

# Self-Criticism and Depressive Symptoms: Mediating Role of Self-Compassion

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Huaiyu Zhang<sup>1</sup>, Natalie N. Watson-Singleton<sup>2</sup>,  
Sara E. Pollard<sup>3</sup>, Delishia M. Pittman<sup>4</sup>,  
Dorian A. Lamis<sup>5</sup>, Nicole L. Fischer<sup>6</sup>,  
Bobbi Patterson<sup>5</sup>, and Nadine J. Kaslow<sup>5</sup>

## Abstract

Self-compassion is gaining recognition as a resilience factor with implications for positive mental health. This study investigated the role of self-compassion in alleviating the effect of self-criticism on depressive symptoms. Participants were 147 urban, low-income African Americans with a recent suicide attempt. They were administered measures of self-criticism, depressive symptoms, and self-compassion. Results from this cross-sectional investigation showed that self-criticism was positively associated with depressive symptoms and negatively associated with self-compassion, and self-compassion was negatively associated with depressive symptoms. Bootstrapping analysis revealed that self-compassion mediated the self-criticism–depressive symptoms link, suggesting that self-compassion ameliorates the negative impact of self-criticism on depressive symptoms. Our findings suggest that low-income African Americans with recent suicide attempt histories may benefit from interventions that focus on enhancing self-compassion. These results also highlight self-compassion as a positive trait with promise to improve people’s quality of

<sup>1</sup>School of Medicine, University of California, San Francisco, CA, USA

<sup>2</sup>Spelman College, Atlanta, GA, USA

<sup>3</sup>University of Texas Southwestern Medical Center, Dallas, TX, USA

<sup>4</sup>George Washington University, Washington, DC, USA

<sup>5</sup>Emory University School of Medicine, Atlanta, GA, USA

<sup>6</sup>University of Virginia, Charlottesville, VA, USA

## Corresponding Author:

Nadine J. Kaslow, Department of Psychiatry and Behavioral Sciences, Emory School of Medicine, Grady Hospital, 80 Jesse Hill Jr. Drive SE, Atlanta, GA 30303, USA.

Email: [nkaslow@emory.edu](mailto:nkaslow@emory.edu)

life and suggest that self-compassion-focused interventions are consistent with a positive psychology framework.

### **Keywords**

African Americans, suicide, self-compassion, self-criticism, depressive symptoms

Theorists from cognitive developmental, cognitive, and analytic perspectives have argued that there is a strong link between threats to self-integrity and self-esteem and the emergence of depression and depressive symptoms (Beck, 1983; Blatt & Zuroff, 1992). Consistent with these models, research reveals that depressed individuals tend to be intensely self-critical (Lerman, Shahar, & Rudich, 2012), and self-criticism serves as a risk factor for the development of depression and depressive symptoms (Campos, Besser, & Blatt, 2010; Ehret, Joormann, & Berking, 2015; Joeng & Turner, 2015). In keeping with the positive psychology movement (Seligman & Csikszentmihalyi, 2000), it is also critical to study protective factors that can alleviate the impact of self-critical personality disposition on the development of depressive symptoms. There is evidence that high levels of self-esteem and family support can serve such a function (Abela, Fishman, Cohen, & Young, 2012; Shahar, Blatt, & Zuroff, 2007). One additional factor that has garnered recent support as a stress buffer and critical resilience factor with implications for positive psychological functioning and good psychotherapy outcomes is self-compassion (Neff, Rude, & Kirkpatrick, 2007; Terry, Leary, & Mehta, 2013). Given that individuals with depression tend to be high in self-blame and self-criticism and low in self-acceptance and self-soothing, it has been suggested that self-compassion as an alternative to self-judgment may protect against depressive symptoms (Baer, Lykins, & Peters, 2012; Germer, 2009).

Self-compassion, an emotionally positive attitude and relationship to oneself, involves treating oneself with warmth and understanding in problematic life situations, assuming a nonjudgmental stance toward one's own emotional suffering and personal weaknesses, and conceptualizing one's own experiences as being in accord with the larger human experience (Neff, 2003). It is defined as being impacted by and receptive to one's own suffering and invested in freeing oneself from this pain through loving kindness. Self-compassion comprises three mutually strengthening dimensional qualities: self-kindness (vs. self-judgment), common humanity (vs. isolation), and mindfulness (vs. overidentification). Self-kindness refers to the ability to view oneself with caring rather than excessive self-criticism in the face of difficult life circumstances. It is similar to the humanistic construct of unconditional positive self-regard but distinct in that the basis for self-kindness comes from shared humanity without separating the self from others. Common humanity is a worldview that recognizes the universality of

suffering and imperfection common to all humans, which enables a nonjudgmental perspective in the face of failure or adversity. Mindfulness reflects the capacity to observe unpleasant feelings and events in the present moment without avoiding or ruminating about them.

Self-criticism is closely linked to all three dimensions of self-compassion, particularly the self-kindness versus self-judgment dimension (Barnard & Curry, 2011). The concept of self-judgment, which means being relentlessly judgmental and critical of oneself and causing self-inflicted mental suffering beyond the challenges of the situation, is often used interchangeably with self-criticism (Germer, 2009). In contrast, self-kindness involves a kind, forgiving, and accepting stance toward oneself, with the understanding that oneself deserves love and empathy despite weaknesses and failures (Neff, 2003). Thus, being self-kind means being empathic toward one's behavior, thoughts, and feelings, including being compassionately aware of self-judgmental and self-critical thoughts. In addition to the conceptual and empirical connections between self-criticism and self-compassion, the fact that interventions that foster self-compassion result in improved self-kindness, increased tolerance of negative internal events, and reductions in self-criticism (Gilbert & Procter, 2006; Leary, Tate, Adams, Allen, & Hancock, 2007; Lucre & Corten, 2013) provides further support to the association between these two constructs. Thus, self-compassion appears to be a beneficial alternative to self-criticism.

Given the implications of self-compassion for positive well-being (Barnard & Curry, 2011; Brienes & Chen, 2012; Kelly, Carter, Zuroff, & Borairi, 2013; Neff, 2012; Terry et al., 2013; Webb & Forman, 2013; Werner et al., 2012; Wren et al., 2012; Yarnell & Neff, 2013), the relation between self-compassion and depressive symptoms has been studied extensively. A recent meta-analysis revealed a large overall effect size ( $r = -.52$ ) for the relation between self-compassion and depressive symptoms (MacBeth & Gumley, 2013). Never-depressed individuals show higher levels of self-compassion than both currently and remitted depressed individuals, even when controlling for depressive symptoms (Ehret et al., 2015; Krieger, Altenstein, Baettig, Doerig, & Holtfort, 2013). Depressive symptoms tend to be inversely related to the positive aspects of self-compassion and directly related to the negative aspects of self-compassion, with the latter associations stronger in magnitude than the former (Barnard & Curry, 2011). In addition, positive changes in terms of the amelioration of depressive symptoms are associated with the self-kindness, self-judgment, mindfulness, and isolation aspects of self-compassion (Brooks, Kay-Lambkin, Bowman, & Childs, 2012; Van Dam, Sheppard, Forsyth, & Earlywire, 2010). Moreover, self-compassion relates to less symptom-focused rumination and less cognitive and behavioral avoidance, both of which mediate the link between low self-compassion and depressive symptoms (Krieger et al., 2013; Raes, 2010). In intervention studies, changes in self-compassion show favorable effects on depressive symptoms

(Kuyen et al., 2010; Shahar et al., 2012). Moreover, interventions that promote mindfulness, one element of self-compassion, are useful in reducing depressive symptoms (Ma & Teasdale, 2004).

Increasingly, investigators have examined the bivariate associations among self-criticism, self-compassion, and depressive symptoms. Only recently have there been efforts to understand interrelations among these variables. In a European American sample, self-criticism and self-compassion demonstrated unique predictive ability with regard to both current and remitted depression status, beyond that of depressive symptoms and correlates of major depressive disorder (e.g., perfectionistic belief and cognitions, rumination, and overall adaptive emotion regulation; Ehret et al., 2015). In other words, increased levels of self-criticism and decreased levels of self-compassion place people at increased risk for experiencing major depressive disorder repeatedly or chronically. In addition, in an online survey study with college students (less than 2% of whom were African American), self-compassion partially mediated the links between both internalized and comparative self-criticism and depressive symptoms (Joeng & Turner, 2015).

Much of the research relies upon college student and ethnically homogeneous samples (Barnard & Curry, 2011). With few exceptions (Ehret et al., 2015), research is lacking for clinical samples, such as suicide attempters who have high levels of depressive symptoms (Bagge, Lamis, Nadorff, & Osman, 2014; Carr et al., 2013; Trivedi et al., 2013). While some studies with specific cultural groups (Ghorbani, Watson, Chen, & Norballa, 2012; Wong & Mak, 2013) have found that higher levels of self-compassion are linked to lower levels of psychopathology (e.g., depression), only recently has attention been paid to self-criticism or self-compassion in African Americans and this is only with youth (Pace et al., 2013; Reddy et al., 2013). In addition, the data on positive psychology constructs in African Americans are sparse (Mattis et al., 2016). This is concerning given African Americans' disproportionate exposure to discrimination and other life stresses (Perry, Harp, & Oser, 2013) and the association between oppression, discrimination, and depression in this population (Carr, Szymanski, Taha, West, & Kaslow, 2014). Moreover, given that mindfulness and self-compassion-based approaches have been recommended for African Americans (Woods-Giscombé & Black, 2010), the relevance of this construct for this population deserves examination.

Guided by a positive psychology framework (Csikszentmihalyi, 2014; Seligman & Csikszentmihalyi, 2000; Seligman, Linley, & Joseph, 2004) and the aforementioned research, we investigated the cross-sectional associations among self-criticism, self-compassion, and depressive symptoms in urban, low-income African American men and women with a recent suicide attempt. We proposed the following hypotheses: (a) self-criticism would be positively associated with depressive symptoms; (b) self-criticism would be negatively

associated with self-compassion; (c) self-compassion would be negatively associated with depressive symptoms; and most importantly, (d) self-compassion would mediate the self-criticism–depressive symptoms link. Enriching our understanding of the relations among these constructs and the mediating role of self-compassion in a clinical and understudied population of adults can shed light on the relevance of self-compassion in this population. The results also may inform the development and implementation of positive psychology-focused interventions designed to ameliorate depressive symptoms and enhance subjective and psychological well-being (Bolier et al., 2013) in African Americans, particularly those at high risk for suicide.

## **Method**

### *Participants*

Participants included 147 (74% of those invited to participate) African American adults from a public hospital that provides medical and mental health treatment to low-income individuals. Individuals who self-identified as African American and who had attempted suicide in the previous year were recruited from the emergency room, inpatient units, and outpatient clinics. The demographic information of the participants is shown in Table 1.

### *Procedure*

This study was part of a large, longitudinal treatment outcome study that involved three assessments with each participant including a preintervention, postintervention, and follow-up assessment. This larger study has been approved by the university's Institutional Review Board, as well as the hospital's Research Oversight Committee. Only data collected during the preintervention assessment were included for the current study. At the outset of the first assessment, the Mini-Mental State Exam (Folstein, Folstein, McHugh, & Fanjiang, 2001) and the Nia Psychotic Screen (Zhang et al., 2013) were administered to evaluate cognitive and psychotic states to ensure competence to continue the assessment. Individuals who did not meet minimum requirements for the Mini-Mental State Exam (scores  $\leq 23$ ) or who endorsed significantly high levels of active psychotic symptoms were excluded from further participation ( $n = 5$ , 3%). Participants were paid \$20 at the conclusion of the complete assessment. At the completion of each assessment, all participants were provided with a therapy group list that includes 20 weekly groups. In addition, suicide risk assessments were conducted if needed based on responses to questionnaires or self-reports of suicidal ideation during group sessions. Individuals deemed at high risk for suicidal behavior on these risk assessments were then evaluated more thoroughly through the hospital's psychiatric emergency service.

**Table 1.** Demographic Characteristics of the Participants.

Demographic characteristics	Descriptive statistics (N = 147)
Age (M; SD)	37.7; 11.9
Gender	
Male	63 (42.9%)
Female	84 (57.1%)
Relationship status	
In relationship	35 (23.8%)
Not in relationship	112 (76.2%)
Have children	98 (66.7%)
Homeless	76 (51.7%)
Unemployed	130 (88.4%)
Individual monthly income	
\$0–\$249	90 (61.2%)
\$250–\$499	14 (9.5%)
\$500–\$999	34 (23.1%)
> \$999	9 (6.2%)

## Measures

**Demographics.** The demographics questionnaire gathered data such as gender, age, relationship status, number of children, religious affiliation, and known medical problems.

**Self-criticism.** The 22-item Levels of Self-Criticism Scale (Thompson & Zuroff, 2004) was used to assess self-criticism. A sample item is as follows: “Failure is a very painful experience for me.” Participants reported how well each statement described them, according to a 7-point Likert scale (1 = *not at all*, 7 = *very well*). Good internal consistency and convergent validity was established for this measure with constructs of depressive symptoms, self-esteem, psychological distress, and perfectionism (Thompson & Zuroff, 2004). However, no information could be located with regard to the reliability and validity of this measure with a comparable sociodemographic sample. In the current study, Cronbach’s alpha was .82, suggesting that the measure has good internal consistency reliability in this sample.

**Depressive symptoms.** The Beck Depression Inventory – II was used to measure severity of depressive symptoms (Beck, Steer, & Brown, 1996). Participants rated 21 items on a scale of 0 to 3 based on their level of symptoms for the prior 2 weeks including the current day. A final score, ranging from 0 to 63, was

calculated according to the sum of all scores. A sample item is as follows: “Sadness: (0) *I do not feel sad*, (1) *I feel sad much of the time*, (2) *I am sad all of the time*, (3) *I am so sad or unhappy that I can’t stand it*.” The measure has extensive psychometric support across all forms of reliability and validity (Beck et al., 1996; Dozois & Covin, 2004). Studies have supported the use of the Beck Depression Inventory – II for African American, low-income, and suicidal populations (Carr et al., 2013; Grothe et al., 2005; Joe, Woolley, Brown, Ghahramanlou-Holloway, & Beck, 2008). In the current study, Cronbach’s alpha was .92, suggesting good internal consistency reliability with this sample.

**Self-compassion.** Participants completed the 26-item Self-Compassion Scale (SCS; Neff, 2003), which measured how often they had thoughts reflective of self-compassion on a scale ranging from 1 (*almost never*) to 5 (*almost always*). The six factors of the SCS are self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus overidentification. Each factor is measured independently according to questions such as “I’m kind to myself when I’m experiencing suffering” and “I try to see my failings as part of the human condition.” Either a composite score or subscale scores can be used (Hollis-Walker & Colosimo, 2011), as the single higher order factor of self-compassion explains the intercorrelations among the six factors. The composite SCS score, which was used in this study, has good test–retest reliability (Neff, 2003). Associations between self-compassion and self-esteem, narcissism, rumination, and depression, among other factors, provided strong evidence for construct validity, convergent validity, and discriminant validity (Neff, Kirkpatrick, & Rude, 2007). However, this measure also has not been used in comparable samples. In the current study, Cronbach’s alpha was .87, suggesting good internal consistency reliability for this sample.

### **Statistical Analyses**

Statistical analyses were conducted using SPSS 20.0. Partial corrections were applied to test the first, second, and third hypotheses (Leech, Barrett, & Morgan, 2011). For the fourth hypothesis, path analysis of the mediation model was conducted to examine the indirect effects between the predictor (i.e., self-criticism) and outcome variable (i.e., depressive symptoms). A bootstrap procedure has been recommended for examining the significance levels of these indirect effects (Shrout & Bolger, 2002). Bootstrap estimates based on 10,000 resamples were created for each indirect pathway using SPSS Macro (Hayes, 2013). The use of bootstrapping has been recommended for testing indirect effects because it offers an empirical method of assessing the significance of statistical estimates and does not require the normality assumption in the sampling distribution (Preacher & Hayes, 2008). Percent mediation was calculated for the mediation effect size (Preacher & Kelley, 2011).

## Results

### *Descriptive Statistics*

The demographic characteristics of the participants are presented in Table 1. The descriptive statistics and intercorrelations of study variables are shown in Table 2. For the subsequent analyses, covariates were selected based on correlates that emerged between sociodemographic variables and depressive symptoms in the current sample, such as homelessness and income:  $r(139) = .465, p < .001$ ;  $r(139) = .419, p < .001$ , respectively. Although independent  $t$  tests did not reveal gender differences, gender and additional covariates were informed by the existing literature (Baker & McNulty, 2011; Gallegos, Hoerger, Talbot, Moynihan, & Duberstein, 2013; Haggag, Geser, Ostermann, & Schusterschitz, 2011; Neff & Beretvas, 2013; Neff & Vonk, 2009; Zhang & Li, 2011).

### *Self-Criticism, Self-Compassion, and Depressive Symptoms*

The first hypothesis is related to the association between self-criticism (i.e., predictor variable) and depressive symptoms (i.e., outcome variable). The result from a partial correlation revealed that self-criticism was positively correlated with depressive symptoms, controlling for age, gender, relationship status, homelessness, unemployment, and monthly income,  $r(139) = .483, p < .001$ . Thus, the finding was consistent with the first hypothesis.

The second hypothesis pertained to the relation between self-criticism (i.e., predictor variable) and self-compassion (i.e., hypothesized mediator). The result from a partial correlation showed that self-criticism was negatively associated with self-compassion, controlling for covariates:  $r(139) = -.607, p < .001$ . Therefore, the finding supported the second hypothesis.

The third hypothesis focused on the link between self-compassion and depressive symptoms. A partial correlation showed that self-compassion was negatively associated with depressive symptoms,  $r(139) = -.421, p < .001$ . Thus, this hypothesis was supported.

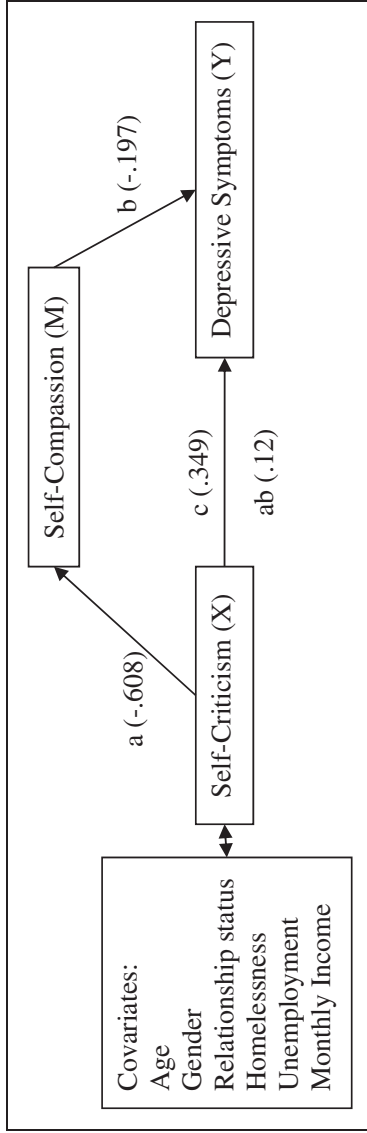
### *Self-Compassion: Mediator of Self-Criticism–Depressive Symptoms Link?*

The fourth hypothesis pertained to the role of self-compassion as a potential mediator in the relation between self-criticism and depressive symptoms. The mediation model was tested to ascertain whether or not the association between self-criticism and depressive symptoms was mediated by self-compassion (as shown in Figure 1). Bootstrap estimates revealed significant indirect effect via self-compassion, coefficient of indirect effect = .076, 95% confidence interval [.007, .158], percent mediation = .26 (large). The detailed results are

**Table 2.** Demographic Statistics and Intercorrelations of Study Variables.

Measure	M	SD	$\alpha$	1	2	3	4	5	6	7	8	9
1. Depression	30.4	13.9	.92	-	.49**	-.43**	-.19*	.52**	-.15	.45**	.38**	-.08
2. Self-criticism	101.4	21.2	.82	-	-	-.62**	-.25**	.65**	-.28**	.53**	.51**	-.27**
3. Self-compassion, total	68.4	15.5	.87	-	-	-	.70**	-.66**	.67**	-.65**	-.60**	.69**
4. Self-compassion, self-kindness	13.76	4.13	.71	-	-	-	-	-.18*	.63**	-.18*	-.06	.69**
5. Self-compassion, self-judgment	11.93	4.21	.73	-	-	-	-	-	-.10	.70**	.63**	-.08
6. Self-compassion, common humanity	11.89	3.91	.77	-	-	-	-	-	-	-.04	-.11	.68**
7. Self-compassion, overidentification	14.24	3.63	.69	-	-	-	-	-	-	-	.58**	-.13
8. Self-compassion, isolation	15.07	3.19	.61	-	-	-	-	-	-	-	-	-.10
9. Self-compassion, mindfulness	11.73	3.73	.75	-	-	-	-	-	-	-	-	-

Note. \* $p < .05$ . \*\* $p < .01$ .



**Figure 1.** Path diagram showing the mediation model with standardized coefficients.

**Table 3.** Regression Results for Mediation With Self-Criticism as the Independent Variable; Depressive Symptoms as the Dependent Variable; Self-Compassion as the Mediator; and Age, Gender, Relationship Status, Homelessness, Unemployment, and Monthly Income as Covariates.

Regression results	Coefficient	<i>t</i>	<i>p</i>
1. BDI-II regressed on LOSC (c)	.297	6.50	<.001
2. SCS regressed on LOSC (a)	−.017	−8.99	<.001
3. BDI-II regressed on SCS controlling for LOSC (b)	−4.54	−2.21	.029
4. BDI-II regressed on LOSC controlling for SCS (c')	.221	3.90	<.001
Indirect effect (ab)	Value		SE
	.076		.037
95% confidence interval of indirect effect (ab) based on 10,000 bootstrap samples	Lower limit		Upper limit
	.007		.158

Note. LOSC stands for Levels of Self-Criticism Scale, which measures self-criticism; SCS stands for Self-Compassion Scale, which measures self-compassion; BDI-II stands for Beck Depression Inventory – II, which measures depressive symptoms.

shown in Table 3. In addition, Figure 1 shows the standardized coefficients of the associations. Thus, the fourth hypothesis was supported by the findings as there were significant indirect effects at the .05 level because the 95% confidence intervals did not include 0. In other words, self-compassion appears to be one additional factor that accounts for the link between self-criticism and depressive symptoms, at least among low-income African American men and women with a recent history of suicidal behavior.

## Discussion

A central tenet of the field of positive psychology is that certain psychological factors are critical for psychological well-being including happiness, hope for the future, and life satisfaction (Seligman & Csikszentmihalyi, 2000). The current study expands our appreciation of the powerful role that self-compassion, a relatively new concept of interest, plays in impacting psychological well-being and provides further support for this construct's relevance to positive psychology including among African Americans. More specifically, the findings provide the first empirical support that self-compassion mediates (i.e., explains) the self-criticism–depressive symptoms link in a clinical sample of low-income African Americans and as such ameliorates the negative impact of self-criticism

for these high-risk individuals. The results extend our recognition of the protective role self-compassion serves in both clinical and nonclinical samples (Ehret et al., 2015; Joeng & Turner, 2015; Wei, Liao, Ku, & Shaffer, 2011) and support the generalizability of the construct across populations, regardless of race/ethnicity, social class, or education level. In keeping with a positive psychology perspective, high levels of self-compassion are associated with happiness, optimism, positive affect, personal initiative and curiosity, life satisfaction, emotional intelligence, relational well-being, and social connectedness (Brienes & Chen, 2012; Neff, 2003; Neff, Rude, et al., 2007; Yarnell & Neff, 2013), whereas low levels are linked to depressive and anxious symptoms, self-criticism, rumination, shame, fear of failure, and burnout (Barnard & Curry, 2011; Neff, 2012; Terry et al., 2013).

Consistent with empirical findings from other studies (Campos et al., 2010; McGrath et al., 2012), the results suggest that the link between self-criticism and depressive symptoms is true for low-income African Americans. This is significant as this is a different population with regard to race/ethnicity and social class than heretofore has been examined. More fine-grained research is needed to determine if the associations between self-criticism and depressive symptoms hold true across ethnic and racial groups, as these links may vary depending on the degree to which one's culture is individualistic versus collectivistic (Yamaguchi & Kim, 2013).

Moreover, a significant negative correlation was found between self-criticism and self-compassion. This finding is consistent with previous work documenting the inverse relationship between self-criticism and the tenets of self-compassion (Barnard & Curry, 2011), an association that appears to be the case across multiple cross-cultural groups (Yamaguchi, Kim, & Akutsu, 2014). The result is not surprising, given that one component of self-compassion is self-kindness (Neff, 2003). Self-criticism and the self-kindness component of self-compassion may reflect opposite sides of the same continuum, a proposition that requires further empirical examination.

In addition, the hypothesized inverse association between self-compassion and depressive symptoms was confirmed indicating that individuals who are kind toward and understanding of themselves tend to be less depressed. This finding is consistent with the literature demonstrating negative associations between self-compassion and psychological symptoms, including depression (Ehret et al., 2015; Joeng & Turner, 2015; MacBeth & Gumley, 2013; Terry et al., 2013; Van Dam et al., 2010), across multiple cultures (Yamaguchi et al., 2014). Self-compassion is correlated with and predictive of levels of depressive symptoms (Raes, 2011; Terry et al., 2013), predicts these symptoms more robustly than does mindfulness (Van Dam et al., 2010), and its presence lessens the level of depressive symptoms (Pauley & McPherson, 2010). However, the link between self-compassion and depression is complex, as multiple factors mediate this association such as shame, rumination, worry, avoidance, and

self-esteem (Johnson & O'Brien, 2013; Krieger et al., 2013; Raes, 2010). Future research needs to consider multiple mediators simultaneously.

The results must be considered in light of the study's limitations. First, the model did not incorporate enough constructs, and it would be strengthened if it incorporated more variables central to positive psychology. Mediating or moderating constructs worthy of attention in this regard include self-efficacy and proactive coping (Greenglass & Fiksenbaum, 2009) and outcomes deserving consideration include happiness (as opposed to depression), hope, mastery, quality of life, and life purpose (Bolier et al., 2013). Second, this study did not incorporate a contextual framework (McNulty & Fincham, 2012). Rather than viewing self-compassion as positive or negative, future positive psychology research needs to ascertain the factors that influence under what circumstances, for whom, and to what extent self-compassion is linked to psychological well-being; the effects of self-compassion for well-adjusted versus distressed individuals and people in health versus maladaptive relationships; longitudinal, not just cross-sectional, implications of self-compassion (McNulty & Fincham, 2012). In addition, understanding the experiences of self-compassion using a hybrid quantitative and qualitative methodology (i.e., mixed-methods approach) has the potential to offer a more nuanced appreciation of the role of this construct in this population (Ponterotto, Matthew, & Raughley, 2013). Third, the sample comprises entirely of African American men and women who are encountering social and environmental challenges, such as low levels of education and high levels of poverty, homelessness, and unemployment. In addition, suicide attempt rates typically are significantly higher in African American women when compared with men (Baca-Garcia et al., 2010); however, our sample was relatively balanced with regard to gender in part due to the fact that African American women with a suicide attempt and intimate partner violence in the past year are referred to another study in the hospital, whereas this is the only study that includes African American male suicide attempters. Given the demographics of the sample, care should be taken in generalizing these findings to other African American samples. Replication of the results with more diverse samples of African American men and women, as well as individuals from other racial and ethnic and social class groups, would allow for cross-validation of our findings. Fourth, the current study relied on self-report data, which introduces the potential for response bias. Fifth, while these findings controlled for confounding variables, the differences in the relations among the variables of interest, particularly gender differences, may hold clinical significance. Future studies with larger and more representative samples will help increase the ability to detect these differences.

Despite the previously noted limitations, there are a number of clinical implications worthy of note. Compassion-based interventions may be effective with African Americans who are depressed. Such interventions have shown promise in alleviating distress associated with medical and mental health problems,

including social anxiety, disordered eating, and problematic drinking (Brooks et al., 2012; Kelly et al., 2013; Webb & Forman, 2013; Werner et al., 2012; Wren et al., 2012). A pilot emotion-focused intervention study found that depressive symptoms can be alleviated by boosting one's kindness, connectedness with common humanity, and mindfulness, and reducing one's vulnerability to self-criticism (Shahar et al., 2012). A small-scale study from Iran indicated that compassionate mind training reduced depressive symptoms and had the potential to reduce self-criticism (Noorbala, Borjali, Ahmadian-Attari, & Noorbala, 2013). In a related vein, a randomized controlled trial with college students at risk for depression revealed that engaging in compassion-focused writing tasks about one's experience of shame led to lower levels of shame and depressive symptoms than did working on emotion-focused writing tasks or not being in a writing-based intervention (Johnson & O'Brien, 2013). Finally, a recent pilot study showed that participation in a Mindful Self-Compassion program led to improvements in well-being, as well as levels of self-compassion and mindfulness (Neff & Germer, 2013).

Taken together, there is mounting evidence that self-compassion may serve as a vital mechanism of change, underscoring the value of mindfulness- and acceptance-based treatments that foster self-compassion (Baer, 2010). Self-compassion-focused approaches with individuals who are depressed are most likely to be effective if they bring people's self-critical tendencies to awareness and help them develop a more self-compassionate stance toward their self-critical attitudes and personal limitations and struggles (Kannan & Levitt, 2013). Several compassion-based intervention studies have supported the efficacy of compassion training in lessening both self-criticism and depressive symptoms, suggesting self-compassion might have served as a mediator in the treatment process (Lucre & Corten, 2013; Shahar et al., 2012). Results from these intervention studies indicate that self-compassion-based interventions may fall within the rubric of positive psychology interventions (Sin & Lyubomirsky, 2009).

Given that African Americans often have limited access to effective treatments for depression or use such services and prefer culturally relevant and positive psychology-based interventions, a focus on self-compassion is likely to be appealing (Alegria et al., 2008; Briscoe, Mowery, Berry, & Austin, 2014; Gonzalez et al., 2010). Compassion-based interventions and mindfulness or acceptance-based interventions that emphasize self-compassion when used with African Americans must take into account cultural factors and be modified accordingly (Dutton, Bermudez, Matas, Majid, & Myers, 2013; Woods-Giscombé & Black, 2010; Woods-Giscombé & Gaylord, 2014). Although no studies have examined compassion-based interventions for African Americans, there is evidence to support the acceptability, feasibility, and efficacy of mindfulness-based interventions with this population (Dutton et al., 2013; Palta et al., 2012). Therefore, the development, implementation, and evaluation of a culturally relevant and positive psychology informed intervention designed

to bolster self-compassion in African Americans who are depressed and self-critical is imperative.

### Declaration of Conflicting Interests

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### **Author Biographies**

**Huaiyu Zhang**, PhD, is an assistant clinical professor in the Psychiatry Department at University of California San Francisco. Her research interests include mood disorders, suicidal behavior, and trauma recovery.

**Natalie N. Watson-Singleton**, PhD, is an assistant professor in the Department of Psychology at Spelman College. Her research interests include health disparities and barriers to psychological help-seeking among African American women as well as cultural adaptations of psychological interventions, like mindfulness meditation training, among racial/ethnic minorities.

**Sara E. Pollard**, PhD, is an assistant professor of Psychiatry at the University of Texas Southwestern Medical Center and a bilingual, licensed psychologist for the Rees-Jones Center for Foster Care Excellence at Children's Medical Center in Dallas, TX, a medical home for children in child welfare custody. An affiliate of the National Child Traumatic Stress Network, she provides integrated care, assessments, and evidence-based intervention for traumatized children and caregivers.

**Delishia M. Pittman**, PhD, is an assistant professor of Counseling at The George Washington University. Her research centers on addressing critical behavioral health disparities in African Americans across the lifespan, including individual, environment, and contextual factors that shape alcohol use behavior in the population. Dr. Pittman is a practicing licensed psychologist in the District of Columbia specializing in addiction treatment and African American mental health.

**Dorian A. Lamis**, PhD, is a licensed clinical psychologist and an assistant professor in the Department of Psychiatry and Behavioral Sciences at the Emory University School of Medicine. His research focuses on mood disorders, substance use, and suicidal behaviors in a variety of populations. He has edited 2 books and published over 120 peer-reviewed articles and book chapters on these topics.

**Nicole L. Fischer**, PhD, is a licensed clinical psychologist at the University of Virginia. She previously held faculty positions at Virginia Commonwealth

University, Marymount University, and Northern Virginia Community College Medical Education Campus. She has published several peer-reviewed articles and book chapters on cross-cultural psychology, race-related stress, and intimate partner violence.

**Bobbi Patterson**, PhD, is a professor of Pedagogy in the Religion Department at Emory University. Her current scholarship focuses on questions of place and space, particularly religion and ecology, focused on the intersections of meaning-making within life systems. Her interests in lived religion in communities also draw on theories and practices of Christian and Buddhist contemplative studies.

**Nadine J. Kaslow**, PhD, ABPP is a professor and vice chair, Emory Department of Psychiatry and Behavioral Sciences, and chief psychologist at the Grady Health System. The past president of the American Psychological Association, she has published extensively on the culturally informed assessment and treatment of suicidal behavior and family violence.