

The Relationships Between Psychological Flexibility, Self-Compassion, and Emotional Well-Being

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Despite theoretical overlap between self-compassion and psychological flexibility, empirical links between these constructs is limited. This study examined the relationships between psychological flexibility, self-compassion, and emotional well-being to add to the literature on understanding the importance of self-compassion as a possible contributor to mental health, adding support to continuing development of compassion-based therapies. Relationships among these constructs were explored using survey data from a sample of 144 university psychology students (110 females and 34 males, aged 17–60 years). Self-compassion was significantly correlated with psychological flexibility processes, including mindful acceptance, defusion, and emotional well-being. Regression analyses indicated that self-compassion predicts significant unique variance above and beyond psychological flexibility across various indices of emotional well-being. These findings support the association between psychological flexibility, self-compassion, and emotional well-being, with implications for 3rd-wave models of therapy, including acceptance and commitment therapy (ACT) and compassion-based approaches. Therapies incorporating compassion processes may potentially lead to improved treatment outcomes.

Keywords: psychological flexibility; self-compassion; acceptance and commitment therapy (ACT); emotional well-being

About 30% of the global population is affected by a mental disorder in a given year, the most common being mood, anxiety, and substance use disorders (Ngui, Khasakhala, Ndeti, & Roberts, 2010). This incidence is increasing (Pauley & McPherson, 2010), and depression is predicted to be the greatest health concern by 2030 (World Health Organization, 2008). Although established treatments such as medication and psychotherapy have made strong gains over the past two decades, there are clinical problems viewed as treatment resistant, and it has been argued that there is much room for improvement (Norcross, Hogan, & Koocher, 2008; O'Donohue & Fisher, 2006). Furthermore, the limitations of biomedical treatments for psychological problems are becoming well documented, adding an impetus for improvements in treatment to come from psychosocial approaches (Deacon, 2013).

This has spurred interest in further understanding newer psychotherapeutic approaches to improve treatment efficacy and effectiveness. This movement toward improving and building on traditional cognitive behavioral therapy (CBT) has led to what some have termed the *third wave* of behavior therapy. Whereas the *second wave* of behavior therapy introduced the importance of negative meaning making processes (cognition) in the maintenance of clinical problems and integrated it with behavior therapy principles to develop “CBT,” the third wave refers to therapies which emphasize the importance of how one *relates* to cognitions and emotions over the *content* (Pérez-Álvarez, 2012). The third wave includes approaches such as acceptance and commitment therapy (ACT; Hayes, Luoma, Bond, Masuda, & Lillis, 2006) and compassion-focused therapy (CFT; Gilbert, 2009).

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

Although third wave therapies are relatively new, there is a growing body of evidence for their support. According to relational frame theory (RFT; Hayes et al., 2006), psychological flexibility is defined as being consciously present and changing or persisting in valued behavior (Hayes et al., 2006). It includes six components: mindfulness (contact with the present moment), defusion (detachment from thoughts), acceptance (nonjudgmental allowance of inner experience), self as context (observing self), values, and committed action. Conversely, inflexibility is linked to emotional distress, such as anxiety and depression. The RFT of psychopathology posits that psychological inflexibility arises from unhelpful contextual control over cognition and language processes (Hayes et al., 2006). It is purported that mental health is affected more by how individuals relate to their thoughts and feelings than their form. RFT is one of the most researched third wave theories with more than 70 empirical studies (Hayes et al., 2006; Pull, 2008). It is thought that mood disorders may share underlying core processes, such as rigid and excessive attempts to avoid experiencing unpleasant or painful emotions and cognition. According to third-wave therapies, such as ACT, acceptance of unpleasant experience is more helpful than attempts to directly control inner events. Furthermore, there is a growing focus on compassion processes and understanding their role in improving mental health (Harris, 2012). It is thought that compassionate acceptance of internal experience is an important factor in emotional well-being.

SELF-COMPASSION IN PSYCHOTHERAPY

Self-compassion is a relatively new concept in Western psychology. It has been defined as extending compassion toward oneself, with three key components: mindfulness, self-kindness, and a sense of common humanity (Neff, 2003). Self-compassion has been shown to correlate positively with happiness and life satisfaction (Neely, Schallert, Mohammed, Roberts, & Chen, 2009), positive affect (Leary, Tate, Adams, Allen, & Hancock, 2007), optimism (Neff, Kirkpatrick, & Rude, 2007), and acceptance (Neff, Hsieh & Dejitterat, 2005). Conversely, research suggests that self-compassion correlates negatively with anxiety and depression (Raes, 2010), negative affect (Leary et al., 2007), rumination, emotional suppression, and avoidance (Neff et al., 2005; Thompson & Waltz, 2008).

Compassion-based therapies include CFT (Gilbert, 2010) and the mindful self-compassion (MSC) program (Neff & Germer, 2012). CFT encourages cultivation of self-kindness through language and behavior. The goal of CFT is to help patients hold their self-critical beliefs with a sense of warmth and self-acceptance. Initial research has demonstrated significant decreases in depression, self-attacking, shame, and feelings of inferiority (Gilbert & Procter, 2006). MSC is an 8-week program designed to train people to be more self-compassionate. It includes a range of

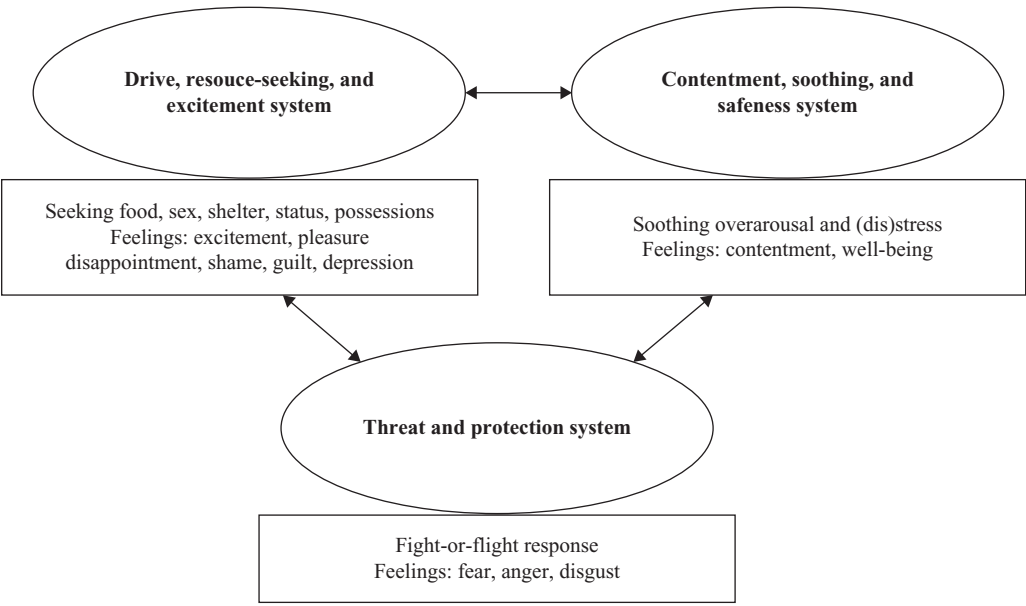


FIGURE 1. Emotion regulation systems. Adapted from Gilbert, P. (2009). *The compassionate mind: A new approach to life's challenges*. London, United Kingdom: New Harbinger.

experiential self-compassion practices, providing clients with tools to alleviate emotional distress. A randomized controlled trial (RCT) of the MSC program showed significant increases in self-compassion, mindfulness, and well-being, with gains maintained at 6-month and 1-year follow-ups (Neff & Germer, 2012).

Compassion-based therapies are underpinned by theories of affect regulation and attachment. Psychopathology is thought to be caused by imbalance in our three emotion regulation systems (Figure 1): *threat and protection system*, *drive, resource-seeking, and excitement system*; and *contentment, soothing, and safeness system* (Gilbert, 2009).

Heightened sensitivity and overactivity of the threat and/or drive systems is common in individuals with high shame and self-criticism. It is thought that they have an inability to access the soothing system, resulting in difficulties feeling content or safe within themselves or interpersonal relationships. Compassion-based therapies focus on developing self-compassion to activate the soothing system and balance overactive threat/drive systems. Initial research shows promising results for compassion-based therapies (Gilbert, 2009; Neff & Germer, 2012).

SELF-COMPASSION AND PSYCHOLOGICAL FLEXIBILITY

Given encouraging results from early studies into self-compassion, there is growing interest in understanding the relationship between compassion and mental health. However, because the concept of self-compassion has only emerged in psychological literature in the last few years, there is not a large body of evidence for understanding its role in psychological well-being. Furthermore, there is a dearth of research on the relationship between psychological flexibility and self-compassion, despite the crossover between the two constructs. Only a handful of studies have demonstrated correlations between self-compassion and aspects of psychological flexibility. For example, Neff and colleagues (2007), in their study of 40 American college students, showed that self-compassion is negatively associated with maladaptive psychological functioning.

Sahdra, Shaver, and Brown (2010) studied 331 American students and demonstrated that self-compassion is positively related to nonattachment. Martin, Staggars, and Anderson (2011) found that self-compassion is positively related to cognitive flexibility. Some limitations of these studies included a predominance of female participants (67%–95%), skew to young adults (18–25 years), nonclinical samples, and in one case a small sample size $n = 40$ (Neff et al., 2007).

Only one study performed regression analyses to provide interaction data between self-compassion and mindfulness in the prediction of emotional distress. However, this included mindfulness only, and not other aspects of psychological flexibility (e.g., defusion, acceptance). Van Dam, Sheppard, Forsyth, and Earleywine (2011) surveyed 504 participants, aged 18–73 years, and found that self-compassion is positively correlated with mindfulness and that self-compassion is a better predictor than mindfulness of emotional distress. A limitation of this study was a predominance of White participants.

THE CURRENT STUDY

Although psychological flexibility is well researched, its relationship with self-compassion has not been well studied. Thus, there is an opportunity to build on current understanding of self-compassion and its relationship with third-wave models such as psychological flexibility. This will aid theoretical understanding of third-wave therapies and how they may contribute to improved treatment outcomes.

It is expected that this study will (a) add to the limited research base on the relationship between self-compassion and various aspects of psychological flexibility, including defusion and acceptance; (b) explore the interaction between self-compassion and psychological flexibility in the prediction of emotional distress; (c) add to the literature on understanding the importance of self-compassion as a possible contributor to mental health, adding support to continuing development of compassion-based therapies. Three research questions are proposed to examine the relationships between psychological flexibility, self-compassion, and emotional well-being: (a) What is the relationship between self-compassion and psychological flexibility? (b) What are the relationships between self-compassion and separate processes of psychological flexibility (i.e., defusion, mindful acceptance, values) and emotional well-being? and (c) To what degree does self-compassion predict variance in indices of emotional well-being beyond flexibility? These research questions are explored with a cross-sectional correlational design to determine the relationship between variables.

METHOD

Participants

Participants were 144 psychology students aged between 17 and 60 years (mean age range = 17–25 years). There were 110 females and 34 males, of whom 43% reported White ethnicity, 26% Asian, 18% Middle Eastern, and 13% other. Previous educational attainment included 75% with high school certificate, 12% technical and further education (TAFE) diploma, 10% undergraduate degree, and 3% postgraduate degree. All participants were enrolled in a psychology degree at the University of Western Sydney.

Procedure

Participants were recruited online, completing an anonymous online survey, participating voluntarily and could withdraw at any stage without penalty. The survey included 11 measures as

outlined in the following text. Demographic questions probing age, gender, ethnicity, and previous academic attainment were also included in the questionnaire. The survey took approximately 30 min. to complete, and students were given credit toward their course grade for their participation. Prior to data collection, the G*Power calculator 3.1.7 (Faul, Erdfelder, Buchner, & Lang, 2009) was used to estimate a required minimum sample size of approximately 84 participants for correlational analyses and 68 participants for regression analyses to detect a medium effect size with power at .80 and $\alpha = .05$.

Analytic Plan

The study was a cross-sectional design using correlation and multiple regression analyses to measure the relationships between psychological flexibility processes, self-compassion, and indices of emotional well-being and distress. Independent variables included psychological flexibility (Acceptance and Action Questionnaire-II), self-compassion (Self-Compassion Scale-Short Form), defusion (Drexel Defusion Scale and Cognitive Fusion Questionnaire), mindful awareness and acceptance (Philadelphia Mindfulness Scale), and values (Meaning in Life Questionnaire and Valuing Questionnaire). Dependent variables included emotional distress (Depression Anxiety Stress Scales–21), and emotional well-being (Satisfaction With Life Scale and Rosenberg Self-Esteem Scale). To explore Research Questions 1 and 2, Pearson's r correlations were calculated for all variables to determine relationships between psychological flexibility, self-compassion, and measures of emotional well-being. To explore Research Question 3, regression analyses were used to determine whether self-compassion contributed significant variance to emotional well-being, above and beyond psychological flexibility.

Process Measures

Psychological Flexibility. The Acceptance and Action Questionnaire-II (AAQ-II; Bond et al., 2011) is a 7-item self-report scale that measures psychological inflexibility (experiential avoidance). Participants rate the degree to which worry and emotional distress interferes with their life. Items are rated on an 8-point scale ranging from 0 (*never true*) to 7 (*always true*). Mean reliability has been reported as .84 in postgraduate and community samples (Bond et al., 2011). The AAQ-II has also been shown to have satisfactory validity and appears to measure the same construct as the Acceptance and Action Questionnaire-I (AAQ-I; $r = .97$), but with better psychometric consistency.

Defusion. The Drexel Defusion Scale (DDS; Forman et al., 2012) is a 10-item self-report scale that measures defusion. Participants rate the degree to which they usually fuse with thoughts and feelings. Items are rated on a 6-point scale ranging from 0 (*not at all*) to 5 (*very much*). The DDS has demonstrated good reliability with Cronbach's alpha reported to be .80 (Forman et al., 2012). It has been shown to have satisfactory incremental validity and high convergent validity (correlated with measures of acceptance and decentering).

A second measure of defusion was also used: the Cognitive Fusion Questionnaire (CFQ; Gillanders et al., 2014). It is a 7-item self-report scale measuring the degree of fusion with thoughts and feelings. Items are rated on a 7-point scale ranging from 1 (*never true*) to 7 (*always true*). The CFQ has been shown to have excellent internal consistency with reported Cronbach's alpha of .81. It has been demonstrated to have satisfactory construct and incremental validity (Gillanders et al., 2014).

Mindfulness. The Philadelphia Mindfulness Scale (PHLMS; Cardaciotto, Herbert, Forman, Moitra, & Farrow, 2008) is a 20-item self-report scale, with two subscales measuring present-moment awareness and nonjudgmental acceptance. Participants rate their awareness and acceptance of internal experience. Items are rated on a 5-point scale ranging from 1 (*never*)

to 5 (*very often*). The PHLMS subscales have been shown to have very good reliability, with Cronbach's alphas of .86 for the Awareness subscale and .91 for the Acceptance subscale. The Awareness subscale is considered to have good convergent validity, correlating with scales measuring awareness, attention, and reflection. The Acceptance subscale is also considered to have good convergent validity, correlating with scales measuring awareness and willingness.

Self-Compassion. The Self-Compassion Scale-Short Form (SCS-SF; Raes, Pommier, Neff, & Van Gucht, 2011) is a 12-item self-report scale measuring six facets of self-compassion: self-kindness, self-judgment, common humanity, isolation, mindfulness, and overidentification. Participants rate their level of self-compassion with items rated on a 5-point scale ranging from 1 (*almost never*) to 5 (*almost always*). The scale has demonstrated strong reliability with Cronbach's alpha reported to be .86 (Raes et al., 2011). It has also been shown to have satisfactory validity and appears to measure the same concept as the long form ($r = .98$; English version; Raes et al., 2011).

Values. The Valuing Questionnaire (VQ; Smout, Davies, Burns, & Christie, 2014) is a 10-item self-report scale measuring valued living, with two subscales: Progress and Obstruction. Participants rate their degree of progress toward valued goals and level of perseverance despite obstruction. Items are rated on a 7-point scale ranging from 0 (*not at all true*) to 6 (*completely true*). Higher scores on the Progress subscale indicate greater levels of living consistently with values. Higher scores on the Obstruction subscale indicate greater levels of living inconsistently with values. The scales are considered to have good internal consistency with reported reliabilities of .81 for the Progress subscale and .79 for the Obstruction subscale (Smout et al., 2014). It has also demonstrated good convergent validity.

Meaning. The Meaning in Life Questionnaire (MLQ; Steger, Frazier, Oishi, & Kaler, 2006) is a 10-item self-report scale measuring (a) Presence of meaning in life and (b) Search for meaning. Participants are asked to rate the degree of presence or search for meaning in their lives. Items are rated on a 7-point scale ranging from 1 (*absolutely untrue*) to 7 (*absolutely true*). The MLQ has demonstrated good internal consistency for both the Presence and Search for Meaning subscales with Cronbach's alphas of .86 and .87, respectively. It has been shown to have satisfactory convergent and discriminant validity (Steger et al., 2006).

Outcome Measures

Emotional Distress. The Depression Anxiety Stress Scales–21 (DASS-21) is a short version of the Depression Anxiety Stress Scales (DASS-42) measure developed by Lovibond and Lovibond (1996) to assess psychological distress. The scale comprises 21 items assessing participants over the past week on three subscales: Depression, Anxiety, and Stress. Individuals are rated on a 4-point scale ranging from 0 (*did not apply to me at all*) to 3 (*applied to me very much or most of the time*). The subscales have been demonstrated to have good reliability, with Cronbach's alphas of .85 for Depression, .81 for Anxiety, and .88 for Stress (Osman et al., 2012). The DASS-21 has been shown to have satisfactory validity, correlating with other measures of mixed depression and anxiety.

Emotional Well-Being. Two measures were used to assess emotional well-being: the Satisfaction With Life Scale (SWLS) and the Rosenberg Self-Esteem Scale (RSES). The SWLS (Diener, Emmons, Larsen, & Griffin, 1985) is a 5-item self-report scale that measures life satisfaction. Items are rated on a 7-point scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). The scale has been shown to have good reliability .87 and satisfactory validity (Diener et al., 1985).

The RSES (Rosenberg, 1965) is a 10-item self-report scale measuring self-esteem. Items are rated on a 4-point scale ranging from *strongly agree* to *strongly disagree*. The scale has been demonstrated to have excellent internal consistency with Cronbach's alpha .96 and satisfactory validity (Gray-Little, Williams, & Hancock, 1997).

TABLE 1. MEANS, STANDARD DEVIATIONS, RELIABILITIES (α), AND CONFIDENCE INTERVALS FOR MEASURES OF PSYCHOLOGICAL FLEXIBILITY, SELF-COMPASSION, AND EMOTIONAL WELL-BEING AND DISTRESS

Measures	<i>M</i> (<i>SD</i>)	α	95% CI
1. AAQ-II psychological inflexibility	24.64 (10.15)	.914	[22.48, 26.81]
2. SCS-SF self-compassion	34.71 (6.59)	.764	[33.31, 36.12]
3. PHLMS nonjudgmental acceptance	25.53 (7.36)	.852	[23.96, 27.10]
4. PHLMS mindful awareness	36.18 (6.17)	.819	[34.87, 37.50]
5. DDS defusion	34.86 (8.38)	.821	[33.08, 36.65]
6. CFQ defusion	26.52 (10.21)	.930	[24.34, 28.69]
7. VQ progress subscale	22.09 (5.97)	.831	[20.82, 23.36]
8. VQ Obstruction subscale	19.24 (6.15)	.785	[17.93, 20.55]
9. MLQ search for meaning	24.24 (6.12)	.886	[22.94, 25.55]
10. MLQ presence of meaning	22.97 (6.77)	.915	[21.52, 24.41]
11. SWLS satisfaction with life	21.15 (6.36)	.884	[19.80, 22.51]
12. RSES self-esteem	27.15 (5.74)	.909	[25.93, 28.37]
13. DASS-21 depression	14.14 (5.49)	.919	[12.97, 15.31]
14. DASS-21 anxiety	14.62 (5.18)	.844	[13.52, 15.73]
15. DASS-21 stress	15.67 (4.70)	.858	[14.67, 16.67]

Note. α refers to Cronbach's α . AAQ-II = Acceptance and Action Questionnaire-II; SCS-SF = Self-Compassion Scale-Short Form; PHLMS = Philadelphia Mindfulness Scale; DDS = Drexel Defusion Scale; CFQ = Cognitive Fusion Questionnaire; VQ = Valuing Questionnaire; MLQ = Meaning in Life Questionnaire; SWLS = Satisfaction With Life Scale; RSES = Rosenberg Self-Esteem Scale. DASS-21 = Depression Anxiety Stress Scales-21.

RESULTS

Data were analyzed using the IBM Statistical Package for Social Sciences. The dataset was initially checked for missing and duplicate data. Bivariate and residual plots revealed no outliers. In tests of normality, none of the variables exhibited significant skewness or kurtosis. Reliability was checked for all scales demonstrating adequate reliability, with Cronbach's alphas ranging from .76 to .93 (Table 1). Descriptive statistics, including means and standard deviations, were also calculated. Gender was not significantly correlated with any of the variables.

Correlational Analyses

To explore Research Questions 1 and 2, Pearson's r correlations were calculated for all variables and corrected for attenuation, as presented in Table 2. Self-compassion was significantly negatively correlated with psychological inflexibility (AAQ-II, $r = -.574, p = .000$). Self-compassion was significantly positively correlated with various processes of psychological flexibility, including mindful acceptance (PHLMS Acceptance, $r = .391, p = .000$), defusion (DDS, $r = .547, p = .000$; CFQ, $r = .630, p = .000$), and valued living (VQ Progress, $r = .701, p = .000$; $r = .526, p = .000$; MLQ Presence, $r = .465, p = .000$). There was also a significant positive relationship between self-compassion and aspects of emotional well-being, including life satisfaction ($r = .550, p = .000$) and self-esteem ($r = .670, p = .000$). Conversely, there was significant negative correlation between self-compassion and indices of emotional distress, including depression (DASS-21 Depression, $r = -.552, p = .000$), anxiety (DASS-21 Anxiety, $r = -.353, p = .000$), and stress (DASS-21 Stress, $r = -.515, p = .000$).

TABLE 2. CORRECTED BIVARIATE CORRELATIONS BETWEEN VARIABLES OF PSYCHOLOGICAL FLEXIBILITY, SELF-COMPASSION, AND EMOTIONAL WELL-BEING AND DISTRESS

Measures	Self-Compassion (SCS-SF)
1. AAQ-II psychological inflexibility	−.574**
2. PHLMS nonjudgmental acceptance	.391**
3. PHLMS mindful awareness	.171
4. DDS defusion	.547**
5. CFQ defusion	.630**
6. VQ Progress subscale	.701**
7. VQ Obstruction subscale	−.546**
8. MLQ search for meaning	−.166
9. MLQ presence of meaning	.465**
10. SWLS satisfaction with life	.550**
11. RSES self-esteem	.670**
12. DASS-21 depression	−.552**
13. DASS-21 anxiety	−.353**
14. DASS-21 stress	−.515**

Note. SCS-SF = Self-Compassion Scale-Short Form; AAQ-II = Acceptance and Action Questionnaire-II; PHLMS = Philadelphia Mindfulness Scale; DDS = Drexel Defusion Scale; CFQ = Cognitive Fusion Questionnaire; VQ = Valuing Questionnaire; MLQ = Meaning in Life Questionnaire; SWLS = Satisfaction With Life Scale; RSES = Rosenberg Self-Esteem Scale. DASS-21 = Depression Anxiety Stress Scales–21.

** $p = .000$.

No significant correlation was found between self-compassion and mindful awareness (PHLMS Mindful awareness, $r = .171$, $p = .082$). Neither was there a significant relationship between self-compassion and search for meaning in life ($r = -.166$, $p = .089$).

Regression Analyses

To explore Research Question 3, regression analyses were used. Assumptions of linearity and normality required for analysis were met. Results of the regression analyses are shown in Table 3. A two-step hierarchical model revealed that psychological flexibility (AAQ-II entered at Step 1) and self-compassion (SCS-SF entered at Step 2) accounted for a significant amount of variance in indices of emotional well-being (i.e., life satisfaction) and distress (i.e., depression and stress), as outlined in the following text. Self-compassion predicted 6.7% significant unique variance above and beyond psychological flexibility (AAQ-II) for life satisfaction (SWLS), $R^2 = .067$, $F(1, 138) = 13.865$, $p = .000$. Self-compassion also predicted significant but modest unique variance above and beyond psychological flexibility (AAQ-II) for depression (DASS-21 Depression), $R^2 = .030$, $F(1, 138) = 7.711$, $p = .006$, and stress (DASS-21 Stress), $R^2 = .025$, $F(1, 138) = 6.094$, $p = .015$. However, self-compassion was not shown to be a significant predictor above and beyond psychological flexibility for anxiety (DASS-21 Anxiety), $R^2 = .000$, $F(1, 138) = .003$, $p = .954$.

TABLE 3. REGRESSION OF PSYCHOLOGICAL FLEXIBILITY (AAQ-II, STEP 1) AND SELF-COMPASSION (SCS-SF, STEP 2) ON LIFE SATISFACTION (SWLS) AND DEPRESSION, ANXIETY, AND STRESS (DASS-21)

Predictor	R ² Change	F Change	Sig. <i>p</i> Change
Psychological flexibility (AAQ-II) as predictor (Step 1)			
SWLS	.263***	49.502	.000
DASS-21 depression	.436**	107.504	.006
DASS-21 anxiety	.359***	77.737	.000
DASS-21 stress	.404*	94.395	.015
Self-compassion (SCS-SF) as predictor (Step 2)			
SWLS	.067***	13.865	.000
DASS-21 depression	.030**	7.711	.006
DASS-21 anxiety	.000	0.003	.954
DASS-21 stress	.025*	6.094	.015

Note. AAQ-II = Acceptance and Action Questionnaire; SCS-SF = Self-Compassion Scale-Short Form; SWLS = Satisfaction With Life Scale; DASS-21 = Depression Anxiety Stress Scales–21.
p* < .05. *p* < .01. ****p* = .000.

DISCUSSION

This study aimed to investigate the relationships between psychological flexibility, self-compassion, and indices of emotional distress and well-being. In addressing Research Questions 1 and 2, the results of this study indicate that self-compassion is significantly positively related to psychological flexibility and its separate processes, including nonjudgmental acceptance, defusion, and valued living. It was also shown that there was a significant positive relationship between self-compassion and emotional well-being. Conversely, there was a significant negative correlation between self-compassion and indices of emotional distress, including depression, anxiety, and stress. Thus, self-compassion has been shown to be significantly related to processes of psychological flexibility and emotional distress and well-being. Although there was a link between self-compassion and nonjudgmental acceptance (PHLMS Acceptance subscale), there was no significant correlation between self-compassion and mindful awareness (PHLMS Awareness subscale). This may indicate that self-compassion goes beyond simple awareness of inner experience and may be an important factor in holding painful internal experience. This was demonstrated further with multiple regression analyses to address Research Question 3. Self-compassion predicted significant unique variance above and beyond psychological flexibility for emotional well-being (SWLS) and emotional distress (DASS-21 Depression and Stress). In contrast, self-compassion was not shown to be a significant predictor above and beyond psychological flexibility for anxiety. This may be because of sampling limitations (e.g., use of a university convenience sample and a nonclinical population), and different results may be found in replicated studies with broader populations.

Generally, the results of this study are consistent with the empirical literature, where initial research has demonstrated links between self-compassion and various aspects of psychological flexibility (e.g., Van Dam et al., 2011) and emotional well-being (e.g., Barnard & Curry, 2011; Neff et al., 2007). Hence, this study corroborates earlier findings that self-compassion is significantly correlated with psychological flexibility and emotional well-being. Furthermore, these findings add to the literature demonstrating that self-compassion is a significant predictor of various indices of emotional well-being, above and beyond psychological flexibility.

Limitations

The sample in this study was drawn from a university population and therefore caution would need to be taken in making inferences to clinical populations and the broader community. There is a skew toward females, given the smaller percentage of males in the current sample, which may have impacted results. Replication with wider samples would bolster the generalizability of these results. It is also important to note that this study used several correlations which may result in an increased risk of Type I error because of multiple tests. However, this risk was minimized because the obtained effect sizes resulted in p values of .000. Notwithstanding, the correlations should be read with caution and would benefit from replication in further studies. In addition, because of the cross-sectional nature of this study, any long-term interaction of the variables requires further investigation.

Implications and Future Research

The results of this study reinforce previous findings on the links between self-compassion and various indices of psychological flexibility (e.g., mindfulness, defusion, values, and acceptance) and emotional well-being. Thus, this study adds to the limited research base on this topic. It also provides new evidence that self-compassion contributes unique variance in emotional well-being, above and beyond psychological flexibility. These findings have implications in terms of the existing model of psychological flexibility which currently does not explicitly include self-compassion. Given the significant relationship between self-compassion and well-being, it may be beneficial for aspects of self-compassion to be incorporated into the model and investigated in further research. There are also implications for ACT and other third wave therapies, suggesting there may be benefit in integrating aspects of self-compassion into therapy, given the significant link between self-compassion and well-being. This reinforces the importance of understanding the role of self-compassion as a contributor to mental health, adding support to continuing research and development of compassion-based treatments (e.g., Gilbert, 2009; Neff & Germer, 2012). This may be especially important for individuals high in shame and self-criticism, common in those with a history of abuse, bullying, and neglect (Gilbert, 2009). Self-critical patients have been shown to make less improvement with traditional approaches, such as CBT and biomedical treatment (Barnard & Curry, 2012). Further research into compassion-focused approaches might include exploration into the processes of change and investigation of short- and long-term treatment impact. In addition, given the current findings that there is a strong link between psychological flexibility and well-being, it may be useful for future research to investigate whether aspects of psychological flexibility could be incorporated into compassion-based therapies to improve treatment outcomes.

CONCLUSION

Overall, the results of this study demonstrate that there is a significant positive relationship between self-compassion and various aspects of psychological flexibility, including mindful acceptance, defusion, and valued living. Furthermore, it was shown that self-compassion is a significant predictor of aspects of emotional well-being, above and beyond psychological flexibility. However, replication in future studies is important to support these findings, especially with broader community and clinical samples. The results of this study extend the current empirical base, enhancing understanding on the relationship between psychological flexibility, self-compassion,

and psychological well-being, adding support to continuing development of compassion-based treatments. Additional research into self-compassion and compassion-based treatments would provide deeper understanding of the role of compassion in therapy and potentially lead to improved treatment outcomes.

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