.” It has acquired validity in a number of clinical trials, showing high correlations and predictive validity when looking at symptom severity, specific depressive symptomology, and treatment outcome (Blatt et al., 1995, 1998; Luyten et al., 2007; Shahar, 2015). The DEQ has been used for over 30 years and is still commonly used as the golden standard for the measurement of self-criticism. According to

Shahar (2015), the DEQ is one of the most robust measures of self-criticism and is the method of choice used in most studies for both research and clinical assessment.

### **Overview and Current Study**

The constructs of self-compassion and self-criticism while conceptually related, have different theoretical origins that likely represent different processes. Further, given their conceptual similarities, it is vital that we differentiate empirically how the constructs of self-compassion and self-criticism are operationalized and differentially relate to subjective well-being.

The aim of the current research was threefold and builds on the previous research on self-compassion in the following ways: The first goal emerges from the recent empirical studies recommending modifications to the SCS in order to derive a better, “cleaner” measure of the self-compassion construct. There is both theoretical (Bernard & Curry, 2011) and psychometric support for the shorter, five item self-kindness subscale of the SCS being sufficient and perhaps optimal for the measurement of self-compassion. Previous work (Armstrong III et al., 2016; López et al., 2015; Montero-Marín et al., 2016) has suggested removing the negative items, and using the 13 positive items for a measure of self-compassion. However, I present support that the five item self-kindness subscale best represents the concept of self-compassion, even over the 13 positive items of Neff’s original SCS, which some research suggests may be redundant (Bernard & Curry, 2011). Secondly, given the empirical findings that the negative items of the SCS represent a construct similar to self-criticism, this new improved briefer instrument was examined for discriminant validity against a well-known measure of self-criticism, the DEQ. This builds on previous studies by asserting that the five self-compassion items and the DEQ will show similar patterns of correlations previously found with the 13 positive and 13 negative items

of the full SCS (López et al., 2015; Montero-Marín et al., 2016), thus furthering support for both the strength of the five item SCS, and the assertion that the negative items represent self-criticism. Finally, further support for construct validity of the new instrument was obtained through a longitudinal study investigating brief online positive psychology interventions (OPPIs) (one of which was a self-compassion exercise) administered in a large community sample. This allowed me to assess the predictive validity of the new five item scale, while also investigating how it compares to self-criticism in predicting well-being over time. This is an important step in expanding on the previous research that has been done with the SCS which has primarily focused on psychometric tests (EFA, CFA) and correlational analyses. To my knowledge, no previous research has used predictive tests with a brief version of the SCS a true measure of self-criticism.

### **Hypotheses**

1) It was hypothesized that face validity for the five items would be obtained from expert raters who would achieve high inter-rater reliability in the selection of the five items from the SCS they believed to best represent self-compassion. These items were expected to correlate with items showing the highest factor loadings from previous studies. It was also hypothesized that the simpler, five item measure (SCS-5) would have high internal consistency and perform as well as the positive 13 items of the SCS.

2) To further validate the SCS-5, construct validity for the new measure was established by examining the pattern of correlations with measures of subjective well-being such as satisfaction with life, happiness, and compassionate and positive affect. Discriminant validity was obtained by comparing the SCS-5 to the DEQ self-criticism factor, expecting the DEQ and SCS-5 to show opposite patterns of correlations, with the DEQ correlating more highly to measures of psychopathology, such as depression and negative affect.



3) Given that “true” and demonstrable discrimination between self-compassion and self-criticism should be possible, and that these constructs are known to differentially relate to well-being and psychopathology through correlational analysis, I predict that a similar pattern will hold when investigating these relationships over time. Given that the OPPIs are meant to induce positive psychological effects, it was hypothesized that the SCS-5 and DEQ scales would show differential predictive validity over six-months, with the SCS-5 being a stronger predictor of outcomes related to well-being, and the DEQ being a stronger predictor of depression and negative affect following the positive psychology interventions.

### **Method**

The current study is a secondary data analysis of a larger data set obtained from Project Hope 1 (2008), a large online study that used a community sample to investigate the effects of Online Positive Psychology Interventions (OPPIs). The study involved the administration of well-being measures obtained at baseline, 1-week post OPPI, with three follow-up measures at 1, 3 and 6 months after the intervention period. The data collected from this study was analyzed in several follow up studies looking at different interventions and using different statistical methods (see Armstrong III et al., 2016; Shapira & Mongrain, 2010).

### **Participants**

The sample from the original Project Hope Study consisted of 3460 Canadian adults between the ages of 18 and 72 ( $M = 33$ ,  $SD = 11$ ). The sample was predominantly female (81%), and Caucasian (79%) with 6% reporting Mixed heritage, 5% Asian, 2% Middle Eastern, 2% East Indian, 2% Aboriginal/Inuit, 1% Hispanic, 1% Black, and 2% Other. With respect to religious affiliation, 49% identified as Christian, 12% as Agnostic, 8% Atheist, 2% Jewish, 2% Islamic, and 2% Buddhist, with 22% of the sample identifying as Other. The majority of the sample had

completed a post-secondary degree (51%), and 48% reported having an annual income of \$30,000 or less. Participants reported baseline depressive symptoms in the mild to moderate range as measured by the Centre for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977) with a mean score of 18.57 ( $SD = 13.47$ ). Lastly, 81% of participants reported having current or past experiences with psychopathology, psychotherapy, or psychopharmacological treatment.

Participants were recruited in Canada between October 2007 and January 2008. Participants had to be 18 years of age or older and have daily access to the internet. Facebook advertising and newspaper ads were utilized for participant recruitment. Compensation of \$30 was offered for the first group of participants ( $n = 1168$ ) once they completed the first post-test assessment. Due to funding constraints, the remaining participants were entered into a draw for \$1000 after completing the post-test assessment and had additional entries to \$1000 draws at each follow-up assessment they completed.

## Measures

**Self-Compassion Scale (SCS; Neff, 2003b).** The 26 item self-report measure is comprised of six subfactors with four to five items measuring each factor of “self-kindness,” “self-judgement,” “common humanity,” “isolation,” “mindfulness,” and “over-identification.” These are the three positive and three negative subfactors that make up the SCS. An example of items measuring the opposing subfactors of “self-kindness” and “self-judgement” are “I try to be loving towards myself when I feel emotional pain” and “I’m disapproving and judgemental of my own flaws and inadequacies,” respectively. Items are rated on a 5-point Likert scale ranging from *almost never* (1) to *almost always* (5). The overall SCS scale has shown good internal

consistency and in the current sample the SCS had a Cronbach's alpha of .94. For all items and their respective subfactors, see Table 1.

**Self-Compassion Scale-5 (SCS-5; adopted from Neff, 2003b).** This five-item measure was the scale adopted from the full version of the SCS and is comprised of the five "self-kindness" subfactor items. These items include "When I'm going through a very hard time, I give myself the caring and tenderness I need," "I'm kind to myself when I'm experiencing suffering," "I try to be understanding and patient towards those aspects of my personality I don't like," "I'm tolerant of my own flaws and inadequacies," and "I try to be loving towards myself when I'm feeling emotional pain." This scale retains the original SCS anchors which rate items on a 5-point Likert scale ranging from *almost never* (1) to *almost always* (5). The SCS-5 demonstrated good internal reliability yielding a Cronbach's alpha of .85 in the current sample.

**Depressive Experiences Questionnaire (DEQ; Blatt et al., 1976).** This 66-item questionnaire is designed to tap personality vulnerability to depression and contains items that describe feelings and experiences common in those who suffer from depression. Being a measure from the psychodynamic school of thinking, both inter and intrapersonal (or introjected) factors are thought to inform the development of depression. Therefore, the DEQ measures three factors: Self-criticism, dependency, and efficacy. Only the self-criticism factor is relevant to the current study given that the SCS's negative items appear to be informed by an apparent conceptual overlap with self-criticism. This appears to be founded on both concepts sharing an internal, "self-evaluative" component. The self-critical factor of the DEQ reflects thoughts and concerns about failure and rejection, with an intense focus on achievement and performance (Blatt, Zohar, Quinlan, Zuroff, & Mongrain, 1995). Participants respond to items such as, "If I fail to live up to expectations, I feel unworthy," "I often find I don't live up to my own standards or ideals," and

“There is a considerable difference between how I am now and how I want to be.” Respondents use a 7-point Likert scale ranging from *strongly disagree* (1) to *strongly agree* (7). The self-critical subfactor of the DEQ has an adequate Cronbach’s alpha of .77, and a five-week test-retest reliability of .83 (Zuroff, Moskowitz, Wielgus, Powers, & Franko, 1983).

**Compassionate, Positive, and Negative Affect Scale (C-PANAS).** The C-PANAS was created for Project Hope and is based on the original Positive and Negative Affect Schedule (PANAS; Watson, Clark, and Tellegen, 1988). Seven compassion adjectives (both positively and negatively valanced) were generated by the Project Hope researchers and then added to the original PANAS to assess the participants level of compassionate affect. Examples of these items include “loving” and “nurtured”. Other items for positive affect (PA) included “content” and “joyful” while negative affect (NA) had items such as “frustrated” and “unhappy.” The C-PANAS obtained a Cronbach’s alpha of .86 for the Compassionate Affect Scale, .91 for the Positive Affect Scale, and .88 for the Negative Affect Scale in the current sample.

**Centre for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977).** This is a reliable and well-validated measure of depressed mood in the general population (Santor, Zuroff, Ramsay, Cervantes, & Palacios, 1995) yielding a Cronbach’s alpha of .85 and a two-week test-retest reliability of .60. The CES-D consists of 20 items and asks about common symptoms of depression that may have been experienced over the past week (e.g., “I thought my life had been a failure”) and rate these items on a 4-point Likert scale from 0 (rarely or none of the time, less than 1 day) to 4 (most or all of the time, 5–7 days). Total scores range from 0 to 60, with 16 as the recommended cutoff score for clinically significant depressive symptomatology.

**Satisfaction with Life Scale (SWLS; Pavot & Diener, 1993).** This scale measures an individual’s global judgment of life satisfaction. Respondents rate their agreement with five

statements (e.g., “In most ways my life is close to ideal”) on a 7-point Likert scale from *strongly disagree* (1) to *strongly agree* (7). A total score between five and nine suggests extreme dissatisfaction with life, whereas a score above 26 represents satisfaction with life. This scale obtained good internal consistency in this sample with a Cronbach’s alpha of .87.

**Steen Happiness Index (SHI; Seligman, Steen, Park, & Peterson, 2005).** This is a 20-item self-report measure of happiness across three domains: Positive emotion, engagement, and meaning in life. For each item, respondents are presented with five statements related to one of the three definitional aspects of happiness. Each statement is assigned a number from 1 to 5. For example, “Question 1: “I dislike my daily routine” (1) to “I enjoy my daily routine so much that I almost hardly ever take breaks from it” (5). The SHI had a Cronbach’s alpha of .94 in the current sample.

## Results

For hypothesis one, independent expert raters assessed the 26 SCS items in order to identify those with the highest face validity. Items with perfect inter-rater reliability (5/5) were: “I try to be loving towards myself when I feel emotional pain,” “When I’m going through a very hard time, I give myself the caring and tenderness I need,” “I’m kind to myself when I’m experiencing suffering,” and “I try to be understanding and patient towards those aspects of my personality I don’t like,” with the item “When I’m feeling down I try to approach my feelings with curiosity and openness” obtaining 4/5 inter-rater reliability. Not only did these items show the highest inter-rater agreement, the first four items comprise the self-kindness subfactor of the original SCS. The one additional item, “When I’m feeling down I try to approach my feelings with curiosity and openness” also with near perfect inter-rater reliability belonged to the mindfulness subscale of the original SCS. The fifth item of the original self-kindness subfactor

from the SCS was selected by one rater. This item “I’m tolerant of my own flaws and inadequacies,” was retained in order to preserve the full five-item self-kindness subfactor of the SCS. From a face validity perspective, it was determined that these five items represented the construct of self-compassion in the clearest way. Further validating this strategy, these items were also previously found to have the highest factor loadings on the total SCS score (Armstrong III et al., 2016). The SCS-5 demonstrated good internal reliability in the current sample with a Cronbach’s alpha of .85. Past studies investigating the psychometric structure of the SCS have suggested using the 13 positive items of the SCS in lieu of the full scale (López et al., 2015, 2018). In the current sample, the SCS-positive had a Cronbach’s alpha of .92. Given the brevity and theoretical “cleanliness” of the SCS-5, I believe it constitutes a viable, short alternative to both the full 26 item, and 13 item positive version of the SCS.

The relationship among the study variables investigated for hypothesis two are displayed in Table 2. The correlations between self-compassion, self-criticism, and measures of emotional well-being were consistent with my second hypothesis. The SCS-5 was negatively related to the CES-D ( $r = -.38, p < .001$ ) and NA ( $r = -.36, p < .001$ ) while the DEQ self-criticism showed a strong positive relationship with NA ( $r = .47, p < .001$ ) and the CES-D ( $r = .50, p < .001$ ). The correlations between the SCS-5 and measures related to subjective well-being (e.g., PA, SWLS) were all positive ( $r$ ’s between .39 and .50, all  $p < .001$ ) while the DEQ self-criticism measure showed negative correlations with measures of subjective well-being ( $r$ ’s ranging from -.43 to -.51). These relationships are consistent with my initial predictions and follow the pattern of similar research looking at the correlations between the positive and negative items of the full scale SCS (e.g., López et al., 2015; Muris, Broek, Otgaar, Oudenhoven, & Lennartz, 2018). This adds further support for my hypothesis that the SCS-5 and the DEQ (a true measure of self-

criticism and similar to the negative items of the full SCS), show positive and negative relationships with subjective well-being and measures of psychopathology, respectively. These results not only add to the growing literature that the SCS should use at least the positive items exclusively when measuring self-compassion, but also adds psychometric merit to the shorter SCS-5 measure, as the comparisons with the SCS-5 and DEQ show similar patterns to previous studies using the positive items to measure well-being, coping abilities, and other “positive” psychological features, while using the negative items to measure negative aspects of mental health such as stress, anxiety, and depression (Muris et al., 2018). Moreover, the shorter SCS-5 (only five items) and SCS-positive (13 items) are highly and positively correlated ( $r = .90$ ). Therefore, evidence suggests that very little information is lost by moving from the 13 item SCS-positive to the briefer five item SCS-5.

Hierarchical linear modeling (HLM) was used to examine the third hypothesis, the relationship between self-compassion, self-criticism, and outcomes measured as depression (CES-D) and negative affect (NA), as well as positive outcomes measured as subjective well-being (e.g., PA, SWLS, SHI, C-PANAS). HLM is commonly used in longitudinal data sets and accounts for individual trajectories while analyzing across different groups over multiple time points. In addition, HLM accounts for missing data by allowing for projected values based on existing data at various time points to be used in the analysis. Therefore, all participants (N=3460) that had baseline scores were retained in the analysis. This method also has the ability to add control variables, fixed effects, and allows for the assessment of higher-order interaction effects. This was especially important in this study as I was interested in looking at which predictors accounted for variance above and beyond the others. With respect to the OPPIs, the control condition of “writing about an early memory” was not included in the analysis given that

I was interested in changes over the course of the study, not which conditions were most effective. The nine active conditions of the OPPIs were examined together in order to compare the effects for self-compassion and for self-criticism over time. These active conditions included exercises such as practicing gratitude, doing loving kindness meditation, and engaging in a self-compassion writing exercise. For all of my prediction of outcome analyses, I controlled for age, gender, income, and if participants received payment. All variables were entered so that any unique contributions to explaining outcome variance could be obtained for all the variables included. The fixed effects were Time, SCS-5, and DEQ, and the interaction effects entered were Time x SCS-5 and Time x DEQ. The use of HLM in this study allowed me to investigate these interaction effects over time while controlling for the variance accounted for by both the SCS-5 and DEQ in all of the models. This enriches my findings by making my tests more conservative, adding confidence to the assertion that these two constructs predict well-being and psychopathology uniquely.

**CES-D – Depression.** At baseline there was a significant positive main effect of self-compassion measured by the SCS-5 on reports of depression, with individuals high on self-compassion showing lower levels of depression (Estimate = -2.54, SE = .23,  $t = -10.9$ ,  $p < .001$ ). This suggests that self-compassion was associated with lower levels of depressive symptoms overall. There was also a significant and negative main effect of self-criticism on depression, with individuals high on self-criticism showing significantly higher levels of depressive symptoms at baseline (Estimate = 5.58, SE = .21,  $t = 27.1$ ,  $p < .001$ ).

There was a significant interaction between Time and the DEQ (Estimate = -.26, SE = .07,  $t = -3.66$ ,  $p < .001$ ). Inspection of the estimates indicated that self-critical individuals in the



active OPPI conditions experienced a significantly greater decrease in depression from baseline to six-months. There was no significant interaction effect of Time and self-compassion.

**C-PANAS – Compassionate Affect.** There was a significant main effect of the SCS-5 on compassionate affect, with individuals high on self-compassion showing higher levels of compassionate affect at baseline (Estimate = .27, SE = .02,  $t = 17.4$ ,  $p < .001$ ). There was also a significant main effect of self-criticism on compassionate affect, with individuals high on self-criticism showing lower levels of compassionate affect at baseline (Estimate = -.27, SE = .02,  $t = -19.1$ ,  $p < .001$ ).

In addition, a significant interaction between Time and the SCS-5 (Estimate = -.03, SE = .01,  $t = -4.40$ ,  $p < .001$ ) was obtained, indicating that individuals high in self-compassion reported less change in compassionate affect from baseline to six-months following the positive psychology interventions. Stated differently, those who were lower on self-compassion at the beginning of the study showed greater increases in compassionate affect following the OPPIs over the six-month follow-up. Self-criticism did not interact with Time in the prediction of compassionate affect.

**PA – Positive Affect.** There was a significant main effect of self-compassion on positive affect, with individuals high on self-compassion showing higher overall levels of positive affect at baseline (Estimate = .32, SE = .02,  $t = 17.4$ ,  $p < .001$ ). There was also a significant main effect of self-criticism on positive affect, with individuals high on self-criticism showing lower levels at baseline (Estimate = -.32, SE = .02,  $t = -19.9$ ,  $p < .001$ ).

Self-compassion (but not self-criticism) interacted with Time in the prediction of PA over the six-month study (Estimate = -.03, SE = .01,  $t = -4.27$ ,  $p < .001$ ). Inspection of the estimates indicated that individuals high in self-compassion showed less change in positive affect from

baseline to six-months. Stated differently, those scoring lower on the SCS-5 showed greater improvements in positive affect over six-months. The self-compassion scale therefore showed relationships with indicators of positive emotional functioning, while self-criticism was not associated with different rates of change on these outcome measures.

**NA – Negative Affect.** There was a significant main effect of self-compassion on negative affect, with individuals high on self-compassion showing lower levels of negative affect at baseline (Estimate =  $-.18$ ,  $SE = .02$ ,  $t = -11.3$ ,  $p < .001$ ). A significant main effect for self-criticism indicated higher levels of negative affect at baseline (Estimate =  $.34$ ,  $SE = .01$ ,  $t = 24.2$ ,  $p < .001$ ).

There was a significant interaction between Time and self-compassion (Estimate =  $.02$ ,  $SE = .01$ ,  $t = 4.26$ ,  $p < .001$ ) indicating that individuals high in self-compassion showed less change in negative affect over time. Conversely, those lacking in self-compassion would have seen a greater improvement in negative affect following the OPPIs. There was also a significant interaction between Time and self-criticism (Estimate =  $-.01$ ,  $SE = .01$ ,  $t = -2.05$ ,  $p = .04$ ) indicating that following the OPPI, individuals high in self-criticism experienced a significantly greater decrease in negative affect from baseline to six-months.

**SWLS – Satisfaction with Life.** There was a significant main effect of self-compassion on satisfaction with life, with individuals high on self-compassion showing higher levels of life satisfaction at baseline (Estimate =  $.36$ ,  $SE = .03$ ,  $t = 12.8$ ,  $p < .001$ ). There was also a significant main effect of self-criticism on life satisfaction, with individuals high on self-criticism showing lower levels of life satisfaction overall (Estimate =  $-.63$ ,  $SE = .03$ ,  $t = -25.6$ ,  $p < .001$ ).

There was a significant interaction between Time and self-criticism (Estimate =  $.02$ ,  $SE = .01$ ,  $t = 2.4$ ,  $p = .017$ ) in the prediction of life satisfaction. Individuals high in self-criticism

experienced an increase in life satisfaction from baseline to six-months. There was no significant interaction effect of Time and self-compassion for life satisfaction.

**SHI – Happiness.** There was a significant main effect of self-compassion on happiness measured by the SHI, with individuals high on self-compassion showing higher levels of happiness overall (Estimate = .24, SE = .01,  $t = 18.7$ ,  $p < .001$ ). There was also a significant main effect of self-criticism on happiness, with individuals high on self-criticism showing lower levels of happiness (Estimate = -.32, SE = .01,  $t = -28.6$ ,  $p < .001$ ).

A significant interaction between Time and self-compassion (Estimate = -.01, SE = .00,  $t = -42.57$ ,  $p = .018$ ) indicated that individuals high in self-compassion did not profit as much in terms of increases in levels of happiness. Stated differently, those who were low on self-compassion showed greater improvements in happiness from baseline to six-months. There was a significant interaction between Time and self-criticism (Estimate = .01, SE = .00,  $t = 2.71$ ,  $p = .007$ ) indicating that individuals high in self-criticism also showed greater long-term gains in happiness following the OPPIs.

## Discussion

The original formulation and conception of the self-compassion scale from Neff (SCS; 2003a, 2003b) introduced a much needed and valuable tool into the literature which filled a measurement gap that allowed for empirical research on self-compassion. However, given the psychometric controversy and shortcomings of the SCS since the scales creation, more research was needed to further clarify and elucidate this vitally important construct. The goal of this study was to create a briefer, “cleaner” measure of self-compassion that was strong psychometrically, and that measured a unitary construct of true self-compassion as suggested by previous research. The other goal of this study was to validate this shorter measure through face validity checks and

by establishing discriminant validity strength by comparing it to a well validated measure of self-criticism using correlational analysis and predictive tests. This allowed me to demonstrate the further distinctiveness of these constructs both conceptually and empirically. The decision to use the DEQ as a comparative measure came from several previous studies (Armstrong III et al., 2016; López et al., 2015; Montero-Marín et al., 2016; Muris et al., 2018) that all had demonstrated considerable overlap with the SCS's negative items and self-criticism. For this study, I wanted to further these findings by relating the short measure consisting of all the highly face valid items measuring self-compassion against a well validated measure of self-criticism. This further demonstrated how self-compassion and self-criticism are distinct constructs.

The results provided evidence to support the three primary hypotheses. As predicted, the face validity checks from hypothesis one provided nearly perfect inter-rater reliability for the SCS-5 items. Also fortuitous was the fact that these items were those that had the highest factor loadings from previous studies (Armstrong III et al., 2016). Results here are also coherent with a study by Muris et al. (2018) that performed a face validity check with students and psychologists assessing the full 26 item SCS. They found that 80-85% of their raters were able to identify the positive items of the SCS, with a further 85% identifying items of the self-kindness scale (my new SCS-5) as being the most representative of self-compassion and healthy, positive attitudes, while the negative items were associated with anxiety, mood, and other psychological difficulties. Furthermore, the SCS-5 proved to have strong internal consistency, rivaling that of the longer, 13 item SCS-positive. I believe that reducing the scale to five items is sufficient both psychometrically and conceptually. Other studies (e.g., Bernard & Curry, 2011) suggest that common humanity and mindfulness may be downstream effects of self-compassion. If “humanity” and “mindfulness” are emergent rather than constitutive factors of the SCS, that

would mean they may then involve processes that are related but conceptually different and theoretically separate from self-compassion itself.

The second hypothesis received some support through the differential pattern of correlations between the SCS-5 (self-compassion), the DEQ (self-criticism) and measures of psychological functioning. More specifically, and most importantly, the SCS-5 showed stronger positive relationships with measures of subjective well-being including satisfaction with life, happiness, positive affect, and compassionate affect, and weaker, negative correlations with depression and negative affect. Further support for the short SCS-5 measure can be found by examining the correlational patterns of the SCS-5 and SCS-positive presented in Table 2. The 13 item SCS-positive scale yields correlations only .02-.03 stronger than the SCS-5. This suggests that very little information is lost by further reducing the scale and using only the five most representative items. In addition, these results mirror recent studies (Muris et al., 2018) suggesting that the positive items of the SCS, and the SCS-5 specifically, represent the healthy, protective nature of self-compassion that is so vitally important to its understanding and implementation with respect to treatment, self-help, and psychological well-being (Gilbert, 2009).

In contrast, the DEQ showed negative relationships to measures of subjective well-being and was positively related to depression and negative affect. However, the magnitude of the correlations between the DEQ and measures of both well-being and psychopathology were similar and did not show the same pattern seen in the SCS-5 with respect to the *strength* of the correlations. These are consistent with the performance of the negative items of the SCS reported in previous studies. Interestingly, some previous studies (e.g., López et al., 2015) using the 13 negative items of the SCS showed even stronger correlations to psychopathology than the DEQ

in the present study. This suggests that the negative items may represent something even more detrimental than self-criticism, and thus adds support for their dismissal from the measurement of self-compassion. As mentioned, both the negative items and self-criticism have shown strong relationships with depressive symptoms, perceived stress, rumination, and neuroticism (López et al., 2015; Montero-Marín et al., 2016; Muris et al., 2018; Muris & Petrocchi, 2017). These studies further underline that the negative items and self-criticism confer vulnerability to negative mental states, such as depression and negative affect, rather than the protective mental health advantages associated with self-compassion. In addition, Armstrong III et al. (2016) suggested that the full SCS does not represent “high” and “low” self-compassion, but rather, self-compassion and self-criticism separately. I believe these results are especially relevant given the high correlation between self-criticism and the negative items of the SCS (see Table 2). This highlights the SCS’s psychometric difficulties in its own right, and my study adds to the growing body of research suggesting the importance of dismissing the negative items of the SCS (Brenner, Heath, Vogel, & Crede, 2017; Coroiu et al., 2018; López, Sanderman, Ranchor, & Schroevers, 2018).

Hypothesis three stated that given self-compassion and self-criticism are different constructs that likely relate to mental health in unique ways, the SCS-5 and DEQ should show differential predictive validity over time. Findings from my predictive validity tests support this hypothesis. The SCS-5 and DEQ showed different patterns of change and contributed uniquely to nearly all outcome measures in a six-month study following brief Online Positive Psychology Interventions (OPPIs).

More precisely, the DEQ (self-criticism) uniquely predicted changes on one of the key outcome measures, depression. The DEQ predicted that those who were more self-critical

experienced greater decreases in depression over the six-month study period. This is an important finding given my assertion that low self-compassion is both empirically and conceptually different from self-criticism. The SCS-5 did not significantly predict any changes in depression over the course of the study. These results are echoed in the literature on depressive vulnerability and illustrates the close relationship between self-criticism and depression, a relationship also seen when using the negative items of the SCS in place of a true self-criticism measure (López et al., 2015).

In contrast to the DEQ's predictive value when assessing depression, the SCS-5 significantly predicted changes over the six-month study period in both compassionate and positive affect. The SCS-5 predicted that those low on self-compassion gain the most from the OPPIs in terms of positive and compassionate affect over six-months. The DEQ showed no significant interaction and therefore no predictive validity with either of these outcome measures. This highlights the differential predictive capabilities of the DEQ and SCS-5 with respect to well-being and psychopathology. This furthers my assertion that self-compassion and self-criticism are not mere opposites, as measured in the full scale SCS, but rather very distinct constructs.

The remaining outcome measures of negative affect, satisfaction with life, and happiness all showed differential patterns as expected with the exception of satisfaction with life. For example, both the SCS-5 and DEQ had significant interactions over time when looking at negative affect. Although both measures showed predictive validity on this outcome variable, their directions mirrored that of the unique findings in depression, compassionate affect, and positive affect. Those higher on self-criticism gained more from the OPPIs, whereas those high on self-compassion did not profit as much. This could indicate that those already high on self-

compassion have a level of protection or vaccination from negative affect, and thus have little to gain from these interventions. This could also help explain why self-compassion did not significantly predict changes in satisfaction with life following the OPPIs. For full HLM results, see Table 3.

Overall, the SCS-5 and DEQ showed differential predictive validity in the longitudinal analyses of subjective well-being, with those high in self-criticism showing the most pronounced improvements in depressive symptoms following the positive psychology exercises. In contrast, those high in self-compassion benefited the least over the six-month study. The flip side of these findings is that those low in self-compassion may look to positive psychology interventions to increase their positive mood states and levels of happiness. Stated differently, the results indicate that those *low* on the SCS-5 improved more over time on measures such as positive affect and compassionate affect. One potential explanation for this is a “ceiling effect” for self-compassion in terms of positive functioning. Previous research by Lindsay and Creswell (2014) found a similar effect with a values affirmation exercise designed to increase self-compassion. This study found that those who are already highly self-compassionate score highly on baseline measures of positive psychological health and gain less from interventions designed to increase trait self-compassion. Future research could assess individuals’ level of resiliency, family background, personality traits, and various other factors that seem to provide these individuals with bolstered levels of positive psychological health.

A possible explanation for why self-critical individuals saw the most improvement is that OPPIs may be more useful and effective for self-critical, distressed individuals (Sergeant & Mongrain, 2015) in dealing with depression, and may help those low on self-compassion flourish rather than languish (Seligman et al., 2005). These results provide new insights suggesting that



the OPPIs are effective for particular populations. These findings are also significant in that they provide evidence that the SCS-5 is an adequate and parsimonious measure of self-compassion, one that is independent from the DEQ, and one that has the predictive capability to detect who does, and does not benefit from OPPIs. This again further supports my assertion that the SCS-5 is not redundant with self-criticism, as has been found in the full scale. Given that the DEQ correlated so strongly with the full SCS's negative items further underlines this result. The SCS-5 provides a clean, accurate measure of self-compassion without the contamination of the negative items. Therefore, it can be said with greater confidence that the SCS-5 measures self-compassion exclusively, in a manner uncomplicated by the negative items in the full scale SCS (Armstrong III et al., 2016).

Although this study represents a thorough, in depth look at the self-compassion scale with findings that are corroborated with current and past research, it is not without limitations. First, with a sample size of nearly 3500 participants, it is likely that even very small effects would be statistically significant, as is reflected in the small estimates obtained in the HLM analyses. Although these small estimates may limit the clinical relevance of certain findings, it also highlights the vast differences in self-compassion and self-criticism. For example, with outcome measures like the CES-D, the DEQ is a significant predictor of outcome at the .001 level over six-months, whereas the SCS-5 does not even near statistical significance. Given this, it can be said with more confidence in these instances that self-compassion and self-criticism are indeed two distinct, and often unrelated constructs. Second, despite having 10 total conditions for the OPPIs including a control group, I assessed the predictive validity of the self-critical and self-compassionate constructs using the nine "active" conditions combined. Although this may limit the insight gained from which specific interventions were most or least effective, it was the

primary objective of my study to assess the differential predictive validity of the SCS-5 and DEQ over time, rather than the effectiveness of specific OPPI conditions. Research on client characteristics and selective treatment matching (Beutler, 1979; Beutler, 1991; Beutler, Consoli, & Lane, 2005) discuss how client differences in coping, environment, level of impairment, and a host of other defining characteristics can influence how individuals respond to psychological treatments. Individual differences may help explain why self-compassion behaves like a trait in some people (see Lindsay & Creswell, 2014) or a state-like, learnable skill in others. Future research could utilize the SCS-5 and test its predictive validity using various types of interventions to see which “types” of individuals benefit from certain specific interventions (see Mongrain, Barnes, Barnhart, & Zalan, 2018). Studies investigating these individual characteristics could further elucidate the important predictive qualities of the short-form measure extracted from this study. These findings suggest that levels of compassionate affect and other positive psychological states can be improved for those low on self-compassion, and it is an encouraging finding in terms of future work in this field.

Lastly, scores on the CES-D indicate that the sample in this study was mildly to moderately depressed. This could help explain the pattern for those who were most depressed and self-critical gaining the most from the interventions. Sergeant and Mongrain (2014) found similar results when they clustered individuals into “distressed” and “non-distressed” groups based on depressive symptoms and life satisfaction. They found that the distressed cluster experienced more of a reduction in depressive symptoms following an OPPI compared to the non-distressed cluster. This could also help explain why the SCS-5 detected that those who are low on self-compassion may benefit most in terms of positive emotional functioning. To further elucidate these findings, future studies should use the SCS-5 in varying populations to identify its

correlates and its predictive potential in terms of psychological functioning following distance interventions.

These results provide good psychometric evidence for using a face-valid measure of self-compassion. Also highlighted is that self-compassion and self-criticism operate in very different ways with respect to mental health, and that these two variables can not be considered true “opposites.” This could have many implications clinically. Clinical research must further differentiate the functions of self-compassion and self-criticism. For example, Korner et al., (2015) showed that self-compassion provides a buffer against a host of psychopathologies like anxiety and depression. It is also believed to be a key factor in lasting therapeutic improvement (López et al., 2015) and that cultivating self-compassion can disrupt maladaptive networks including negative effects of self-criticism (Segal, Williams, & Teasdale, 2002). As such it must be discovered how individuals develop this capacity, from early environments or other mechanisms. Self-compassion appears to act as a protective factor and self-criticism as a predisposing factor, but each acting effectively with different client problems. Entire therapies such as Compassionate Mind Training (Gilbert & Proctor, 2006) and Compassion Focused Therapy (Gilbert, 2009) are based on the idea that self-compassion and self-criticism are separate constructs and that the former can be cultivated towards to better outcomes. I have provided some compelling evidence in this study that these assumptions are true. There is evidence to suggest that self-compassion can be used as an antidote to self-criticism (Gilbert & Irons, 2004), but only when one targets the self-criticism directly. Therefore, self-compassion may mediate the impact of OPPIs on self-criticalness and then depression. This may be because people who are harsh on themselves have a great deal of difficulty being kind to themselves (Gilbert, 2009). Gilbert then appears to be correct in his discussion of how self-compassion and self-criticism

active different evolutionary and biological systems in the body. Given Gilbert's point of view, self-criticism and self-compassion may not only be seen as separate constructs theoretically and empirically, but these differences may have biological bases. Future research on neurological mechanisms may be required to fully understand this.

An important takeaway from the clinical studies is that not only do self-compassion and self-criticism act at odds with one another, but that simply reducing self-criticism does not necessarily increase self-compassion. Gilbert (2009) suggests that one must work to silence the critical, blaming voice in order for individuals to move into a space where they can feel safe and content enough to care for themselves.

In sum, I believe this study has provided a psychometrically strong, short, and uncontaminated version of the original SCS. This study assesses a gap in the previous research by providing a more psychometrically sound measure of self-compassion than has previously been constructed by focusing on the core items that reflect true self-compassion. Perhaps most importantly, this study used a true measure of self-criticism (the DEQ) as a comparison, rather than comparing the positive items to the negative items, as has been done in many previous studies (Armstrong III et al., 2015; Brenner et al., 2017; Coroiu et al., 2018 López et al., 2015, 2018; Montero-Marín et al., 2016; Muris et al., 2018). This allowed me to expand on these previous studies by using this well validated measure of self-criticism to highlight the important differences between self-criticism and self-compassion that has previously been underrepresented in the literature. With the host of benefits self-compassion provides, and its implications with both positive and negative mental health, gaining a further understanding of true self-compassion through the SCS-5 not only expands the literature base, but can aid in the development of new interventions for both clinical and community populations in future

research. Given this, I urge others in the field to utilize this information when using a measure of self-compassion that allows researchers and clinicians alike to accurately measure this important and protective psychological process.

## References

- Armstrong, B.F., Zuroff, D.C., Mongrain, M., Kelly, A.C., Hermanto, N., Hope, N., Koestner, R. (2016). Self-Compassion Revisited: Examining the Dimensionality of the Self-Compassion Scale in Community and College Samples. (*in press*).
- Barnard, L. K., & Curry, J. F. (2011). Self-compassion: Conceptualizations, correlates, & interventions. *Review of general psychology*, 15(4), 289.
- Beutler, L. E. (1979). Toward specific psychological therapies for specific conditions. *Journal of Consulting and Clinical Psychology*, 47(5), 882.
- Beutler, L. E. (1991). Selective treatment matching: Systematic eclectic psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 28(3), 457.
- Beutler, L. E., Consoli, A. J., & Lane, G. (2005). Systematic treatment selection and prescriptive psychotherapy: An integrative eclectic approach. *Handbook of psychotherapy integration*, 2, 121-143.
- Blatt SJ, D'Afflitti JP, Quinlan DM. (1976). Experiences of depression in normal young adults. *Journal Abnormal Psychology*, 85(4), 383.
- Blatt, S. J., Quinlan, D. M., Pilkonis, P. A., & Shea, M. T. (1995). Impact of perfectionism and need for approval on the brief treatment of depression: the National Institute of Mental Health Treatment of Depression Collaborative Research Program revisited. *Journal of Consulting and Clinical Psychology*, 63(1), 125.
- Blatt, S. J., Shichman, S., Stayner, D., Auerbach, J., Behrends, R. S., Wild, C., ... & Zuroff, D. C. SS Luthar u. B. Hart (1996): Levels of relatedness within the dependency factor of the Depressive Experiences Questionnaire for Adolescents. *J Pers Assess*, 67, 52-71.

- Blatt, S. J., Zohar, A. H., Quinlan, D. M., Zuroff, D. C., & Mongrain, M. (1995). Subscales within the dependency factor of the Depressive Experiences Questionnaire. *Journal of Personality Assessment*, 64(2), 319-339.
- Blatt, S. J., & Zuroff, D. C. (1992). Interpersonal relatedness and self-definition: Two prototypes for depression. *Clinical Psychology Review*, 12(5), 527-562.
- Blatt, S. J., Zuroff, D. C., Bondi, C. M., Sanislow III, C. A., & Pilkonis, P. A. (1998). When and how perfectionism impedes the brief treatment of depression: further analyses of the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of consulting and clinical psychology*, 66(2), 423.
- Brenner, R. E., Heath, P. J., Vogel, D. L., & Credé, M. (2017). Two is more valid than one: Examining the factor structure of the Self-Compassion Scale (SCS). *Journal of counseling psychology*, 64(6), 696.
- Coroiu, A., Kwakkenbos, L., Moran, C., Thombs, B., Albani, C., Bourkas, S., ... & Körner, A. (2018). Structural validation of the Self-Compassion Scale with a German general population sample. *PloS one*, 13(2), e0190771.
- Covey, S. (1989). The seven habits of highly successful people. *Fireside/Simon & Schuster*.
- Deci, E. L., & Ryan, R. M. (1995). Human autonomy. In *Efficacy, agency, and self-esteem* (pp. 31-49). Springer US.
- Epstein, M. D. (1995). Thoughts without a thinker. New York: Basic Books.
- Gilbert, P. (2009a). Introducing compassion-focused therapy. *Advances in psychiatric treatment*, 15(3), 199-208.

- Gilbert, P., Catarino, F., Duarte, C., Matos, M., Kolts, R., Stubbs, J., ... & Basran, J. (2017). The development of compassionate engagement and action scales for self and others. *Journal of Compassionate Health Care*, 4(1), 4.
- Gilbert P, Clarke M, Hempel S, Miles J n. v., Irons C. (2004). Criticizing and reassuring oneself: An exploration of forms, styles and reasons in female students. *British Journal of Clinical Psychology*, 43(1), 31-50.
- Gilbert, P., & Irons, C. (2004). A pilot exploration of the use of compassionate images in a group of self-critical people. *Memory*, 12(4), 507-516.
- Gilbert, P., & Irons, C. (2005). Focused therapies and compassionate mind training for shame and self-attacking. *Compassion: Conceptualisations, research and use in psychotherapy*, 263-325.
- Gilbert, P., & Miles, J. N. (2000). Sensitivity to Social Put-Down: it's relationship to perceptions of social rank, shame, social anxiety, depression, anger and self-other blame. *Personality and individual differences*, 29(4), 757-774.
- Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology & Psychotherapy*, 13(6), 353-379.
- Kabat-Zinn, J., Massion, A. O., Kristeller, J., & Peterson, L. G. (1992). Effectiveness of a meditation-based stress reduction program in the treatment of anxiety disorders. *American Journal of Psychiatry*, 149, 936-943.
- Körner, A., Coroiu, A., Copeland, L., Gomez-Garibello, C., Albani, C., Zenger, M., & Brähler, E. (2015). The role of self-compassion in buffering symptoms of depression in the general population. *PloS one*, 10(10), e0136598.



- Lindsay, E. K., & Creswell, J. D. (2014). Helping the self help others: self-affirmation increases self-compassion and pro-social behaviors. *Frontiers in Psychology*, 5, 421.
- López, A., Sanderman, R., Ranchor, A. V., & Schroevers, M. J. (2018). Compassion for others and self-compassion: Levels, correlates, and relationship with psychological well-being. *Mindfulness*, 9(1), 325-331.
- López, A., Sanderman, R., Smink, A., Zhang, Y., van Sonderen, E., Ranchor, A., & Schroevers, M. J. (2015). A reconsideration of the Self-Compassion Scale's total score: self-compassion versus self-criticism. *PloS one*, 10(7), e0132940.
- Luyten, P., Sabbe, B., Blatt, S. J., Meganck, S., Jansen, B., De Grave, C., ... & Corveleyn, J. (2007). Dependency and self-criticism: relationship with major depressive disorder, severity of depression, and clinical presentation. *Depression and anxiety*, 24(8), 586-596.
- Molino, A. (Ed). (1998). The couch and the tree: Dialogues in psychoanalysis and Buddhism. New York: North Point Press.
- Mongrain, M., Barnes, C., Barnhart, R., & Zalan, L.B. (2018). Acts of kindness reduce depression in individuals low on agreeableness. *Transitional Issues in Psychological Science*, 13(30), 1-15. <http://dx.doi.org/10.1037/tps0000168>
- Mongrain, M., & Leather, F. (2006). Self-criticism and dependence predict the recurrence of major depression. *Journal of Clinical Psychology*, 62 (June), 705-713.
- Montero-Marín, J., Gaete, J., Demarzo, M., Rodero, B., López, L. C. S., & García-Campayo, J. (2016). Self-Criticism: A Measure of Uncompassionate Behaviors Toward the Self, Based on the Negative Components of the Self-Compassion Scale. *Frontiers in Psychology*, 7, 1281. <http://doi.org/10.3389/fpsyg.2016.01281>

- Muris, P., van den Broek, M., Otgaar, H., Oudenhoven, I., & Lennartz, J. (2018). Good and Bad Sides of Self-Compassion: A Face Validity Check of the Self-Compassion Scale and an Investigation of its Relations to Coping and Emotional Symptoms in Non-Clinical Adolescents. *Journal of Child and Family Studies*, 1-11.
- Muris, P., & Petrocchi, N. (2017). Protection or vulnerability? A meta-analysis of the relations between the positive and negative components of self-compassion and psychopathology. *Clinical psychology & psychotherapy*, 24(2), 373-383.
- Neff, K. (2003). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and identity*, 2(2), 85-101.
- Neff K. (2003b). The development and validation of a scale to measure self-compassion. *Self Identity*, 2(3), 223-250.
- Neff, K. D., & Beretvas, S. N. (2013). The role of self-compassion in romantic relationships. *Self and Identity*, 12(1), 78-98.
- Neff, K. D., Hsieh, Y. P., & Dejitterat, K. (2005). Self-compassion, achievement goals, and coping with academic failure. *Self and identity*, 4(3), 263-287.
- Neff, K. D., Kirkpatrick, K. L., & Rude, S. S. (2007). Self-compassion and adaptive psychological functioning. *Journal of research in personality*, 41(1), 139-154.
- Neff, K. D., Rude, S. S., & Kirkpatrick, K. L. (2007). An examination of self-compassion in relation to positive psychological functioning and personality traits. *Journal of Research in Personality*, 41(4), 908-916.
- Pavot, W., & Diener, E. (1993). Review of the satisfaction with life scale. *Psychological assessment*, 5(2), 164.
- Perls, F., Hefferline, G., & Goodman, P. (1951). Gestalt therapy. *New York*.

- Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied psychological measurement*, 1(3), 385-401.
- Santor, D. A., Zuroff, D. C., Ramsay, J. O., Cervantes, P., & Palacios, J. (1995). Examining scale discriminability in the BDI and CES-D as a function of depressive severity. *Psychological Assessment*, 7(2), 131.
- Schifffrin, H. H., & Nelson, S. K. (2010). Stressed and happy? Investigating the relationship between happiness and perceived stress. *Journal of Happiness Studies*, 11(1), 33-39.
- Segal, Z. V., Williams, J. M. G., & Teasdale, J.D. (2002). Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse New York: Guilford Press.
- Seligman, M. E. (1995). The optimistic child. Boston: Houghton Mifflin.
- Seligman, M. E., & Csikszentmihalyi, M. (2000). *Positive psychology: An introduction* (Vol. 55, No. 1, p. 5). American Psychological Association.
- Seligman, M. E., Rashid, T., & Parks, A. C. (2006). Positive psychotherapy. *American psychologist*, 61(8), 774.
- Seligman, M. E., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology progress: empirical validation of interventions. *American psychologist*, 60(5), 410.
- Sergeant, S., & Mongrain, M. (2015). Distressed users report a better response to online positive psychology interventions than nondistressed users. *Canadian Psychology/Psychologie Canadienne*, 56(3), 322.
- Shahar, G. (2015). *Erosion: The psychopathology of self-criticism*. Oxford University Press, USA.
- Shapira, L.B., Mongrain, M. (2010). The benefits of self-compassion and optimism exercises for individuals vulnerable to depression. *The Journal of Positive Psychology*, 5(5), 377-389.

- Watson, D.; Clark, L. A.; Tellegen, A. (1988). "Development and validation of brief measures of positive and negative affect: The PANAS scales". *Journal of Personality and Social Psychology*, 54, 1063–1070.
- Zuroff, D. C., & Fitzpatrick, D. K. (1995). Depressive personality styles: Implications for adult attachment. *Personality and Individual Differences*, 18(2), 253-265.
- Zuroff, D. C., Moskowitz, D. S., Wielgus, M. S., Powers, T. A., & Franko, D. L. (1983). Construct validation of the dependency and self-criticism scales of the Depressive Experiences Questionnaire. *Journal of Research in Personality*, 17(2), 226-241.
- Zuroff, D. C., Mongrain, M., & Santor, D. A. (2004). Conceptualizing and measuring personality vulnerability to depression: comment on Coyne and Whiffen (1995).
- Zuroff, D. C., Santor, D., & Mongrain, M. (2005). Dependency, self-criticism, and maladjustment. *Relatedness, self-definition and mental representation. Essays in honour of Sidney J. Blatt*, 75-90.

Table 1. *All 26 items and six subscales of the full self-compassion scale (Neff, 2003b).*

| Items   |
|---|
| Self-Kindness Subscale <sup>a</sup>   |
| <b>I try to be understanding and patient towards those aspects of my personality I don't like.</b>                |
| <b>I'm kind to myself when I'm experiencing suffering.</b>  |
| <b>When I'm going through a very hard time, I give myself the caring and tenderness I need.</b>                   |
| <b>I'm tolerant of my own flaws and inadequacies.</b>   |
| <b>I try to be loving towards myself when I'm feeling emotional pain.</b>   |
| Self-Judgment Subscale <sup>b</sup>   |
| When I see aspects of myself that I don't like, I get down on myself.   |
| When times are really difficult, I tend to be tough on myself.  |
| I can be a bit cold-hearted towards myself when I'm experiencing suffering.                                       |
| I'm disapproving and judgmental about my own flaws and inadequacies.  |
| I'm intolerant and impatient towards those aspects of my personality I don't like.                                |
| Common Humanity Subscale <sup>a</sup>   |
| When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people. |
| I try to see my failings as part of the human condition.  |
| When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.        |
| When things are going badly for me, I see the difficulties as part of life that everyone goes through.            |
| Isolation Subscale <sup>b</sup>   |
| When I fail at something that's important to me I tend to feel alone in my failure.                               |
| When I think about my inadequacies it tends to make me feel more separate and cut off from the rest of the world. |
| When I'm feeling down I tend to feel like most other people are probably happier than I am.                       |
| When I'm really struggling I tend to feel like other people must be having an easier time of it.                  |
| Mindfulness Subscale <sup>a</sup>   |
| When something upsets me I try to keep my emotions in balance.  |
| When I'm feeling down I try to approach my feelings with curiosity and openness.                                  |
| When something painful happens I try to take a balanced view of the situation.                                    |
| When I fail at something important to me I try to keep things in perspective.                                     |
| Over-Identification Subscale <sup>b</sup>   |
| When something upsets me I get carried away with my feelings.   |
| When I'm feeling down I tend to obsess and fixate on everything that's wrong.                                     |
| When something painful happens I tend to blow the incident out of proportion.                                     |
| When I fail at something important to me I become consumed by feelings of inadequacy.                             |

<sup>a</sup> Positive subscales of the original self-compassion scale (SCS-Positive; Neff, 2003b). <sup>b</sup> Negative subscales of the original self-compassion scale (SCS-Negative; Neff, 2003b).

*Note:* **Bolded** items comprise the SCS-5.

Table 2. *Correlation matrix and descriptive statistics for all measures.*

| <i>Measures</i>    | 1.     | 2.     | 3.     | 4.     | 5.     | 6.     | 7.     | 8.     | 9.     | 10.  |
|--------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------|
| 1. SCS-5           | 1.00   |        |        |        |        |        |        |        |        |      |
| 2. DEQ             | -0.54* | 1.00   |        |        |        |        |        |        |        |      |
| 3. CESD            | -0.38* | 0.50*  | 1.00   |        |        |        |        |        |        |      |
| 4. NA              | -0.36* | 0.47*  | 0.77*  | 1.00   |        |        |        |        |        |      |
| 5. CPANAS          | 0.40*  | -0.43* | -0.57* | -0.54* | 1.00   |        |        |        |        |      |
| 6. PA              | 0.41*  | -0.45* | -0.64* | -0.58* | 0.85*  | 1.00   |        |        |        |      |
| 7. SWLS            | 0.39*  | -0.51* | -0.61* | -0.56* | 0.59*  | 0.63*  | 1.00   |        |        |      |
| 8. SHI             | 0.50*  | -0.58* | -0.70* | -0.64* | 0.67*  | 0.72*  | 0.74*  | 1.00   |        |      |
| 9. SCS-Positive    | 0.90*  | -0.53* | -0.40* | -0.37* | 0.42*  | 0.43*  | 0.42*  | 0.52*  | 1.00   |      |
| 10. SCS-Negative   | -0.59* | 0.72*  | 0.48*  | 0.44*  | -0.36* | -0.41* | -0.42* | -0.54* | -0.60* | 1.00 |
| Mean               | 2.77   | 0.26   | 18.57  | 2.13   | 3.19   | 3.01   | 4.17   | 2.74   | 2.93   | 2.62 |
| Standard Deviation | 0.92   | 1.04   | 13.47  | 0.91   | 0.92   | 1.06   | 1.61   | 0.77   | 0.82   | 0.85 |

As measured by the Self-Compassion Scale-5 (SCS-5; adopted from Neff, 2003b), the Depressive Experiences Questionnaire (DEQ; Blatt et al., 1976), the Centre for Epidemiological Studies Depression Scale (CESD; Radloff, 1977), the Negative Affect (NA), Compassionate Affect (CPANAS), and Positive Affect (PA) Scales (adopted from Watson, Clark, and Tellegen, 1988), the Satisfaction with Life Scale (SWLS; Pavot & Diener, 1993) and the Steen Happiness Index (SHI; Seligman, Steen, Park & Peterson, 2005), the Self-Compassion Scale's Positive (SCS-Positive) & Negative Items (SCS-Negative), respectively (Neff, 2003b).

$N = 3460$ ,  $*p < .001$ .

Table 3. *Hierarchical Linear Model Tests of Psychological Well-Being and Psychopathology.*

| Model Effect  | Estimate | SE   | p     |
|---------------|----------|------|-------|
| <b>CESD</b>   |          |      |       |
| Time          | -0.52    | 0.24 | .033  |
| Income        | -0.60    | 0.07 | <.001 |
| Paid          | -2.23    | 0.36 | <.001 |
| Age           | 0.09     | 0.02 | <.001 |
| DEQ           | 5.58     | 0.21 | <.001 |
| SCS-5         | -2.54    | 0.23 | <.001 |
| Time*DEQ      | -0.26    | 0.07 | <.001 |
| Time*SCS-5    | 0.13     | 0.08 | .115  |
| Intercept     | 24.91    | 0.86 | <.001 |
| <b>NA</b>     |          |      |       |
| Time          | -0.09    | 0.02 | <.001 |
| Income        | -0.03    | 0.00 | <.001 |
| Paid          | -0.11    | 0.02 | <.001 |
| Age           | 0.00     | 0.00 | <.001 |
| DEQ           | 0.34     | 0.01 | <.001 |
| SCS-5         | -0.18    | 0.02 | <.001 |
| Time*DEQ      | -0.01    | 0.00 | .040  |
| Time*SCS-5    | 0.02     | 0.01 | <.001 |
| Intercept     | 2.59     | 0.06 | <.001 |
| <b>CPANAS</b> |          |      |       |
| Time          | 0.06     | 0.02 | <.001 |
| Income        | 0.02     | 0.00 | <.001 |
| Paid          | 0.04     | 0.02 | .134  |
| Age           | -0.00    | 0.00 | .074  |
| DEQ           | -0.27    | 0.01 | <.001 |
| SCS-5         | 0.27     | 0.02 | <.001 |
| Time*DEQ      | 0.00     | 0.01 | .553  |
| Time*SCS-5    | -0.03    | 0.01 | <.001 |
| Intercept     | 2.51     | 0.06 | <.001 |
| <b>PA</b>     |          |      |       |
| Time          | 0.10     | 0.02 | <.001 |
| Income        | 0.02     | 0.01 | <.001 |
| Paid          | 0.11     | 0.03 | <.001 |
| Age           | -0.00    | 0.00 | .007  |
| DEQ           | -0.32    | 0.02 | <.001 |
| SCS-5         | 0.32     | 0.02 | <.001 |
| Time*DEQ      | 0.01     | 0.01 | .097  |
| Time*SCS-5    | -0.03    | 0.01 | <.001 |
| Intercept     | 2.16     | 0.07 | <.001 |

Table 3 *Continued.*

| Model Effect | Estimate | <i>SE</i> | <i>p</i> |
|--------------|----------|-----------|----------|
| <b>SWLS</b>  |          |           |          |
| Time         | 0.10     | 0.02      | <.001    |
| Income       | 0.10     | 0.01      | <.001    |
| Paid         | 0.14     | 0.04      | .002     |
| Age          | -0.03    | 0.00      | <.001    |
| DEQ          | -0.63    | 0.02      | <.001    |
| SCS-5        | 0.36     | 0.03      | <.001    |
| Time*DEQ     | 0.02     | 0.01      | .017     |
| Time*SCS-5   | -0.02    | 0.01      | .052     |
| Intercept    | 3.72     | 0.10      | <.001    |
| <b>SHI</b>   |          |           |          |
| Time         | 0.04     | 0.01      | <.001    |
| Income       | 0.04     | 0.00      | <.001    |
| Paid         | 0.08     | 0.02      | <.001    |
| Age          | -0.01    | 0.00      | <.001    |
| DEQ          | -0.32    | 0.01      | <.001    |
| SCS-5        | 0.24     | 0.01      | <.001    |
| Time*DEQ     | 0.01     | 0.00      | .007     |
| Time*SCS-5   | -0.01    | 0.00      | .020     |
| Intercept    | 2.13     | 0.05      | <.001    |

As measured by the Self-Compassion Scale-5 (SCS-5; adopted from Neff, 2003b), the Depressive Experiences Questionnaire (DEQ; Blatt et al., 1976), the Centre for Epidemiological Studies Depression Scale (CESD; Radloff, 1977), the Negative Affect (NA), Compassionate Affect (CPANAS), and Positive Affect (PA) Scales (adopted from Watson, Clark, and Tellegen, 1988), the Satisfaction with Life Scale (SWLS; Pavot & Diener, 1993) and the Steen Happiness Index (SHI; Seligman, Steen, Park & Peterson, 2005), Time = Score change over entire study from baseline to 6-month follow-up, Paid = the first 1168 participants who received direct monetary compensation rather than the remaining participants who were entered in draws.  $N = 3044$ .