# Self-compassion is a better predictor than mindfulness of symptom severity and quality of life in mixed anxiety and depression

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**ABSTRACT**

Mindfulness has received considerable attention as a correlate of psychological well-being and potential mechanism for the success of mindfulness-based interventions (MBIs). Despite a common emphasis of mindfulness, at least in name, among MBIs, mindfulness proves difficult to assess, warranting consideration of other common components. Self-compassion, an important construct that relates to many of the theoretical and practical components of MBIs, may be an important predictor of psychological health. The present study compared ability of the Self-Compassion Scale (SCS) and the Mindful Attention Awareness Scale (MAAS) to predict anxiety, depression, worry, and quality of life in a large community sample seeking self-help for anxious distress ($N = 504$). Multivariate and univariate analyses showed that self-compassion is a robust predictor of symptom severity and quality of life, accounting for as much as ten times more unique variance in the dependent variables than mindfulness. Of particular predictive utility are the self-judgment and isolation subscales of the SCS. These findings suggest that self-compassion is a robust and important predictor of psychological health that may be an important component of MBIs for anxiety and depression.

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## 1. Introduction

Mindfulness covaries with psychological well-being and mental health. A recent meta-analysis suggests that mindfulness-based interventions (MBIs) are efficacious (Hedge's $g \approx 1$) in treating anxiety and mood disorders and reduce anxious and depressive symptoms (Hedge's $g \approx 0.6$) (Hofmann, Sawyer, Witt, & Oh, 2010). At least two different operationalizations of mindfulness have been shown to mediate outcomes in MBIs (Carmody & Baer, 2008; Nyklíček & Kuijpers, 2008). Despite the common link to mindfulness among MBIs, there is variability in the extent that varying treatments promote mindfulness (see Hofmann et al., 2010; Rapgay & Bystrisky, 2009). Further, debate about whether mindfulness can be assessed and if so, how to measure it, is widespread (e.g., *Psychological Inquiry*, 2007, Vol. 18, 4).

Mindfulness is commonly defined as a quality of consciousness involving present-centered attention and awareness that is accepting and non-judgmental (Bishop et al., 2004). It is a complex intentional phenomenon with attributes of meta-consciousness, attentional allocation, and directed awareness (e.g., Grossman,

2008; Kabat-Zinn, 2005). Mindfulness also entails a progressive understanding of the "moment to moment workings of adaptive and maladaptive thoughts and feelings" (Rapgay & Bystrisky, 2009, p. 154). Although changes in meta-cognition, attentional allocation, and directed awareness are known contributors to the effects of MBIs (e.g., Davidson et al., 2003; Lutz, Slagter, Dunne, & Davidson, 2008), these mechanisms prove difficult to assess via traditional self-report (e.g., Christopher, Charoensuk, Gilbert, Neary, & Pearce, 2009; Grossman, 2008; Van Dam, Earleywine, & Danoff-Burg, 2009).

An important difficulty inherent to self-report for these constructs is that human participants have limited access to higher order cognitive processes of the type discussed in modern mindfulness research (Nisbett & Wilson, 1977). Although the experiments showing limited access to cognitive states are not without drawbacks (e.g., White, 1980), their conclusions have particular application to meta-conscious states, which some mindfulness scales may require. Attempts at re-representing conscious states are limited on philosophical, practical, and neuroscientific bases (see Schooler, 2002). These limitations may suggest the need for consideration of the various other qualities typically considered to support positive outcomes in MBIs (e.g., Kabat-Zinn, 1990; Leary & Tate, 2007). It may be that the attitudes and behaviors that support positive MBI outcomes are easier to assess and therefore may serve as better indicators of potential treatment progress. An early step to identifying potentially important constructs to effective MBIs is to

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examine the ability of supporting attitudes and behaviors to predict psychopathology and well-being, especially in direct comparison to mindfulness.

### 1.1. Positive mental states as robust mindful phenomena

Positive mental states are a robust construct commonly associated with MBIs; these may include the attitudes with which one approaches things (e.g., nonjudging awareness, nonstriving, acceptance; Kabat-Zinn, 1990), the behaviors one intends and commits (e.g., prosocial behavior; Leary & Tate, 2007), or the approach that one takes to interpreting private experience (e.g., self-compassion; Germer, 2009; Rosch, 2007). Although many MBIs cultivate positive mental states (e.g., Hayes, Strosahl, & Wilson, 1999; Kabat-Zinn, 1990, 2005), their contributions to process and outcomes have been largely overlooked. Positive mental states like lovingkindness, joy, compassion, and equanimity (see Germer, 2009; Kabat-Zinn, 2005), have only recently begun to receive attention for their ability to increase life satisfaction, improve resilience, and "living well" (Cohn, Fredrickson, Brown, Mikels, & Conway, 2009; Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008; Gilbert, 2009). MBIs increase positive emotions and induce patterns of neurophysiological asymmetry indicative of positive affect (e.g., Davidson et al., 2003; Fredrickson et al., 2008). Positive emotions also display a reciprocal relationship with the meta-cognitive, attentional, and neuroscientific changes often associated with mindfulness (e.g., Lutz, Slagter, et al., 2008), and foster positive outcomes of MBIs (e.g., Shapiro, Astin, Bishop, & Cordova, 2005).

### 1.2. Self-compassion may be a critical component

One such positive mental state and one of the only other theoretically consistent constructs that has been shown to mediate MBI outcomes (Shapiro et al., 2005), is self-compassion. Within a traditional mindfulness context, ". . . compassion is viewed as a necessary underpinning for the whole path, a kind of pilot light for the other virtues . . ." (Rosch, 2007, p. 260). Self-compassion may be an especially important component of the positive mental states associated with MBIs (Germer, 2009). Normal function is characterized by self-evaluation (e.g., Leary & Tate, 2007; Rosch, 2007); the contents of which are often negative and self-deprecating in anxiety and depression (e.g., Beck, Rush, Shaw, & Emery, 1979; Mineka, Watson, & Clark, 1998). Attitudes of non-judgment and gentleness with one's private and public behaviors are commonly promoted in various MBIs (e.g., Hayes et al., 1999; Kabat-Zinn, 1990). These attitudes seem reflected by self-compassion, defined as "being touched by and open to one's own suffering, not avoiding or disconnecting from it, [and] generating the desire to alleviate one's suffering and to heal oneself with kindness" (Neff, 2003a, p. 87). By offering a radical alternative to the self-criticism, excessive self-control, and self-imposed rigid standards characteristic of anxiety and depression, self-compassion may contribute to the efficacy of MBIs in these disorders (e.g., Germer, 2009; Gilbert, 2009).

Self-compassion also has benefits relative to more traditional psychotherapeutic factors. It is less contingent upon external outcomes than self-esteem and is a significant predictor of happiness, optimism, and positive affect (Neff & Vonk, 2009). Higher self-compassion is associated with greater psychological well-being and provides a buffer against acute stressors (Neff, Kirkpatrick, & Rude, 2007). Self-compassion can also be developed indirectly and has implications for other components of MBIs. Forms of meditation training non-specific to compassion increase self-compassion (e.g., Shapiro, Brown, & Biegel, 2007). Further, changes in self-compassion strongly predict changes on the MAAS during meditation training (Shapiro et al., 2007) and the Self-Compassion Scale (SCS; Neff, 2003b) mediates increases

in quality of life and decreases in general psychological distress and perceived stress following a commonly used MBI (Shapiro et al., 2005).

There are three theoretical facets to self-compassion as defined by Neff (2003a). These theoretical facets are represented by pairs of opposing subscales and identified by their positive quality; self-kindness and self-judgment, common humanity and isolation, and mindfulness and over-identification (Neff, 2003b). The self-kindness facet represents an alternative to self-criticism, self-condemnation, blaming, and rumination, which are common to classic notions of depression (see Beck et al., 1979) and other forms of psychopathology (e.g., anxiety disorders; Forsyth & Eifert, 2008). It represents an internalization of the attitude that therapists often attempt to portray toward their clients.

The common humanity facet represents a recognition that one's suffering does not occur in isolation, but is inherent to the nature of life and intimately related to the suffering of others. While this facet lacks theoretical associations with specific psychiatric symptomatology, it appears to have links to general well-being (Neff, 2003a). It also bears considerable similarity to the notion of de-centering, one potential mechanism of mindfulness (see Carmody, Baer, Lykins, & Oldendzki, 2009) and an important predictor of relapse in cognitive behavioral therapy for depression (Fresco, Segal, Buis, & Kennedy, 2007).

Finally, the mindfulness facet represents a stance of equanimity towards difficult and uncomfortable thoughts and experiences rather than over-identification or excessive fixation, a view similar to the distinction between cognitive defusion and cognitive fusion in Acceptance and Commitment Therapy (ACT; Hayes et al., 1999). The mindfulness facet of the SCS suggests an important role for adaptive and maladaptive emotion regulation, similar to classical notions of mindfulness (Rapgay & Bystrisky, 2009). Mindfulness, as operationalized in the SCS, represents a state of mental balance (one of the most promising of the mental states cultivated in MBIs; see Kabat-Zinn, 2005) rather than a specific type of attention or awareness (as mindfulness is more commonly operationalized; Bishop et al., 2004). Given the comprehensive multi-faceted nature, its relationship and theoretical relationship to MBIs (e.g., Shapiro et al., 2005), and positive relation to psychological health (Neff & Vonk, 2009), self-compassion may be an important component of MBIs and alternative indicator to mindfulness.

### 1.3. Current study

Using multiple regression and correlation analyses, we examined the cross-sectional ability of two known MBI mechanisms (e.g., mindfulness and self-compassion) to predict symptom severity (anxiety, depression, worry) and a measure of well-being (quality of life) in an international sample reporting anxious and depressive distress ($N = 504$). To our knowledge there is no prior work exploring the relationship of self-compassion and mindfulness simultaneously to psychological health in a sample with anxious and depressive symptoms. As such, the present study is exploratory in nature and adds to knowledge about self-compassion in relation to anxiety and depression, alone and in concert with mindfulness.

## 2. Methods

### 2.1. Procedure

Data presented in the current paper were collected as part of the initial assessment protocol of an ongoing randomized clinical trial evaluating the effectiveness of a popular self-help workbook for anxious suffering: *The mindfulness & acceptance workbook for anxiety*: *A guide to breaking free from anxiety, phobias, and worry using*