ELSEVIER

Self-Compassion in Depression: Associations With Depressive Symptoms, Rumination, and Avoidance in Depressed Outpatients

Tobias Krieger
David Altenstein
Isabelle Baettig
Nadja Doerig
Martin Grosse Holtforth
University of Zurich

Self-compassion involves being kind to oneself when challenged with personal weaknesses or hardship and has been claimed to be associated with resilience in various areas. So far, there are only a handful of studies that investigate self-compassion and its relation to clinical depression. Therefore, the principal goals of the present study were (a) to compare self-compassion in clinically depressed patients and never-depressed subjects, (b) to investigate self-compassion and its relation to cognitive-behavioral avoidance and rumination in depressed outpatients, and (c) to investigate rumination and avoidance as mediators of the relationship between self-compassion and depressive symptoms. One hundred and forty-two depressed outpatients and 120 never-depressed individuals from a community sample completed a self-report measure of self-compassion along with other measures. Results indicate that depressed patients showed lower levels of self-compassion than never-depressed individuals, even when controlled for depressive symptoms. In depressed outpatients, self-compassion was negatively related to depressive symptoms, symptom-focused rumination, as well as cognitive and behavioral avoidance. Additionally, symptom-focused rumination and cognitive and behavioral avoidance mediated the relationship between self-compassion and depressive symptoms. These findings extend previous research on self-compassion, its relation to depression, as well as processes mediating this relationship, and highlight the importance of self-compassion in clinically depressed patients. Since depressed patients seem to have difficulties adopting a self-compassionate attitude, psychotherapists are well advised to explore and address how depressed patients treat themselves.

Keywords: self-compassion; rumination; avoidance; depression; outpatients

0005-7894/44/501–513/$1.00/0

SELF-COMPASSION HAS RECENTLY SPURRED much interest in social, personality, and clinical psychology research. As self-compassion is "compassion turned inward" (Neff, 2012, p. 79), it describes a kind attitude towards oneself when challenged with personal weaknesses and in the face of mental or physical pain. A self-compassionate attitude includes a balanced view of oneself as well as one's (negative) emotional experiences (Neff, 2012). Neff (2003b) defined self-compassion in terms of three bipolar components: (a) self-kindness (vs. self-judgment), which refers to the ability of treating oneself with care and understanding as opposed to harsh self-judgment; (b) common humanity (vs. isolation), which refers to the recognition that imperfection is a shared aspect of the human experience, as opposed to feeling isolated and alone by one's failures and imperfections; and (c) mindfulness (vs.

overidentification), which involves holding and accepting one's present-moment experience as opposed to getting involved with the emotion. Whether measured as a trait (for review, see Neff, 2012) or induced as a state (e.g., Breines & Chen, 2012; Leary, Tate, Adams, Allen, & Hancock, 2007), self-compassion relates positively to mental health and adaptive psychological functioning. For example, higher levels of self-compassion are associated with greater life satisfaction, emotional intelligence, social connectedness, and stronger mastery goals, as well as with lower levels of depressive symptoms, anxiety, rumination, shame, self-criticism, fear of failure, and burnout (Barnard & Curry, 2011; Neff, 2012).

A recent meta-analysis by MacBeth and Gumley (2012) found a large overall effect size ($r = -.52$) for the relationship between self-compassion and depressive symptoms across various studies. However, most research on self-compassion and depression was conducted with nonclinical samples, whereas research in clinical samples has yet been sparse (Barnard & Curry, 2011). With regard to the components of self-compassion, some studies investigated the relation of components of self-compassion with depressive symptoms in nonclinical samples (Mills, Gilbert, Bellew, McEwan, & Gale, 2007; Ying, 2009) and in people seeking help for anxious distress (Van Dam, Sheppard, Forsyth, & Earleywine, 2011). Overall, whereas depressive symptoms were negatively correlated with positive aspects of self-compassion, they were positively correlated with negative aspects. As Barnard and Curry (2011) point out, the strength of the associations of depressive symptoms with the positive aspects of self-compassion, especially with common humanity, tend to be weaker than those with the negative aspects.

So far, only a handful of studies have assessed self-compassion in clinically depressed patients. Results of intervention studies in currently depressed patients (Shahar et al., 2012) and depressed patients in partial or full remission (Kuyken et al., 2010) suggest favorable effects of change in self-compassion on depressive symptoms. Hence, it can be assumed that depressed individuals lack self-compassion. Nevertheless, to our knowledge, there is no study that examines the difference in self-compassion between clinically depressed patients and never-depressed subjects. Furthermore, apart from a study in a sample seeking treatment for anxious and depressive symptoms (Van Dam et al., 2011), there is no study that examines the relation of components of self-compassion with depressive symptoms in clinically depressed patients. However, such information may be important when considering the implementation of self-compassion-focused interventions in existing treatments of depression.

Avoidance has originally been associated with anxiety disorders, but has recently gained attention in depression research (for review, see Trew, 2011). Research indicates that depressed individuals seem to be more responsive to anticipated aversive stimuli (e.g., Abler, Erk, Herwig, & Walter, 2007) and have difficulties disengaging attention from negative material (Gotlib & Joormann, 2010). Therefore, it can be assumed that avoidance of aversive stimuli or situations may be especially likely in depressed individuals. While in the short term, avoidance may provide relief from distressing experiences, individuals do not get closer to a problem solution. Therefore, avoidance may exacerbate unresolved problems or even create new problems (Jacobson, Martell, & Dimidjian, 2001; Ottenbreit & Dobson, 2008). Thus, avoidance may contribute to a vicious circle, with future aversive conditions evoking avoidance that is maintained by negative reinforcement (Manos, Kanter, & Busch, 2010). Accordingly, several studies have found that avoidance is significantly related to depressive symptoms and highlight the importance of distinguishing social from nonsocial and behavioral from nonbehavioral avoidance (Moulds, Kandris, Starr, & Wong, 2007; Ottenbreit & Dobson, 2004; Roethlin, Grosse Holtforth, Bergomi, Berking, & Caspar, 2010). Overall, these results support further examining the role of avoidance in depression for research and clinical purposes alike.

Rumination has been found to prospectively predict the onset, severity, and, in some studies, the duration of depression (Just & Alloy, 1997; Kuehner & Weber, 1999; Spasojevic & Alloy, 2001; for review, see Wisco & Nolen-Hoeksema, 2008). Rumination has originally been defined as persistent and recurring thoughts, unintentionally entering consciousness and focusing one's attention on one's depressive symptoms as well as on the implications of these symptoms (Nolen-Hoeksema, 1991). Rather than assuming homogeneity, most authors have suggested that rumination may be best conceptualized as a multifactored construct, which captures both negative and positive forms of self-focus (for review, see Watkins, 2008). Accordingly, brooding (referring to self-critical moody pondering) has been shown to be associated with higher levels of depression, whereas results are mixed with regard to reflective rumination (capturing emotionally neutral pondering; e.g., Burwell & Shirk, 2007; Rimes & Watkins, 2005; Roelofs, Huibers, Peeters, Arntz, & van Os, 2008; Treynor, Gonzalez, & Nolen-Hoeksema, 2003). These inconclusive findings regarding reflection seem to also depend on the (negative) valence of the thought content and on the abstractness of construal (Watkins, 2008). Other researchers differentiate between

symptom-focused and self-focused rumination (Bagby & Parker, 2001; Buerger & Kuehner, 2007; Cox, Enns, & Taylor, 2001; Roberts, Gilboa, & Gotlib, 1998), with the latter largely overlapping with the reflection subscale. Whereas symptom-focused rumination assesses a coping style of perseveratively thinking about one's depressive symptoms as well as their implications, self-focused rumination is related to self-analysis and self-isolation (Huffziger, Reinhard, & Kuehner, 2009). With this distinction, symptom-focused rumination has been found to predict depressive symptoms in longitudinal studies, whereas self-focused rumination did not (Buerger & Kuehner, 2007; Huffziger et al., 2009).

It has been argued that rumination and avoidance share certain commonalities (Giorgio et al., 2010; Moulds et al., 2007; Ottenbreit & Dobson, 2008; Smith & Alloy, 2009). While Watkins and Moulds (2007) proposed that rumination may function to limit the emotional impact of negative material, the Behavioral Activation Model (Ferster, 1973; Lewinsohn, 1974) would suggest that rumination may function to limit contact with the environment. Yet, Moulds and colleagues (Moulds et al., 2007) suggested that both of these proposed functions of rumination may be considered as forms of avoidance that prevent people from confronting aversive stimuli potentially triggering negative emotions (cf. Ottenbreit & Dobson, 2008).

PATHWAYS FROM SELF-COMPASSION TO DEPRESSION

So far, there is little research on potential pathways through which a lack of self-compassion may lead to or increase depressive symptoms. In their review on self-compassion and coping, Allen and Leary (2010) conclude that a self-compassionate attitude promotes a way of coping with negative events that is primarily characterized by functional nonavoiding coping tactics, such as positive cognitive reframing or problem solving. Self-compassion involves directing the same kind of compassion toward oneself that one conveys toward loved ones who are suffering, and to minimize one's future suffering. In turn, a lack of self-compassion may foster an avoiding way of functioning. Consistent with this assumption, people with low levels of self-compassion have been found to be more likely to ruminate (Neff, 2003a; Neff & Vonk, 2009). Furthermore, in an intervention study with a student sample, Neff and colleagues (Neff, Kirkpatrick, & Rude, 2007) found that an increase in self-compassion over a 1-month interval was associated with a decrease in rumination and depressive symptoms. In addition, a lack of self-compassion has been associated with cognitive avoidance. For example, Neff (2003a) found that

self-compassion is negatively associated with thought suppression, as a form of cognitive avoidance (see also Neff et al., 2007). Furthermore, in a study by Neff, Hsieh, and Dejitterat (2005), self-compassion was found to be negatively associated with denial and mental disengagement in response to receiving an unsatisfactory midterm grade. In a recent study, Raes (2010) showed that rumination mediated the relation between self-compassion and depressive symptoms. Supporting the assumed multifaceted nature of rumination, he found that only brooding but not reflection mediated the relationship between self-compassion and depressive symptoms. Taken together, previous research suggests a mediational model, in which self-compassion is associated with avoidant functioning (avoidance and rumination), which in turn is related to symptoms of depression.

The Present Study

Most of the research cited above focused on nonclinical subjects, and little is known about self-compassion in clinically depressed patients. The present study aims at shedding more light on self-compassion in clinically depressed subjects by pursuing three main goals: (a) to compare self-compassion in never-depressed with self-compassion in clinically depressed subjects, (b) to investigate the relation between components of self-compassion and depressive symptoms, and (c) to investigate the relation between self-compassion, avoidant functioning, and depressive symptoms in depressed patients.

Based on the research cited above, we tested the following hypotheses:

1. Depressed patients show lower levels of self-compassion than never-depressed subjects (overall and in its subscales).
2. In depressed patients, self-compassion and its components are associated with depressive symptoms (negative associations between depressive symptoms and overall self-compassion, self-kindness, common humanity, and mindfulness; positive associations between depressive symptoms and self-judgment, isolation, and overidentification).
3. Self-compassion is negatively associated with symptom-focused rumination and cognitive and behavioral avoidance.
4. Symptom-focused rumination and cognitive and behavioral avoidance mediate the relationship between self-compassion and depressive symptoms.

METHODS

Participants

The analyses in this study were conducted with the data of two samples. The first sample consisted of

clinically depressed patients; the other sample consisted of never-depressed subjects from a community sample. The depressed sample (DS) involved 142 clinically depressed patients who were seeking psychotherapeutic treatment at a university-based outpatient clinic and were already enrolled in a clinical trial. Patients had been enrolled over a 26-month period from January 2010 to February 2012. Patients were recruited for the clinical trial via local media, Internet, public advertisement, local general practitioners, and local psychiatrists. All patients fulfilled the criteria of a current major depressive episode (MDE). DSM-IV diagnoses were obtained using the German version of the Structural Clinical Interview for DSM-IV (SCID; Wittchen, Wunderlich, Gruschwitz, & Zaudig, 1997) conducted by trained interviewers. The interviewers were advanced psychology students, who received a 2-day training conducting the SCID-Interview including role-plays and watching videotaped SCID-Interviews. Additionally, results of all interviews were discussed with a clinically experienced supervisor (last author) in order to confirm the diagnoses. Post-hoc interrater agreement for the SCID interviews (based on a random selection of DVDs of 22% of the interviews) was κ = .65 for MDE and κ = .80 for the course of the depression (single or recurrent episode). These values can be categorized as *good* for MDE and as *excellent* for the course (Cichetti, 1994) and are in line with the recently reported interrater reliability of the SCID diagnosis for major depression (Lobbestael, Leurgans, & Arntz, 2011). For purposes of the clinical trial, persons with MDEs were excluded if they met one or more of the following criteria: past or current psychotic or bipolar disorder; posttraumatic stress disorder; borderline, schizotypal, or antisocial personality disorder; current substance dependence; acute suicidality; or mood disorders due to medical conditions. Patients could take antidepressant medication, but they had to have kept the dosage and type of medication stable for at least 1 month prior to enrollment and had to continue with their medication unchanged throughout the trial. The mean age of the DS was 40.6 years (SD = 11.3). Seventy-nine subjects were women (56%). Thirty-nine percent had a university degree; 17% had at least 12 years of schooling, 39% at least 9 years, 2% less than 9 years; and for 4% information on education was missing. Forty percent of the sample was single; 39% were in a relationship or married; 16% were separated, divorced or widowed; and for 6%, information on marital status was missing. The large majority of the sample was Caucasian (> 95%). Seventy-three percent of the sample had a recurrent MDE, 27% had a single

MDE. Thirty-four percent of the sample had a least one additional comorbid anxiety disorder. The local ethics committee had approved the study protocol, and all participants provided informed consent prior to assessment.

For the never-depressed sample (NDS), 196 subjects (122 women, 74 men) were recruited from the social environment of researchers and students of the university. All participants provided informed consent before admission to the study and completed the questionnaires in an online survey. Participants took part voluntarily. Students received credit toward a course requirement regarding research participation. The survey adhered to the guidelines of the ethics committee of the psychological department of the university. The Self-Compassion Scale (SCS), the Beck Depression Inventory-II (BDI-II), as well as the Cognitive-Behavioral Avoidance Scale (CBAS) were part of a larger package of questionnaires (mean completion time was approximately 40 minutes). In order to screen for current and past depression, each participant answered two questions regarding the cardinal symptoms of MDE taken from the SCID-I-interview for the last month and at any time (depressed mood; decreased interest or pleasure). Additionally, participants were asked whether they had ever been treated for depression. One hundred twenty participants (61% of the total sample; 57% female) answered all of these screening questions with "no" and were included in the NDS of the present study. The mean age of the NDS was 31.2 years (SD = 10.2). Forty-six percent had a university degree; 26% had at least 12 years of schooling, and 28% at least 9 years. Fifty-five percent were single; 40% were in a committed relationship or married; 4% were separated, divorced, or widowed; and for 1%, information on marital status was missing.

MEASURES
Self-Compassion
Self-compassion was measured by the Self-Compassion Scale (SCS; Neff, 2003a). The SCS is a 26-item self-report inventory that consists of six subscales: self-kindness, self-judgment, common humanity, isolation, mindfulness, and overidentification. Each item was rated on a 5-point scale (1 = *strongly disagree* to 5 = *strongly agree*). In the present study, we used the German version of the SCS, which has shown adequate factorial validity and good construct validity, high internal consistency and retest reliability for the total score, as well as the subscales in a community sample (Hupfeld & Ruffieux, 2011). Internal consistencies of the SCS in the DS of the present study were as follows (Cronbachs' alphas for the NDS are given in

parentheses): total score: α = .91 (.86); self-kindness α = .87 (.78); self-judgment α = .70 (.72); common humanity α = .74 (.58); isolation α = .74 (.82); mindfulness α = .75 (.66); and over-identification α = .56 (.64).

Depressive Symptoms

The Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996; German version: Kuehner, Bürger, Keller, & Hautzinger, 2007) is a self-report measure consisting of 21 items describing symptoms of depression. Total scale scores range from 0 to 63, with a higher score indicating more depressive symptoms. The reliability and validity of the German version of BDI-II have been well established (Kuehner et al., 2007). Cronbach's α in the present study was .88 for the DS and .77 for the NDS.

Rumination

Symptom-focused (RSQ-SYM) and self-focused rumination (RSQ-SELF) were assessed using the corresponding subscales of the German short form of the Response Styles Questionnaire (RSQ; Buerger & Kuehner, 2007). Whereas RSQ-SYM assesses a coping style of perseveratively thinking about one's depressive symptoms and their implications, RSQ-SELF consists of items primarily related to self-analysis and self-isolation. The RSQ asks participants about their general responses to sadness or depressed mood on a 4-point-Likert scale. Sample items for each scale are: "When I feel sad or depressed, I think I won't be able to do my job/work because I feel so badly" (RSQ-SYM) and "When I feel sad or depressed, I go away by myself and think about why I feel this way" (RSQ-SELF). The two subscales of the RSQ have previously shown appropriate to good psychometric properties, including internal consistency, temporal stability, as well as concurrent, discriminant, and predictive validity (Buerger & Kuehner, 2007). In the DS, Cronbach's α was .70 for RSQ-SYM, and .67 for RSQ-SELF.

Avoidance

The Cognitive-Behavioral Avoidance Scale (CBAS; Ottenbreit & Dobson, 2004) is a multidimensional measure that assesses avoidance across four factors: (a) behavioral-social (CBAS-BS; e.g., "I find that I often want to leave social gatherings"); (b) behavioral-nonsocial (CBAS-BN; e.g., "I quit activities that challenge me too much"); (c) cognitive-social (CBAS-CS; e.g., "I fail to discuss/address tension that builds in a relationship"); and (d) cognitive-nonsocial (CBAS-CN; e.g., "I avoid making decisions about my future"). The study by Ottenbreit and Dobson indicated that the CBAS shows good internal consistency, strong test-retest reliability, as well as good convergent and divergent validity. In the current study, we used the German translation of the CBAS (Roethlin et al., 2010), which has demonstrated similarly good psychometric properties. In the DS, Cronbach's α was .92 for the total scale (CBAS-T), .85 for CBAS-BS, .67 for CBAS-BN, .80 for CBAS-CS, and .84 for CBAS-CN.

STATISTICAL ANALYSIS

The Statistical Package for Social Sciences 20 (SPSS) for Macintosh was used for computing descriptive statistics, correlations and internal consistencies, as well as for analyses of covariances. Furthermore, we conducted mediation analyses using the INDIRECT script by Preacher and Hayes (2008). In assessing mediation, it is important to make a distinction between several different effects. The total effect (c) of an independent variable (IV) on a dependent variable (DV) is composed of a direct effect (c') of the IV on the DV and an indirect effect of the IV on the DV through a proposed mediator (M). Weight a represents the effects of the IV on the M, whereas weight b is the effect of the M on the DV, partialing out the effect of the IV. The indirect effect is computed by multiplying the regression weights of a and b. We used a bootstrapping re-sampling with 1000 resamples to assess the indirect effects (Preacher & Hayes). Bootstrapping is a nonparametric resampling procedure that generates an empirical approximation of the sampling distribution of a statistic from the available data. Thus, point estimates and 95% confidence intervals are estimated for the indirect effects. We report the bias-corrected and accelerated confidence interval. We considered point estimates of the indirect effects as significant in case zero was not included in the confidence interval. According to the sample size guidelines of Fritz and MacKinnon (2007), we had a sufficient number of participants in the DS to detect a mediation effect with the bootstrapping procedure.

Additionally, we tested a mediation model in a structural-equation modeling (SEM) framework. SEM was performed with the lavaan package (Rosseel, 2012) with maximum likelihood estimation in the R environment (R Development Core Team, 2011). Model fit was assessed using the following indices: χ^2-test statistic, the Comparative Fit Index (CFI), the Tucker-Lewis Index (TLI), the Root Mean Square of Approximation (RMSEA), and the Standardized Root Mean Square Residual (SRMR). A model was seen as acceptable, in which the χ^2-test was not significant, CFI and TLI were each greater than 0.90, the RMSEA index was below .08, and the SRMR was below .10 (Hu & Bentler, 1999; Kline, 2005).

Table 1
Self-Compassion in Never-Depressed Subjects and Clinically Depressed Patients

	Never-Depressed Subjects M (SD)	Depressed Patients M (SD)	F	Partial η²	F	Partial η²
					(Controlling for depressive symptoms)	
SCS	3.31 (.36)	2.75 (.41)	126.70**	.34	12.39**	.05
SCS-sk	3.31 (.78)	2.47 (.78)	59.49**	.19	4.82*	.02
SCS-ch	2.97 (.76)	2.55 (.71)	15.00**	.06	0.67	.00
SCS-m	3.32 (.70)	2.82 (.70)	37.23**	.13	0.84	.00
SCS-sj	2.34 (.70)	3.55 (.62)	230.65**	.48	30.73**	.11
SCS-i	1.93 (.84)	3.40 (.81)	220.52**	.47	26.76**	.10
SCS-oi	2.51 (.80)	3.62 (.66)	146.21**	.37	12.40**	.05

Notes. Due to missing values in covariates, sample size was $n = 119$ for the never-depressed sample and $n = 134$ for the depressed sample. SCS = Self-Compassion total score, -sk = Self-Kindness subscale, -ch = Common Humanity subscale, -m = Mindfulness subscale, -sj = Self-Judgment subscale, -i = Isolation subscale, -oi = Over-Identification subscale. Age, marital status and education were entered as covariates in all analyses.
* $p < .05$. ** $p < .01$.

Results

PRELIMINARY ANALYSES
The DS and the NDS differed significantly regarding depressive symptoms (DS: $M = 25.61$, $SD = 9.04$; NDS: $M = 3.95$, $SD = 3.88$; $t[198, 93] = 25.86$, $p < .001$). Further, the samples differed significantly regarding age, ($t[258, 84] = 7.05$, $p < .001$) and marital status ($\chi^2[2] = 10.99$, $p < .01$), and there was an insignificant trend with regard to education ($\chi^2[3] = 9.31$, $p = .051$). Samples did not differ regarding gender distribution ($\chi^2[1] = 0.28$, $p = .87$). Due to the results of these analyses, we decided to include age, marital status, and education as covariates in subsequent analyses comparing the two samples.

Self-Compassion in Clinically Depressed Patients and Never-Depressed Subjects
As Table 1 indicates, clinically depressed patients were significantly less self-compassionate than never-depressed subjects. Furthermore, the two samples differed regarding all subscales of self-compassion.[1] In order to investigate whether levels of depressive symptoms may account for this difference, we reconducted the analyses of depressed and never-depressed subjects regarding levels of self-compassion with depressive symptoms as an additional covariate.

[1] Following the advice of an anonymous reviewer, we also compared the never-depressed sample and the depressed sample with respect to the scales of the CBAS, correcting for age, marital status, and education. Results indicated that the depressed sample showed significantly higher scores on the total score as well as on all four subscales of the CBAS [CBAS-T: $F(1, 244) = 382.74$, $p < .01$, $\eta_p^2 = .61$; CBAS-BS = $F(1, 244) = 245.54$, $p < .01$, $\eta_p^2 = .50$; CBAS-BN: $F(1, 244) = 275.66$, $p < .01$, $\eta_p^2 = .53$; CBAS-CS: $F(1, 244) = 178.90$, $p < .01$, $\eta_p^2 = .42$; CBAS-CN: $F(1, 244) = 320.65$, $p < .01$, $\eta_p^2 = .57$]. A comparison of the two samples with regard to the rumination scores was not possible, because the samples completed different rumination scales.

Results indicated that the two samples still differed significantly regarding the self-compassion total score, as well as the self-kindness, self-judgment, isolation, and overidentification subscale.

Self-Compassion, Its Components, and Depressive Symptoms
Next, we performed correlational analyses for self-compassion as measured by the SCS, its subscales, and depressive symptoms in both samples. As can be seen in Table 2, self-compassion was significantly negatively correlated with depressive symptoms in the DS ($r = -.23$, $p < .01$) as well as in the NDS ($r = -.37$, $p < .01$). These correlation coefficients did not differ significantly from each other ($Z_{diff} = 1.23$, $p = .22$). All subscales of the SCS correlated in the expected direction with the total self-compassion score in the depressed sample as well as in the never-depressed sample. Furthermore, correlational analyses indicated that in both samples all subscales except common humanity correlated with depressive symptoms in the expected direction.

Self-Compassion, Rumination, and Avoidance in Depressed Patients
Table 3 gives an overview of how self-compassion is related to the different facets of rumination and avoidance in the DS. As expected, self-compassion was significantly negatively associated with symptom-focused rumination, but not with self-focused rumination. Furthermore, self-compassion was significantly negatively associated with all avoidance scales except for cognitive social avoidance.

Mediation Analyses: Rumination and Avoidance as Mediators of the Relation Between Self-Compassion and Depressive Symptoms
The results of the mediation analyses are presented in Table 4. The indirect effect of self-compassion on

Table 2

Intercorrelations of Self-Compassion, Its Components, and Depressive Symptoms in Depressed Outpatients and Never-Depressed Subjects

	1	2	3	4	5	6	7	8
1. SCS	-	.79**	.65**	.68**	-.43**	-.52**	-.22*	-.37**
2. SCS-sk	.87**	-	.46**	.44**	-.22*	-.23*	-.11	-.19*
3. SCS-ch	.74**	.61**	-	.50**	.14	.02	.04	-.11
4. SCS-m	.79**	.68**	.55**	-	-.17	-.25**	-.38**	-.31**
5. SCS-sj	-.70**	-.61**	-.28**	-.37**	-	.61**	.61**	.37**
6. SCS-i	-.58**	-.37**	-.20**	-.39**	.52**	-	.62**	.48**
7. SCS-oi	-.35**	-.37**	-.21**	-.36**	.44**	.68**	-	.40**
8. BDI-II	-.23**	-.21**	-.15	-.18*	.23**	.22**	.24**	-

Notes. SCS = Self-Compassion total score, -sk = Self-Kindness subscale, -ch = Common Humanity subscale, -m = Mindfulness subscale, -sj = Self-Judgment subscale, -i = Isolation subscale, -oi = Over-Identification subscale, BDI-II = Beck Depression Inventory II. Correlation coefficients for the depressed sample ($n = 142$) are shown in the lower-left part of the table and for the never-depressed sample ($n = 120$) in the upper-right part of the table.
* $p < .05$, ** $p < .01$.

depressive symptoms through symptom-focused rumination was $ab = -.06$ ($SE = .03$) with a 95% bootstrap confidence interval ($CI_{95\%}$) of -.12 to -.002. Because zero is not in the 95% confidence interval for symptom-focused rumination, it can be concluded that this indirect effect is significantly different from zero at $p < .05$, and that symptom-focused rumination mediates the relationship between self-compassion and depressive symptoms. With respect to self-focused rumination, this was not the case ($ab = -.02$, $SE = .02$, $CI_{95\%} = -.07$ to .002).

Next, we tested whether total avoidance and the subscales of avoidance mediate the relationship between self-compassion and depressive symptoms. Results of these analyses suggest that total avoidance completely mediated the relation between self-compassion and depression. The indirect effect of self-compassion on depressive symptoms through avoidance was $ab = -0.08$ ($SE = .03$) with

a 95% bootstrap confidence interval of -.17 to -.02. Subsequent analyses for the subscales of avoidance showed that all subscales of the CBAS (CBAS-BN: $ab = -.06$, $SE = .03$, $CI_{95\%} = -.13$ to -.01; CBAS-BS: $ab = -.07$, $SE = .03$, $CI_{95\%} = -.15$ to -.02; CBAS-CN: $ab = -.06$, $SE = .03$, $CI_{95\%} = -.13$ to -.01), except for cognitive social avoidance ($ab = -.02$, $SE = .02$, $CI_{95\%} = -.08$ to .002), mediated the relation between self-compassion and depressive symptoms.

In a last step, we tested the hypothesis that the relation between self-compassion and depressive symptoms is mediated through a latent variable "avoidant functioning", which was composed of the avoidance total score and symptom-focused rumination. A model of the association between participants' self-compassion and their current depressive symptoms was specified. Low levels of self-compassion were significantly associated with increased depressive

Table 3

Descriptives and Intercorrelations of Self-Compassion, Rumination, Avoidance and Depressive Symptoms in Depressed Outpatients

	1	2	3	4	5	6	7	8	M (SD)
1. SCS	-								2.76 (.41)
2. RSQ-SYM	-.19*	-							2.70 (.54)
3. RSQ-SELF	-.16	.52**	-						2.42 (.49)
4. CBAS-T	-.30**	.38**	.25**	-					2.86 (.63)
5. CBAS-BS	-.27**	.25**	.28**	.84**	-				2.70 (.84)
6. CBAS-BN	-.32**	.39**	.35**	.84**	.62**	-			3.12 (.71)
7. CBAS-CS	-.16	.22**	.01	.80**	.57**	.52**	-		2.68 (.77)
8. CBAS-CN	-.23**	.38**	.20*	.80**	.51**	.63**	.53**	-	2.95 (.73)
9. BDI-II	-.23**	.40**	.17*	.36**	.37**	.28**	.20**	.34**	25.61 (9.04)

Notes. $n = 140$-142. SCS = Self-Compassion total score, RSQ-SYM = Symptom-focused rumination, RSQ-SELF = Self-focused rumination, CBAS-T = Cognitive-Behavioral Avoidance total score, -BS = CBAS, Behavioral Social subscale, -BN = CBAS, Behavioral Nonsocial subscale, -CS = CBAS, Cognitive Social subscale, -CN = CBAS, Cognitive Nonsocial subscale, BDI-II = Beck Depression Inventory-II.
* $p < .05$. ** $p < .01$.

Table 4
Summary of Mediational Analyses (1000 Bootstrap Samples)

Independent variable (IV)	Mediating variable (M)	Dependent variable (DV)	Effect of IV on M (a)	Effect of M on DV (b)	Direct effect (c')	Indirect effect (ab)	Total effect (c)
1. SCS	RSQ-SYM	BDI-II	-.22*	.28**	-.12	-.07[a]	-.18**
2. SCS	RSQ-SELF	BDI-II	-.19	.10	-.17*	-.02	-.18**
3. SCS	CBAS-T	BDI-II	-.34**	.24**	-.11	-.08[a]	-.19**
4. SCS	CBAS-BS	BDI-II	-.31**	.24**	-.12	-.07[a]	-.19**
5. SCS	CBAS-BN	BDI-II	-.36**	.16**	-.13	-.06[a]	-.19**
6. SCS	CBAS-CS	BDI-II	-.18	.12*	-.17*	-.02	-.19**
7. SCS	CBAS-CN	BDI-II	-.27**	.22**	-.13	-.06[a]	-.19**

Notes. n = 140-142. SCS = Self-Compassion total score, RSQ-SYM = Symptom-focused rumination, RSQ-SELF = Self-focused rumination, CBAS-T = Cognitive-Behavioral Avoidance total score, -BS = CBAS, Behavioral Social subscale, -BN = CBAS, Behavioral Nonsocial subscale, -CS = CBAS, Cognitive Social subscale, -CN = CBAS, Cognitive Nonsocial subscale, BDI-II = Beck Depression Inventory-II. [a] Significant point estimate ($p < .05$).
* $p < .05$. ** $p < .01$.

symptoms (β = -.23, z = -2.91, $p < .01$). Subsequently, a model including the direct association between self-compassion and current depressive symptoms as well as the indirect association of self-compassion through its association with avoidant functioning (defined as a latent factor and including avoidance total score and symptom-focused rumination) on depressive symptoms was specified and estimated. This model was found to fit the observed data adequately: $\chi^2(1) = 1.53$, $p = .22$, CFI = 0.99, TLI = 0.95, RMSEA = .06, SRMR = .02. As shown in Fig. 1, low levels of self-compassion were significantly associated with high levels of avoidant functioning (β = -.39, z = -3.03, $p < .01$). Avoidant functioning, in turn, was significantly associated with high levels of depressive symptoms (β = .63, z =3.49, $p < .01$). Furthermore, the significant association between participants' self-compassion and their depressive symptoms decreased when avoidant functioning was included in the model (β = .03, z = .23, $p = .82$). Finally, a bootstrapping procedure with 1000 resamples indicated that the indirect effect of
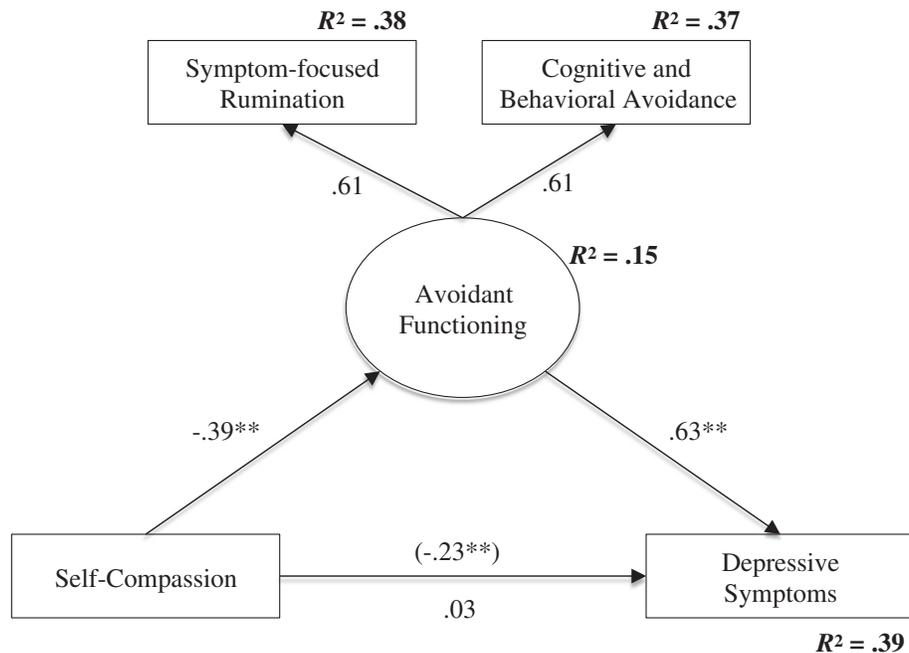

FIGURE 1 Direct and indirect standardized association between self-compassion, avoidant functioning and levels of depressive symptoms in depressed patients (n = 140). Rectangles indicate measured variables and the circle represents a latent construct. * $p < .05$. ** $p < .01$.

self-compassion on depressive symptoms through avoidant functioning was significant ($p = .04$).

Discussion

The purpose of the present study was to investigate self-compassion in clinical depression. To our knowledge, this is the first study investigating self-compassion in a clinically depressed outpatient sample in comparison to a never-depressed sample. In support of our hypotheses, clinically depressed patients differed from never-depressed subjects regarding total self-compassion as well as all components of self-compassion. Furthermore, all subscales (except for common humanity) were associated with depressive symptoms in both samples. In depressed patients, self-compassion was negatively correlated with symptom-focused rumination and with the total score as well as with three of four facets of cognitive and behavioral avoidance. Symptom-focused rumination as well as the total score and three out of four facets of cognitive-behavioral avoidance fully mediated the relation between self-compassion and depression. Finally, assuming that symptom-focused rumination and behavioral and cognitive avoidance are aspects of a higher-level construct "avoidant functioning," results of a SEM framework confirmed that avoidant functioning fully mediates the relationship between self-compassion and current depressive symptoms in depressed patients.

Our results demonstrate that depressed outpatients differ significantly in self-compassion from never-depressed subjects. Although this effect can be considered large, the effect became small when controlling for depressive symptoms. Nevertheless, this result seems to be important in that previous studies have shown that, as compared to individuals with lower levels of self-compassion, individuals with higher levels of self-compassion seem better able to keep negative situations in perspective and appear more resilient after experiencing a stressor (Leary et al., 2007; Neff et al., 2007). Therefore, our finding suggests that people currently suffering from depression miss out on this protective effect of self-compassion and therefore might profit from interventions fostering self-compassion (cf. Kuyken et al., 2010). Furthermore, we also observed significant group differences on some subscales of the SCS. Interestingly, differences regarding mindfulness and common humanity were no longer significant after controlling for depressive symptoms. This result may suggest that in treatment depressed patients may profit most from interventions aimed at self-kindness and the negative aspects of self-compassion. Moreover, a recent study (Wong & Mak, 2013) suggests that subjects prone to

specific vulnerability factors of depression (e.g., self-criticism) might profit most from different aspects of self-compassion. Previous intervention studies testing the specific hypothesis that self-critical people particularly profit from self-compassion interventions yielded mixed results (Kelly, Zuroff, & Shapira, 2009; Shapira & Mongrain, 2010). However, there is a lack of studies that test this hypothesis in currently depressed patients. Furthermore, one has to keep in mind that the interventions applied in the studies mentioned above were based on online- and computer-based instructions (i.e., in the absence of a therapist). Therefore, more studies are needed that investigate this specific hypothesis in depression treatment (Shahar et al., 2012). Furthermore, despite the reported differences between currently depressed patients and never depressed subjects, the effect might not be specific to depression, since Werner and colleagues (Werner et al., 2011) also have found differences in socially anxious patients regarding all subscales after controlling for symptomatology. Therefore, the question of disorder-specificity remains unresolved and needs further clarification in future research. In sum, results of the present study lend support to the notion that self-compassion is substantially lower in depressive patients than in never-depressed subjects.

Moreover, the present study's results showed small- to medium-sized correlations in the expected direction between the total score of self-compassion and all its subscales (except common humanity) with depressive symptoms in the depressed and the never-depressed sample. This finding replicates and extends similar results found by other researchers in various samples (Brooks, Kay-Lambkin, Bowman, & Childs, 2012; Hupfeld & Ruffieux, 2011; Van Dam et al., 2011; Ying, 2009). However in the depressed sample, the relationship between total self-compassion and depressive symptoms was smaller than in a recent meta-analysis in clinical and nonclinical samples finding a large effect size (MacBeth & Gumley, 2012). This difference may be explained, on the one hand, by the finding that, especially in the depressed sample, self-compassion scores were very low, and on the other hand, that the etiology and the severity of a clinical depression cannot be explained comprehensively by one single factor but by a combination of multiple biological, psychological, and social factors (Gotlib & Hammen, 2009).

Our results further showed that the observed small relation between self-compassion and current depressive symptoms in depressed patients is fully mediated by symptom-focused rumination and avoidance. Furthermore, analyses showed that this was not the case for self-focused rumination and

cognitive social avoidance. Our results regarding rumination back up the results by Raes (2010), who showed in a student sample that the relation between self-compassion and depression was partially mediated by brooding (as a maladaptive type of rumination) but not by reflection. So far, results on the potential adaptiveness of self-focused rumination or reflection in depressed patients led to mixed results, which may be due to the fact that distinguishing different forms of rumination might be difficult for individuals currently in a depressive mood state (Joormann, Dkane, & Gotlib, 2006). This interpretation is supported by the finding of the present study that both rumination factors were positively associated with depressive symptoms. Additionally, we expanded previous research by showing that cognitive-behavioral avoidance also mediates the relationship between self-compassion and depressive symptoms. Both rumination as well as cognitive and behavioral avoidance can be understood as facets of experiential avoidance (Ottenbreit & Dobson, 2008). Along these lines, a mediation analysis in an SEM framework supports the hypothesis that less self-compassionate people tend to function in a more avoiding manner and, as a result, are more likely to experience depressive symptoms. Nevertheless, this hypothesis should be tested in sufficiently powered studies with longitudinal designs and measures that more explicitly tap emotional avoidance. These studies will need to explore whether more specific measures of emotional avoidance have similar or different patterns of relationship with self-compassion and depression.

If future research can consolidate the causal status of too little self-compassion in the development and/or the severity of depression, refining interventions as to specifically target an increase of self-compassion seems a promising venue in the enhancements of depression therapy. The interventions that have already been presented (e. g., Germer, 2009; Gilbert, 2010; Neff & Germer, 2012) provide a suitable vantage point for this line of inquiry. Given that certain changes in self-concept figure as positive outcomes in psychotherapies (Connolly Gibbons et al., 2009), the study of change in self-compassion as a closely related concept in established treatment approaches may advance a better understanding of mechanisms of change in psychotherapy.

LIMITATIONS AND CONCLUSIONS

A number of limitations warrant acknowledgment. First, the cross-sectional design of the study limits interpretations of the differences between depressed and never-depressed subjects, as well as of the findings of the mediation analyses. For example, it cannot be determined whether differences between depressed and never-depressed subjects may be due to scar effects of the current or a past depressive episode rather than being attributable to depression vulnerability (Just, Abramson, & Alloy, 2001). Consequently, future research on the assumed links between self-compassion, rumination, avoidance, and depression should use prospective longitudinal study designs. Second, the never-depressed participants were screened for depression, but not for other disorders. As a consequence, never-depressed subjects might have suffered from other psychological disorders not being assessed. Not finding differences regarding two positive aspects of self-compassion after controlling for depressive symptoms may also be due to this limitation. Thus, future studies are well advised to screen for other psychological disorders in order to exclude this possibility. Third, the presented study is based on self-report measures that are sensitive to memory biases. Future studies may profit from using more objective measures such as behavioral measures or rater-based assessments of self-compassion in order to measure the degree of self-compassion more objectively (cf. Sbarra, Smith, & Mehl, 2012). Fourth, as described, the samples in the present study were recruited in different ways. Therefore, it might be possible that the observed differences in total self-compassion and its components may be due to variables not accounted for. For example, Baer, Lykins, and Peters (2012) showed that meditation experience is a potential confounding variable with regard to self-compassion. Therefore, future studies should assess for meditation experience when comparing different samples on self-compassion. Fifth, although there is a growing body of literature that supports the validity of the total score of the SCS, there are only few studies to date that lend at least some support to the validity of the six subscales (e.g., Hupfeld & Ruffieux, 2011). Hence, the results obtained with the subscales of the SCS need to be interpreted with caution, and more studies investigating the validity of these subscales are needed.

In summary, the results of this study add to the existing literature on self-compassion by suggesting that clinically depressed people are much less self-compassionate than never-depressed subjects, even when controlling for depressive symptoms. In addition, the present study promises to advance our understanding of how rumination and avoidance may relate to depression. Our results propose that a lack of self-compassion may further the development of depressive symptoms via excessive avoidance. To test such hypotheses on disease mechanisms, future research seems well advised to continue investigating self-compassion in clinical and high-risk samples.

Since self-compassion has repeatedly been proposed as a stress buffer (e.g., Terry, Leary, & Metha, 2012), adding interventions fostering self-compassion to established treatments such as cognitive-behavioral therapy might help to decrease the number of depressive relapses after successful psychotherapies. Also, investigating differential changes in the components of self-compassion in response to various interventions may contribute to the refinement of depression therapy. However, we suspect that a lack of self-compassion represents a more general vulnerability factor for psychopathology, and that a wider range of people may profit from developing more self-compassion.

References

Abler, B., Erk, S., Herwig, U., & Walter, H. (2007). Anticipation of aversive stimuli activates extended amygdala in unipolar depression. *Journal of Psychiatric Research*, *41*, 511–522.

Allen, A. B., & Leary, M. R. (2010). Self-compassion, stress, and coping. *Social and Personality Psychology Compass*, *4*, 107–118.

Baer, R. A., Lykins, E. L. B., & Peters, J. R. (2012). Mindfulness and self-compassion as predictors of psychological well-being in long-term meditators and matched nonmeditators. *The Journal of Positive Psychology*, *7*, 230–238.

Bagby, R. M., & Parker, J. D. A. (2001). Relation of rumination and distraction with neuroticism and extraversion in a sample of patients with major depression. *Cognitive Therapy and Research*, *25*, 91–102.

Barnard, L. K., & Curry, J. F. (2011). Self-compassion: Conceptualizations, correlates, and interventions. *Review of General Psychology*, *15*, 289–303.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for Beck Depression Inventory –Second Edition*. San Antonio, TX: The Psychological Corporation.

Breines, J. G., & Chen, S. (2012). Self-compassion increases self-improvement motivation. *Personality and Social Psychology Bulletin*, *38*, 1133–1143.

Brooks, M., Kay-Lambkin, F., Bowman, J., & Childs, S. (2012). Self-compassion amongst clients with problematic alcohol use. *Mindfulness*, *3*, 308–317.

Buerger, C., & Kuehner, C. (2007). Copingstile im Umgang mit depressiver Stimmung. *Zeitschrift fur Klinische Psychologie und Psychotherapie*, *36*, 36–45.

Burwell, R. A., & Shirk, S. R. (2007). Subtypes of rumination in adolescence: Associations between brooding, reflection, depressive symptoms, and coping. *Journal of Clinical Child and Adolescent Psychology*, *36*, 56–65.

Cichetti, D. V. (1994). Guidelines, criteria, and rules of thumb for evaluating normed and standardized assessment instruments in psychology. *Psychological Assessment*, *6*, 284–290.

Connolly Gibbons, M. B., Crits-Christoph, P., Barber, J. P., Wiltsey Stirman, S., Gallop, R., Goldstein, L. A., Temes, C. M., & Ring-Kurtz, S. (2009). Unique and common mechanisms of change across cognitive and dynamic psychotherapies. *Journal of Consulting and Clinical Psychology*, *77*, 801–813.

Cox, B. J., Enns, M. W., & Taylor, S. (2001). The effect of rumination as a mediator of elevated anxiety sensitivity in major depression. *Cognitive Therapy and Research*, *25*, 525–534.

Ferster, C. B. (1973). A functional analysis of depression. *American Psychologist*, *28*, 857–870.

Fritz, M. S., & MacKinnon, D. P. (2007). Required sample size to detect the mediated effect. *Psychological Science*, *18*, 233–239.

Germer, C. K. (2009). *The mindful path to self-compassion: Freeing yourself from destructive thoughts and emotions*. New York, NY: The Guilford Press.

Gilbert, P. (2010). *Compassion focused therapy: Distinctive features*. East Sussex: Routledge.

Giorgio, J. M., Sanflippo, J., Kleiman, E., Reilly, D., Bender, R. E., Wagner, C. A., Liu, R. T., & Alloy, L. B. (2010). An experiential avoidance conceptualization of depressive rumination: Three tests of the model. *Behaviour Research and Therapy*, *48*, 1021–1031.

Gotlib, I. H., & Hammen, C. L. (2009). *Handbook of depression* (2nd ed.). New York, NY: The Guilford Press.

Gotlib, I. H., & Joormann, J. (2010). Cognition and depression: Current status and future directions. *Annual Review of Clinical Psychology*, *6*, 285–312.

Hu, L., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling: A Multidisciplinary Journal*, *6*, 1–55.

Huffziger, S., Reinhard, I., & Kuehner, C. (2009). A longitudinal study of rumination and distraction in formerly depressed inpatients and community controls. *Journal of Abnormal Psychology*, *118*, 746–756.

Hupfeld, J., & Ruffieux, N. (2011). Validierung einer deutschen Version der Self-Compassion Scale (SCS-D) [Validation of a German version of the Self-Compassion Scale (SCS-D)]. *Zeitschrift fur Klinische Psychologie und Psychotherapie*, *40*, 115–123.

Jacobson, N., Martell, C., & Dimidjian, S. (2001). Behavioral activation treatment for depression: Returning to contextual roots. *Clinical Psychology Science and Practice*, *8*, 255–270.

Joormann, J., Dkane, M., & Gotlib, I. H. (2006). Adaptive and maladaptive components of rumination? Diagnostic specificity and relation to depressive biases. *Behavior Therapy*, *37*, 269–280.

Just, N., Abramson, L. Y., & Alloy, L. B. (2001). Remitted depression studies as tests of the cognitive vulnerability hypotheses of depression onset: A critique and conceptual analysis. *Clinical Psychology Review*, *21*, 63–83.

Just, N., & Alloy, L. B. (1997). The response styles theory of depression: Tests and an extension of the theory. *Journal of Abnormal Psychology*, *106*, 221–229.

Kelly, A. C., Zuroff, D. C., & Shapira, L. B. (2009). Soothing oneself and resisting self-attacks: The treatment of two intrapersonal deficits in depression vulnerability. *Cognitive Therapy and Research*, *33*, 301–313.

Kline, R. B. (2005). *Principles and practice of structural equation modeling* (2nd ed.). New York, NY: The Guilford Press.

Kuehner, C., Bürger, C., Keller, F., & Hautzinger, M. (2007). Reliabilität und Validität des revidierten Beck-Depressionsinventars (BDI-II): Befunde aus deutschsprachigen Stichproben. *Der Nervenarzt*, *78*, 651–656.

Kuehner, C., & Weber, I. (1999). Responses to depression in unipolar depressed patients: An investigation of Nolen-Hoeksema's response styles theory. *Psychological Medicine*, *29*, 1323–1333.

Kuyken, W., Watkins, E., Holden, E., White, K., Taylor, R. S., Byford, S., . . . Dalgleish, T. (2010). How does mindfulness-based cognitive therapy work? *Behaviour Research and Therapy*, *48*, 1105–1112.

Leary, M. R., Tate, E. B., Adams, C. E., Allen, A. B., & Hancock, J. (2007). Self-compassion and reactions to unpleasant self-relevant events: The implications of treating oneself kindly. *Journal of Personality and Social Psychology*, 92, 887–904.

Lewinsohn, P. M. (1974). A behavioral approach to depression. In R. M. Friedman & M.M. Katz (Eds.), *The psychology of depression: Contemporary theory and research*. New York: Wiley.

Lobbestael, J., Leurgans, M., & Arntz, A. (2011). Inter-rater reliability of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID I) and Axis II Disorders (SCID II). *Clinical Psychology & Psychotherapy*, 18, 75–79.

MacBeth, A., & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review*, 545–552.

Manos, R. C., Kanter, J. W., & Busch, A. M. (2010). A critical review of assessment strategies to measure the behavioral activation model of depression. *Clinical Psychology Review*, 30, 547–561.

Mills, A., Gilbert, P., Bellew, R., McEwan, K., & Gale, C. (2007). Paranoid beliefs and self-criticism in students. *Clinical Psychology & Psychotherapy*, 14, 358–364.

Moulds, M. L., Kandris, E., Starr, S., & Wong, A. (2007). The relationship between rumination, avoidance and depression in a non-clinical sample. *Behaviour Research and Therapy*, 45, 251–261.

Neff, K. D. (2003a). The development and validation of a scale to measure self-compassion. *Self and Identity*, 2, 223–250.

Neff, K. D. (2003b). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity*, 2, 85–101.

Neff, K. D. (2012). The science of self-compassion. In C. K. Germer & R. Siegel (Eds.), *Compassion and wisdom in psychotherapy* (pp. 79–92). New York, NY: Guilford Press.

Neff, K. D., & Germer, C. K. (2012). A pilot study and randomized controlled trial of the mindful self-compassion program. *Journal of Clinical Psychology*, 69, 28–44.

Neff, K. D., Hsieh, Y. P., & Dejitterat, K. (2005). Self-compassion, achievement goals, and coping with academic failure. *Self and Identity*, 4, 263–287.

Neff, K. D., Kirkpatrick, K. L., & Rude, S. S. (2007). Self-compassion and adaptive psychological functioning. *Journal of Research in Personality*, 41, 139–154.

Neff, K. D., & Vonk, R. (2009). Self-compassion versus global self-esteem: Two different ways of relating to oneself. *Journal of Personality*, 77, 23–50.

Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressive episodes. *Journal of Abnormal Psychology*, 100, 569–582.

Ottenbreit, N. D., & Dobson, K. S. (2004). Avoidance and depression: The construction of the Cognitive-Behavioral Avoidance Scale. *Behaviour Research and Therapy*, 42, 293–313.

Ottenbreit, N. D., & Dobson, K. S. (2008). Avoidance. In K. S. Dobson & D.J.A. Dozois (Eds.), *Risk factors in depression* (pp. 447–470). San Diego, CA: Elsevier Academic Press.

Preacher, K. J., & Hayes, A. F. (2008). Asymptotic and resampling strategies for assessing and comparing indirect effects in multiple mediator models. *Behavior Research Methods*, 40, 879–891.

R Development Core Team. (2011). *R Foundation for Statistical Computing. Vienna, Austria*.

Raes, F. (2010). Rumination and worry as mediators of the relationship between self-compassion and depression and anxiety. *Personality and Individual Differences*, 48, 757–761.

Rimes, K. A., & Watkins, E. (2005). The effects of self-focused rumination on global negative self-judgements in depression. *Behaviour Research and Therapy*, 43, 1673–1681.

Roberts, J. E., Gilboa, E., & Gotlib, I. H. (1998). Ruminative response style and vulnerability to episodes of dysphoria: Gender, neuroticism, and episode duration. *Cognitive Therapy and Research*, 22, 401–423.

Roelofs, J., Huibers, M., Peeters, F., Arntz, A., & van Os, J. (2008). Rumination and worrying as possible mediators in the relation between neuroticism and symptoms of depression and anxiety in clinically depressed individuals. *Behaviour Research and Therapy*, 46, 1283–1289.

Roethlin, P., Grosse Holtforth, M., Bergomi, C., Berking, M., & Caspar, F. (2010). Vermeidung und Depression: Die psychometrische Evaluation der deutschen Version der "Cognitive-Behavioral Avoidance Scale (CBAS)". *Diagnostica*, 56, 46–55.

Rosseel, Y. (2012). lavaan: An R Package for Structural Equation Modeling. *Journal of Statistical Software*, 48, 1–36.

Sbarra, D. A., Smith, H. L., & Mehl, M. R. (2012). When leaving your ex, love yourself: Observational ratings of self-compassion predict the course of emotional recovery following marital separation. *Psychological Science*, 23, 261–269.

Shahar, B., Carlin, E. R., Engle, D. E., Hegde, J., Szepsenwol, O., & Arkowitz, H. (2012). A pilot investigation of emotion-focused two-chair dialogue intervention for self-criticism. *Clinical Psychology and Psychotherapy*, 19, 496–507.

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, 377–389.

Smith, J. M., & Alloy, L. B. (2009). A roadmap to rumination: A review of the definition, assessment, and conceptualization of this multifaceted construct. *Clinical Psychology Review*, 9, 116–128.

Spasojevic, J., & Alloy, L. B. (2001). Rumination as a common mechanism relating depressive risk factors to depression. *Emotion*, 1, 25–37.

Terry, M. L., Leary, M. R., & Metha, S. (2012). Self-compassion as a buffer against homesickness, depression, and dissatisfaction in the transition to college. *Self and Identity*, 1–13.

Trew, J. L. (2011). Exploring the roles of approach and avoidance in depression: an integrative model. *Clinical Psychology Review*, 31, 1156–1168.

Treynor, W., Gonzalez, R., & Nolen-Hoeksema, S. (2003). Rumination reconsidered: A psychometric analysis. *Cognitive Therapy and Research*, 27, 247–259.

Van Dam, N. T., Sheppard, S. C., Forsyth, J. P., & Earleywine, M. (2011). Self-compassion is a better predictor than mindfulness of symptom severity and quality of life in mixed anxiety and depression. *Journal of Anxiety Disorders*, 25, 123–130.

Watkins, E. R. (2008). Constructive and unconstructive repetitive thought. *Psychological Bulletin*, 134, 163–206.

Watkins, E. R., & Moulds, M. L. (2007). Reduced concreteness of rumination in depression: A pilot study. *Personality and Individual Differences*, 43, 1386–1395.

Werner, K. H., Jazaieri, H., Goldin, P. R., Ziv, M., Heimberg, R. G., & Gross, J. J. (2011). Self-compassion and social anxiety disorder. *Anxiety, Stress, & Coping*, 25, 543–558.

Wisco, B. E., & Nolen-Hoeksema, S. (2008). Ruminative response style. In K. S. Dobson & D.J.A. Dozois (Eds.), *Risk factors in depression* (pp. 221–236). San Diego, CA: Elsevier Academic Press.

Wittchen, H. -U., Wunderlich, U., Gruschwitz, S., & Zaudig, M. (1997). *Strukturiertes Klinisches Interview fur DSM-IV, Achse I (SKID)*. Göttingen: Hogrefe.

Wong, C. C. Y., & Mak, W. W. S. (2013). Differentiating the role of three self-compassion components in buffering cognitive-personality vulnerability to depression among Chinese in Hong Kong. *Journal of Counseling Psychology*, *60*, 162–169.

Ying, Y. W. (2009). Contribution of self-compassion to competence and mental health in social work students. *Journal of Social Work Education*, *45*, 309–323.