



Review article

A systematic review of the relation between self-compassion and depressive symptoms in adolescents



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ABSTRACT

Research on self-compassion and depressive symptoms is growing at an exponential pace. This systematic review provides an in-depth exploration of the relation between self-compassion and depressive symptoms in adolescents. In accordance with PRISMA guidelines, MEDLINE, CINAHL, and PsycINFO databases were systematically searched and 18 studies were identified. Results demonstrate the potentially pertinent role that self-compassion may play in the development, maintenance, and treatment of depression in adolescents, yet reflect on the paucity of research on this topic with respect to mechanisms of change. These studies further highlight how the impact of self-compassion may differ according to gender and age and underscore the need to account for other diversity-related variables, such as ethnic-racial group, socioeconomic status, and sexual orientation. Despite such limitations in the literature, the current findings extend research in adults by providing support for the relevance of self-compassion in adolescence, particularly with respect to the prevention of depressive symptoms.

1. Introduction

Depression is a pervasive mental health problem in adolescents (Rasing, Creemers, Janssens, & Scholte, 2017), with 14% of boys and 28% of girls reporting high and persistent depressive symptoms (Chaiton et al., 2013; Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012; Schubert, Clark, Van, Collinson, & Baune, 2017). Depressive symptomatology influences a range of somatic, cognitive, and affective processes, which have been linked with prominent difficulties in youth, including non-suicidal self-injury (NSSI), attention-deficit/hyperactivity disorder, obesity, and poor academic performance (Bron et al., 2016; Jaycox et al., 2009; Merikangas, Mendola, Paster, Reuben, & Cleary, 2012; Zubrick et al., 2017). Considering the array of functional impairments and costly ramifications of recurrent depressive symptoms on developmental trajectories, it is imperative to examine intervention targets that can be fostered and developed from a young age.

Self-compassion has recently emerged as a robust factor that protects against the development and maintenance of depressive symptoms (MacBeth & Gumley, 2012; Marsh, Chan, & MacBeth, 2017). Self-compassion is comprised of three main components demonstrated during times of personal failure or suffering: (1) *self-kindness*, which involves kindness towards the self as opposed to self-criticism and judgment, (2) *common humanity*, which involves viewing pain as a common human experience rather than as isolating and (3) *mindfulness*, which involves a willingness to approach painful experiences with acceptance and curiosity as opposed to over-identifying with thoughts and emotions (Neff, 2003a). Given that adolescence is a key developmental period for cultivating one's identity and self-efficacy, self-compassion may play a pivotal role in positively shaping adolescents' self-perceptions and

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fostering resilience in the face of adversity (Cunha, Xavier, & Castilho, 2016; Neff & McGehee, 2010).

From a theoretical standpoint, Gilbert (2009) explains how self-compassion activates affective regulation systems associated with feelings of contentment, safety, and connectedness, which help regulate elevated threat-oriented emotions in individuals with high levels of shame and self-criticism. Indeed, Chishima, Mizuno, Sugawara, and Miyagawa (2018) demonstrate how self-compassion predicts adaptive coping following the recollection of a stressful event by reducing perceptions of threat. Similarly, Bluth et al. (2016a) found that higher levels of self-compassion buffered the impact of a stress-induction on physiological stress responses. These findings provide empirical support for the notion that kindness and compassion turned inwards may protect against the negative effects of stressful events, which in turn could work to promote resilience against depressive symptoms and related pathology.

While a recently published meta-analysis underscores the strong negative link between self-compassion and psychological distress (i.e., an aggregate variable comprised of stress, anxiety, and depressive symptoms; Marsh et al., 2017), not one review to date has synthesized the rapidly emerging literature on self-compassion and depressive symptoms in adolescents. The primary purpose of this review was to examine: (1) the relation between self-compassion and adolescent depressive symptoms both cross-sectionally and over time and (2) the effect of interventions on self-compassion and depressive symptoms. Given research indicating that self-compassion and self-esteem are closely related to each other yet distinctly related to depressive symptomatology (Neff, 2003a; Orth, Robins, & Roberts, 2008), this review further aimed to elucidate whether studies examined the differential impact of self-compassion in comparison to self-esteem.

2. Methods

2.1. Study selection

The data extraction process was performed according to the guidelines outlined by the PRISMA Statement (Preferred Reporting Items for Systematic Reviews and Meta-Analyses; Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2009). PsycINFO (1972 to April 2018), MEDLINE (1946 to April 2018) and CINAHL (1982 to April 2018) databases were searched using the EBSCO interface for studies conducted on the relation between self-compassion and depressive symptoms in adolescents. The search outline was created in PsycINFO and applied to other databases (See Appendix A). The Cochrane library was searched for additional references. After eliminating duplicate studies, two authors independently reviewed the titles, abstracts and full-length articles of identified studies (J.C. and S.B.; Fig. 1). Final decisions regarding whether studies met inclusion criteria were discussed with the first author (R.P.). For all included studies, hand searches of the reference section and cited reference searches in the Web of Science database (1989 to April 2018) were conducted to identify additional research.

2.2. Study inclusion and evaluation criteria

Studies were included if they (a) investigated the relationship between self-compassion and depressive symptoms, (b) were published in peer-reviewed journals, and (c) were written in English. All included articles were reviewed in detail and thematically analyzed according to experimental design (i.e., cross sectional versus longitudinal).

3. Results

Eighteen studies published between 2010 (January) and 2018 (April) met inclusion criteria for our review (Table 1). Of these articles, four studies utilized the Self-Compassion Scale (SCS; Neff, 2003b), nine studies utilized the short form of the SCS (SCS-SF; Raes, Pommier, Neff, & Van Gucht), two studies used a Portuguese version of the SCS revised for adolescents (SCS-A, Cunha, Xavier, & Castilho, 2016), one used a revised child suitable version of the SCS (SCS-R-CS; Stolor, Zuroff, Young, Karlin, & Abela, 2016), one used the shortened and modified version of the SCS (S-SCS-A; Muris, Meesters, Pierik, & de Kock, 2016), and one study employed the fear of compassion for self (FCself) subscale from the Fears of Self-Compassion Scale (Gilbert, McEwan, Matos, & Ravis, 2011). Depressive symptoms and related outcomes were assessed with 14 different measures. Two studies controlled for self-esteem utilizing two different measures (see Table 1).

Of the 18 included studies, eleven employed a cross-sectional research design, two utilized a prospective-correlational longitudinal design, and five were intervention-based. The common themes of these studies are presented below and organized according to cross-sectional and longitudinal findings.

3.1. Cross-sectional findings

Thirteen studies examined the relation between self-compassion and depressive symptoms at one point in time. All of these studies revealed a strong negative relationship between self-compassion and depressive symptoms in boys and girls (Bluth, Campo, Futch, & Gaylord, 2017; Castilho, Carvalho, Marques, & Pinto-Gouveia, 2017; Ferrari, Yap, Scott, Einstein, & Ciarrochi, 2018; Galla, 2016; Galla, 2017; Kemper, Heyer, Pakalnis, & Binkley, 2016; Muris et al., 2016; Neff & McGehee, 2010; Stolor et al., 2016; Tanaka, Wekerle, Schmuck, Paglia-Boak, & The MAP Research; Team, 2011; Van der Gucht, Takano, Raes, & Kuppens, 2017; Vigna, Poehlmann-Tynan, & Koenig, 2017; Xavier, Pinto-Gouveia, & Cunha, 2016b).

With respect to cross-sectional regression analyses, one study found that self-compassion was linked with lower depressive symptoms ($p < .01$; Bluth et al., 2017). Another study found that self-compassion accounted for 10% of the variance in depressive

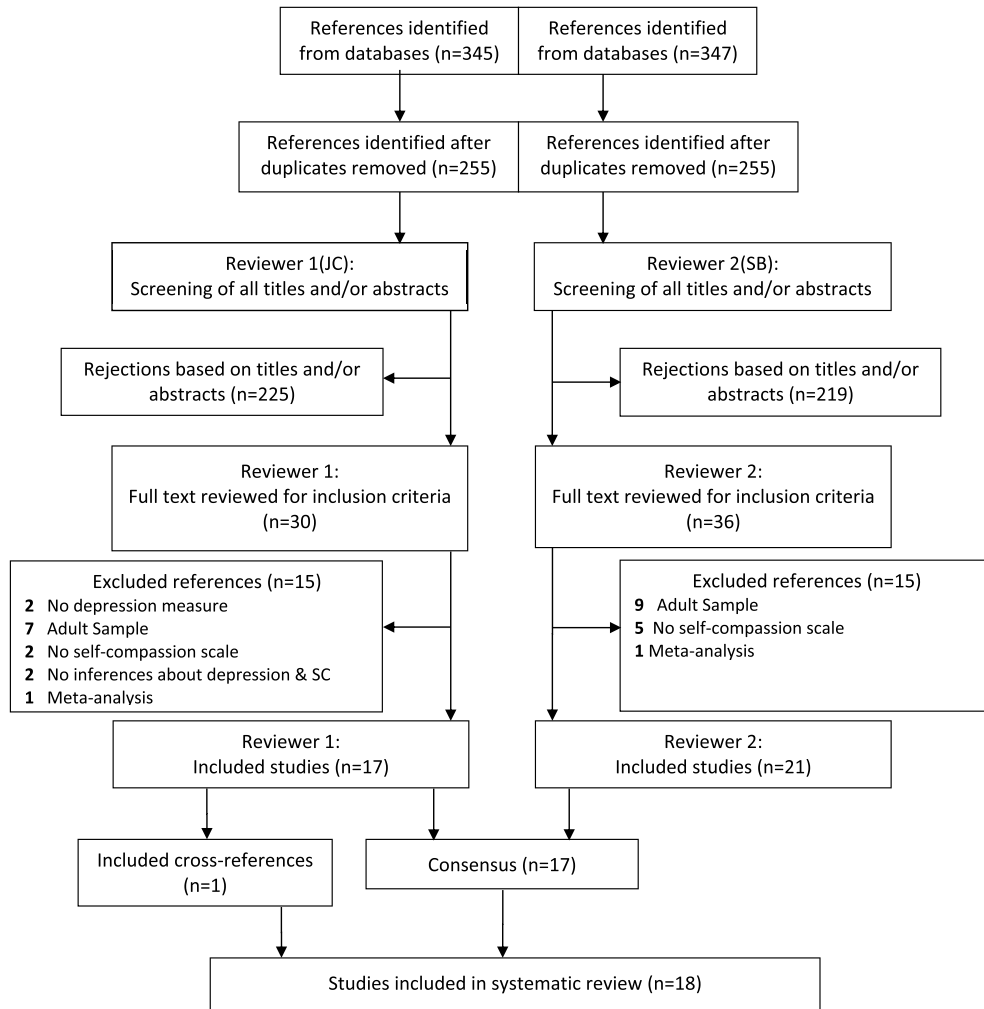


Fig. 1. Literature review flow chart.

symptoms after controlling for other significant predictors (i.e., peer victimization, bias-based bullying, and adverse childhood experiences; all $ps < .001$; Vigna et al., 2017). A recently conducted study found that the interaction between maladaptive perfectionism and self-compassion was associated with depressive symptoms ($p < .001$; Ferrari et al., 2018). Interestingly, Xavier, Pinto Gouveia, and Cunha (2016a) demonstrated that depressive symptoms mediated the negative relationship between fear of self-compassion and NSSI.

Several studies examined a broader range of outcome variables that encompassed depressive symptoms. To elaborate, Neff and McGehee (2010) created a well-being composite score from measures of depression, anxiety, and social connectedness. They found that self-compassion was positively associated with wellbeing in both adolescents and young adults (all $ps < .001$), even after controlling for other significant predictors (i.e., maternal support, family functioning, attachment style, and the personal fable defined as the belief that one's experiences are entirely unique; Neff & McGehee, 2010). Similarly, Tanaka, Wekerle, Schmuck, and Paglia-Boak (2011) created a maltreatment-related impairment risk score based on exceeding cut-offs on measures of depressive symptoms, current psychological distress, alcohol use, substance abuse, and recent suicide attempts (Tanaka et al., 2011). Self-compassion was negatively associated with maltreatment-related impairment risk in child welfare-involved adolescents after controlling for emotional/physical abuse and neglect ($p < .001$; Tanaka et al., 2011).

Finally, one study examined the positive subscales of the SCS separately (i.e., self-kindness, mindfulness, and common humanity; Muris et al., 2016). Results indicated that mindfulness ($p < .001$; $r = -0.45$) and self-kindness ($p < .01$; $r = -0.28$) were negatively correlated with depressive symptoms, while common humanity was not. Of note, global self-compassion no longer accounted for variance in depressive symptoms once gender, self-efficacy, and global self-esteem were included in the regression model (Muris et al., 2016).

Self-compassion as a cross-sectional mediator/moderator. Three studies examined the role of self-compassion as a potential mediating variable. Castilho et al. (2017) found that self-compassion helped explain the relationship between depressive symptoms and shame traumatic memories (i.e., emotionally charged memories of negative social experiences that may exhibit traumatic

Table 1
Overview of included studies.

Study	Design	Self-Compassion Measure	Depressive Symptoms Measure	Sample Characteristics	Controlled for Self-Esteem?	Summary of Key Findings
Bluth and Eisenlohr-Moul (2017)	Longitudinal Intervention SC-focused (8-weeks)	SCS-SF	SMFQ	Adolescent, student (N = 47; 53% girls)	N	No significant reduction in depressive symptoms at follow-up Mindfulness and SC negatively associated with depressive symptoms Baseline SC positively associated with emotional well-being
Bluth et al. (2016a)	Cross-sectional Experimental	SCS	SLSS	Adolescent, community and student (N = 29; 76% girls)	N	Baseline SC and mindfulness predicted decreases in depressive symptoms Tx group demonstrated greater SC, life satisfaction, and lower levels of depressive symptoms than WLC group
Bluth et al. (2016b)	Longitudinal Intervention SC-focused (6-weeks)	SCS-SF	SMFQ	Adolescent, community and student (N = 34; 74% girls)	N	Older girls (ages 17–19) reported lower levels of SC than younger girls and boys of all age groups SC moderated the relation between age and depressive symptoms
Bluth et al. (2017)	Cross-sectional	SCS-SF	SMFQ SLSS	Adolescent, student (N = 765; 53% girls)	N	SC negatively associated with depressive symptoms and positively associated with life satisfaction Males reported higher SC than girls SC negatively associated with traumatic shame memories and depressive symptoms Self-compassion and emotional intelligence both mediated the relation between traumatic shame
Castilho et al. (2017)	Cross-sectional	SCS-Portuguese version	CDI	Adolescent student (N = 1101; 57.4% girls)	N	SC negatively associated with depressive symptoms and traumatic memories and depressive symptoms SC negatively associated with depressive symptoms
Ferrari et al. (2018) Study 1	Cross-sectional	SCS-SF	SMFQ	Adolescent student (N = 541; 82% girls)	N	Elevated SC weakened the relation between maladaptive perfectionism and depressive symptoms Improvements in SC, rumination, and life satisfaction were maintained at 3-month follow-up, whereas depressive symptoms were not Within-subject changes in SC predicted increases in life satisfaction and positive affect
Galla (2016)	Longitudinal Intervention Meditation (5-days)	SCS-SF	CES-DC RSQ-rs SLS	Adolescent, self-selected for meditation retreat (N = 132; 61% girls)	N	Intervention group had significantly fewer at-risk levels of depressive symptoms post-intervention in comparison to waitlist control group SC mediated the relation between intervention and emotional functioning
Galla (2017)	Longitudinal Intervention Meditation (1-week)	SCS-SF	CES-DC	Adolescent, self-selected for meditation retreat (N = 79; 61% girls)	N	SC negatively associated with sleep disturbances, depression and positivity associated with mindfulness and resilience
Kemper et al. (2016)	Cross-sectional	SCS-SF	PROMIS-SF-pds	Adolescent, migraine clinical sample (4 + headaches per month; N = 29; 69% girls)	N	SC negatively associated with depressive symptoms but no unique link when accounting for self-efficacy and self-esteem
Muris et al. (2016)	Cross-sectional	S-SCS-A	CDI	Adolescent, student (N = 132; 58% girls)	Y SPPC	Mindfulness subscale most related to depressive symptoms Global self-esteem and self-efficacy associated with depressive symptoms above and beyond SC
Neff and McGehee (2010)	Cross-sectional	SCS	BDI-R	Adolescent, student (N = 235; 52% girls). Adult, student (N = 286; 57% girls)	N	SC negatively associated with depressive symptoms SC partially mediated the association between attachment styles, maternal support, family functioning, and the personal fable in relation to depressive symptoms

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Table 1 (continued)

Study	Design	Self-Compassion Measure	Depressive Symptoms Measure	Sample Characteristics	Controlled for Self-Esteem?	Summary of Key Findings
Stolow et al. (2016)	Longitudinal (prospective-correlational)	SCS-R-CS	CDI CDEQ	Adolescent, student (N = 193; 59% girls)	Y SEQ	Higher levels of SCS positive subscales (aggregate) and self-esteem independently predicted decreases in depressive symptoms at 3-month follow-up SCS negative subscales (aggregate) did not predict changes in depressive symptoms Negative correlation between SC and depressive symptoms SC negatively associated with childhood emotional abuse, emotional neglect and physical abuse Global SC did not mediate the relation between Tx effects and depressive symptoms Self-kindness (aggregate) negatively associated with depressive symptoms and cognitive reactivity Self-coldness (aggregate) mediated the relation between Tx effects and depressive symptoms at 6-month follow-up SC was significantly lower in SGM when compared to heterosexuals SGM reported over 2x frequency of depressive symptoms when compared to heterosexuals SC predicted depressive symptoms disparity above bias-based bullying, general victimization, and adverse childhood experiences
Tanaka et al. (2011)	Cross-sectional	SCS	CES-D	Adolescent, receiving/received child protection services (N = 117; 54.7% girls)	N	
Van der Gucht et al. (2017)	Longitudinal Intervention Mindfulness (8-weeks)	SCS-SF	DASS-Dutch version LEIDS-R	Adolescent, student (N = 408; ~63% girls)	N	
Vigna et al. (2017)	Cross-sectional	SCS-SF	YRBSS-3 items	Adolescent student (N = 1872; 50% girls)	N	
Xavier et al. (2016a)	Cross-sectional	FCself-Portuguese version	DASS	Adolescent, student (N = 782; 52.8% girls)	N	Elevated biased bullying weakened the relation between SC and depressive symptoms Fear of self-compassion positively associated with peer hassles and depressive symptoms Depressive symptoms and peer hassles mediated the link between fear of SC, hated-self, and external shame in relation to NSSI SC negatively associated with depressive symptoms SC moderated the effects of depressive symptoms on NSSI Low SC group demonstrated strongest positive association between depressive symptoms and NSSI SC negatively predicted depressive symptoms and mediated the relation between time and well-being
Xavier et al. (2016b)	Cross-sectional	SCS-A-Portuguese version	DAAS	Adolescent, student (N = 643; 51.6% girls)	N	
Zeller et al. (2015)	Longitudinal (prospective-correlational)	SCS	IDAS	Adolescent, students proximally exposed to a potentially traumatic stressor (N = 64; 26.6% girls)	N	

*Note. SC = self-compassion, Tx = treatment, NSSI = non-suicidal self-injury, WLC = wait-list control, SF = short form, SGM = sexual and gender minorities. *Self-compassion measure*: SCS = Self-Compassion Scale, SCS-A = Self-Compassion Scale for Adolescents, SCS-R-CS = Self-Compassion Scale-Revised Child Suitable, s-SCS-A = Shortened Self-Compassion Scale for Adolescents, FCself = Fear of Compassion for Self subscale of the Fear of Self-Compassion Scale. *Depressive symptoms measure*: BDI-R = Beck Depression Inventory-revised, CES-D = Centre for Epidemiological Studies Depression Scale, CES-DC = Centre for Epidemiological Studies Depression Scale for children, CDEQ = Children's Depressive Expression Questionnaire, CDI = Children's Depression Inventory, DASS = Depression Anxiety Stress Scale, IDAS = Inventory of Depression and Anxiety Symptoms, LEIDS-R = Inventory of Depression and Anxiety Symptoms, PROMIS = Patient Reported Outcome Measurement Information System, RSQ-rs = Rumination subscale of the Rumination-Reflection Questionnaire, SLS = Satisfaction with Life Scale, SLSS = Student Life Satisfaction Scale, SMFQ = Short Mood and Feelings Questionnaire, YRBSS = Youth Risk Behavior Surveillance Survey. *Self-Esteem Scales*: SPPC = Self-Perception Profile for Children, SEQ = Self-Esteem Questionnaire.

features; $p = .001$). Neff and McGehee (2010) demonstrated that self-compassion helped explain the link between maternal support, family functioning, attachment style, and the personal fable in relation to wellbeing. More specifically, heightened levels of maternal support, positive family relations, and secure attachment were distinctly and positively associated with self-compassion, which in turn was negatively associated with depressive symptoms (all $ps < .001$). Furthermore, maternal criticism, fearful attachment, preoccupied attachment, and negative family relationships demonstrated the opposite pattern. Finally, Vigna et al. (2017) found that bias-based bullying (i.e., bullying based on perceived LGBTQ identity) moderated the degree to which self-compassion mediated the relationship between sexuality/gender status and depressive symptoms.

Two studies examined self-compassion as a moderator. Ferrari et al. (2018) found that self-compassion buffered the strength of the relationship between perfectionism and depressive symptoms in adolescents ($p < .001$). Specifically, perfectionism was positively linked with depressive symptoms among those with low-medium, but not high, levels of self-compassion ($p < .001$), with low levels of self-compassion demonstrating the strongest association. Furthermore, Xavier et al. (2016b) found that as levels of self-compassion increased, the positive association between depressive symptoms and NSSI weakened ($p < .01$).

3.2. Longitudinal findings

Two longitudinal studies employed a prospective-correlational design (Stolow et al., 2016; Zeller, Yuval, Nitzan, Assayag, & Bernstein, 2015), whereas five longitudinal studies examined the efficacy of interventions in ameliorating depressive symptoms and increasing self-compassion (Bluth & Eisenlohr-Moul, 2017; Bluth, Gaylord, Campo, Mullarkey, & Hobbs, 2016b; Galla, 2016, 2017; Van der Gucht et al., 2017).

Self-compassion as a predictor of depressive symptoms. One of two studies recruited a sample of adolescents who were exposed to a potentially traumatic event (i.e., a forest fire; Zeller, Yuval, Nitzan, Assayag, & Bernstein, 2015). They found that higher levels of self-compassion predicted decreased depressive symptoms at three follow-up periods (four weeks, three months, and six months, respectively). Similarly, Stolow et al. (2016) demonstrated that elevated levels of the positive aspects of self-compassion (i.e., an aggregate score of the SCS positive subscales) predicted decreased depressive symptoms at three-month follow-up, whereas the SCS negative subscale scores did not.

The impact of interventions on self-compassion and depressive symptoms. Although only two of five studies utilized a self-compassion intervention (Bluth et al., 2016b; Bluth & Eisenlohr, 2017), all five studies reported changes in self-compassion post-intervention and four of these studies reported changes in depressive symptoms. Bluth et al. (2016b) conducted a pilot study that examined the acceptability of a 6-week mindful self-compassion intervention for teenagers (“Making Friends with Yourself: A Mindful Self-Compassion Program for Teens”; MFY). They found that adolescents in the intervention group reported higher self-compassion ($p < .05$) and lower depressive symptoms ($p < .01$) one day-post-intervention when compared to those in the waitlist control group. Following this study, Bluth and Eisenlohr-Moul (2017) conducted a full version of the MFY program over an eight-week period. While within-person self-compassion inversely co-varied with depressive symptoms over time, depressive symptoms did not decrease from pre- to post-treatment (Bluth & Eisenlohr-Moul, 2017). However, self-compassion increased from pre- to post-intervention and changes were maintained at 6-week follow-up ($p < .001$).

Galla (2016) studied the effects of a five-day meditation retreat for adolescents. This study revealed that within-person increases in self-compassion predicted decreases in depressive symptoms post-intervention ($p < .001$), with changes in self-compassion explaining 15.8% of the variance in depressive symptoms (Galla, 2016). When compared to baseline, only higher levels of self-compassion were maintained at 3-month follow-up. Based on these findings, Galla (2017) employed a waitlist control group to examine the efficacy of a weeklong residential meditation retreat for teenagers. The intervention group reported increased self-compassion ($p < .05$) and decreased depressive symptoms post-intervention when compared to the waitlist control group ($p < .05$). Notably, changes in self-compassion mediated the association between meditation training and post-intervention reductions in depressive symptoms (Galla, 2017).

Van der Gucht et al. (2017) analyzed data from a randomized controlled trial which evaluated an 8-week school-based mindfulness program. Their intervention was effective in reducing “self-coldness” (i.e., an aggregate score comprised of the SCS negative subscales). In addition, changes in self-coldness mediated post-treatment reductions in depressive symptoms. Although self-kindness (i.e., an aggregate score of the SCS positive subscales) did not increase over the course of the intervention, reductions in depressive symptoms were observed and maintained at 6-month follow-up (all $ps < .01$).

Gender and age differences. Seven studies included in this review found higher levels of depressive symptoms or fear of self-compassion and lower overall self-compassion among girls when compared to boys (Bluth et al., 2017; Castilho et al., 2017; Ferrari et al., 2018; Van der Gucht et al., 2017; Muris et al., 2016; Van Der; Xavier et al., 2016b). Stolow et al. (2016) found that only girls reported higher negative SCS subscale aggregate scores. Two studies indicated no gender differences in baseline levels of depressive symptoms (Stolow et al., 2016; Van der Gucht et al., 2017). With regard to interventions, Bluth and Eisenlohr-Moul (2017) found that girls experienced more robust increases in self-compassion than boys post-intervention (Bluth & Eisenlohr-Moul, 2017). Several studies found no evidence of gender moderating the relation between self-compassion and depressive symptoms over time (Bluth et al., 2017; Galla, 2016; Stolow et al., 2016; Van der Gucht et al., 2017).

With respect to age and self-compassion, one study indicated that older adolescents (ages 12–16) reported higher levels of negative SCS subscale aggregate scores than younger adolescents (ages 9–10), but found no age differences in levels of positive SCS subscale aggregate scores (Stolow et al., 2016). Bluth and Eisenlohr-Moul (2017) demonstrated that older adolescents (ages 14–17) experienced greater increases in self-compassion post-intervention than younger adolescents (ages 11–13). Similarly, Bluth et al.

(2017) revealed how the strength of the relationship between self-compassion and depressive symptoms increased with age in a large adolescent sample ($p < .01$).

Regarding depressive symptoms, [Xavier et al. \(2016a\)](#) found that middle adolescents (ages 14–15) and older adolescents (ages 16–18) had higher levels of depressive symptoms than early adolescents (ages 12–13). Likewise, [Stolow et al. \(2016\)](#) found that older adolescents (ages 15–16) reported the highest levels of depressive symptoms, followed by the second oldest group (ages 12–13), and lastly by the youngest group (ages 9–10).

Finally, five studies investigated the simultaneous influence of gender and age on self-compassion. Two studies found that older girls (i.e., age 14 and above) had lower levels of self-compassion when compared to younger girls or boys across the developmental spectrum ([Bluth et al., 2017](#); [Muris et al., 2016](#)). Additionally, [Tanaka et al. \(2011\)](#) found that gender and age accounted for 10.3% of the total variance in adolescent self-compassion. Lastly, two studies examined both adolescent and adult samples ([Ferrari et al., 2018](#); [Neff & McGehee, 2010](#)). Although [Neff and McGehee \(2010\)](#) did not find gender differences in adolescent self-compassion (ages 14–17), they demonstrated that girls reported lower levels of self-compassion than boys in young adulthood (ages 19–24; [Neff & McGehee, 2010](#)). These gender differences were replicated by [Ferrari et al. \(2018\)](#), who found that adult women reported lower levels of self-compassion when compared to men (ages 18–71).

4. Discussion

The link between self-compassion, wellbeing, and psychopathology has been well established in the adult literature ([MacBeth & Gumley, 2012](#); [Zessin, Dickhäuser, & Garbade, 2015](#)). Yet, it is only in recent years that the relationships between these variables have been explored in adolescents ([Marsh et al., 2017](#); [Neff & McGehee, 2010](#)). While research on adolescent self-compassion is nascent, the findings synthesized in this review underscore the impact of self-compassion on adolescent depressive symptoms. A negative association between self-compassion and depressive symptoms was routinely found in the current studies, with preliminary research highlighting the influence of self-compassion over time. Altogether, these findings indicate that self-compassion may protect against the development and maintenance of depressive symptoms by: (a) decreasing depressive symptoms both cross-sectionally and longitudinally; (b) explaining how risk factors impact depressive symptoms, and (c) interacting with risk factors to attenuate their detrimental effects. Notably, the studies included in this review reveal several themes that merit further exploration.

The roles of age and gender. Numerous studies controlled for age and/or gender or revealed age and gender differences in self-compassion and depressive symptoms. These gender-related findings are mirrored in the adult literature, where meta-analyses indicate slightly higher levels of self-compassion and lower levels of depressive symptoms in men when compared to women ([Nolen-Hoeksema, 2001](#); [Yarnell et al., 2015](#)). The current review suggests that girls between ages 12 and 16 years are at an increased risk for lower self-compassion and elevated depressive symptoms. While further longitudinal research is needed to elucidate directionality of relationships and delineate potential mechanisms of change, it appears as though this population may particularly benefit from early self-compassion training.

Other diversity-related variables. Aside from gender and age, it was uncommon for studies included in this review to investigate the impact of diversity-related variables (e.g., ethnic-racial group, socioeconomic status (SES), and sexual orientation). Research in adults indicates that gender differences in self-compassion may be more pronounced in ethnic minority groups ([Yarnell et al., 2015](#)). Findings in adolescents demonstrate that ethnic minority groups may experience higher levels of depressive symptoms than their peers ([Twenge & Nolen-Hoeksema, 2002](#)). As such, the impact of self-compassion on depressive symptoms in ethnic minority groups warrants attention in future research.

With respect to SES, a recent meta-analysis on self-compassion and psychological distress in adolescents noted that it was not possible to examine differential effects given that SES is so rarely reported in the literature ([Marsh et al., 2017](#)). While research in adults has demonstrated the link between low SES and increased depression ([Everson, Maty, Lynch, & Kaplan, 2002](#); [Lorant et al., 2003](#)), the relation between SES and self-compassion remains unstudied across the lifespan. Neglecting the potential role of SES could lead to heterogeneity in results that are unaccounted for ([Marsh et al., 2017](#)). It is therefore imperative that future research elucidate whether self-compassion remains protective across the SES spectrum.

Only one study in this review examined the role of self-compassion in LGBTQ + communities ([Vigna et al., 2017](#)). Research demonstrates that LGBTQ + youth face stigma, harassment, prejudice, and discrimination, which in turn leads to elevated psychological distress ([Kelleher, 2009](#)). This is consistent with findings from the adult literature, which reveal heightened depressive symptoms among LGBTQ + communities and indicate how sexual minority-related stress, stigma consciousness, and gender non-conformity predict depressive symptoms ([Keng & Liew, 2017](#); [Lewis, Derlega, Griffin, & Krowinski, 2003](#)). As such, it is posited that self-compassion may be particularly important for sexual and gender minority (SGMi) adolescents to improve psychological outcomes ([Beard, Eames, & Withers, 2017](#); [Kelleher, 2009](#); [Keng & Liew, 2017](#)). Indeed, [Vigna et al. \(2017\)](#) found that SGMi adolescents not only had lower self-compassion than their peers, but also that self-compassion accounted for more variance in mental health problems than bias-based bullying alone. The authors suggest that bias-based bullying in conjunction with low trait self-compassion may have a potent effect on psychological functioning and well-being. Extension of research in this domain will help clarify whether fostering self-compassion can combat the risk of adverse health outcomes in minority groups.

Disaggregating self-compassion. It is important to note that the majority of studies included in this review exclusively studied global self-compassion and its relation to depressive symptoms. As indicated above, the SCS is comprised of the following six subscales ([Neff, 2003b](#)): self-kindness, common humanity, mindfulness, self-judgment, isolation, and over-identification. A handful of studies demonstrated how each of the SCS subscales might differentially impact depressive symptoms. For example, [Muris et al. \(2016\)](#) found that the mindfulness subscale was most prominently related to depressive symptoms. Furthermore, [Xavier et al. \(2016b\)](#)

found that self-kindness and mindfulness weakened the impact of depressive symptoms on NSSI and that the SCS negative subscales magnified the effects of depressive symptoms on NSSI ($ps < .05$). These findings indicate that certain aspects of self-compassion may exert a stronger effect on depressive symptomatology than others. Although there has been some controversy surrounding the factor structure of the SCS, further research on the global and constituent components of self-compassion may help illuminate precisely how self-compassion impacts psychopathology in adolescents.

Self-compassion versus self-esteem. While there are many definitions of self-esteem, global self-esteem can be defined as the extent to which the self is deemed competent in various life domains (James, 1983). A large body of research indicates that high self-esteem protects against depressive symptoms, whereas low self-esteem is a risk factor for the development of depression in adolescents (Orth, Robins, Trzesniewski, Maes, & Schmitt, 2009). Given the moderate correlation between self-compassion and self-esteem, two studies included in this review opted to control for self-esteem when examining whether self-compassion impacts mental health outcomes. As indicated above, one study found that self-esteem and self-efficacy were related to depressive symptoms above and beyond self-compassion (Muris et al., 2016). Conversely, another study indicated that both self-esteem and an aggregate score of the positive aspects of self-compassion independently predicted depressive symptoms at 3-month follow-up (Stolow et al., 2016).

In light of these findings, there are key differences between self-compassion and self-esteem that warrant discussion (Neff & Vonk, 2009). Self-esteem can be contingent on external factors and may shift depending on life circumstances, whereas self-compassion has been deemed more stable because it is not evaluation-based (Crocker & Park, 2004; Neff & Vonk, 2009). Moreover, although self-esteem is negatively associated with depression, research underscores how fragile and fluctuating self-esteem is linked with defensiveness, self-punishment, and potential exacerbation of depressive symptoms (Borton, Crimmins, Ashby, & Ruddiman, 2012; Kernis, 2000; Masselink, Van Roekel, & Oldehinkel, 2018). Altogether, research posits that rather than aiming to foster self-esteem, which can lead to unpredictable forms of self-regard (Baumeister, Bushman, & Campbell, 2000; Crocker & Park, 2004), people may experience more positive thoughts and behaviours if they approach suffering with self-kindness, mindful awareness, and a sense of common humanity (Neff, 2003a).

Indeed, the extant literature demonstrates that self-compassion contributes to various indicators of wellbeing and positively impacts people's thoughts and behaviours in distinct and sometimes more beneficial ways than self-esteem (Breines, Toole, Tu, & Chen, 2014; Leary, Tate, Adams, Allen, & Hancock, 2007; Neff, 2003b). Given intervention research indicating that self-compassion can be increased in the short-term and maintained in the long-term, self-compassion may promote greater resilience against depression than self-esteem (Neff & Germer, 2013; Neff & Vonk, 2009). Further research in adolescents with and without depression is required to provide empirical support for this strong theoretical notion.

Between versus within-person effects. While the majority of studies included in the current review examined between-group differences in self-compassion and its role both cross-sectionally and over time, two studies revealed within-person associations between self-compassion and depressive symptoms (Bluth & Eisenlohr-Moul, 2017; Galla, 2016). Research in adults demonstrates the within-person effects of self-compassion in relation to other mental health problems (e.g., eating disorders; Kelly & Tasca, 2016; Kelly & Stephen, 2016). Altogether, these studies reveal the merit of conceptualizing self-compassion at the within-persons level. Such a conceptualization may be particularly relevant in adolescence, given that youth are constantly comparing themselves to one another as they aim to establish their identities. However, this methodology has not yet been applied in the realm of self-compassion and depressive symptoms. It may therefore be informative for future research to examine the impact of within-person variance in self-compassion on depressive symptoms and consider whether the effect of within-person variance differs according to diversity variables such as gender, sexual orientation, age, ethnic-racial group, and SES.

4.1. Limitations of current research

Cross-sectional versus longitudinal research. Although an accumulating evidence base underscores the potentially protective role of self-compassion in adolescent depressive symptoms, the majority of research is cross-sectional, thereby limiting our ability to infer causality (Krieger, Berger, & Holtforth, 2016). Seven longitudinal studies were included in this review, two of which employed a prospective-correlational design (Stolow et al., 2016; Zeller et al., 2015) and five of which were intervention-based (Bluth & Eisenlohr-Moul, 2017; Bluth et al., 2016b; Galla, 2016, 2017; Van der Gucht et al., 2017). Of these intervention studies, three were controlled and utilized a non-treatment control group (Van der Gucht et al., 2017), a waitlist control group with random assignment (Bluth et al., 2016b), and a waitlist control without randomization (Galla, 2017), respectively. Two of the interventions examined changes solely in a treatment group (Bluth & Eisenlohr-Moul, 2017; Galla, 2016). To define underlying causal relationships and fully determine the efficacy and specificity of mindfulness-based self-compassion interventions, it is imperative that we continue to conduct controlled intervention studies.

Research methodology discrepancies. Another limitation of research in this area includes discrepancies between studies with respect to measures used, recruited populations, definitions of “older” and “younger” adolescents, and intervention design. Fourteen different measures of depressive symptoms and four different versions of the SCS were utilized. Additionally, two studies employed aggregate scores of wellbeing as their outcome variable (Neff & McGehee, 2010; Tanaka et al., 2011; Xavier et al., 2016a). While the majority of studies recruited samples from the general population, several studies investigated the relationship between these variables in specific samples. For example, one study recruited adolescents with chronic headaches (Kemper et al., 2016), another study recruited child welfare-involved adolescents (Tanaka et al., 2011), and an additional study included a sample of at-risk youth who had been exposed to a potentially traumatic event (Zeller et al., 2015). Other notable methodological differences include varied intervention designs in three out of five studies. Although the use of different methodologies and samples can lead to increased generalizability, the disparities noted in this research makes it challenging to compare, amalgamate, and disseminate study findings.

Furthermore, such differences suggest that research in this area is being extended before it is being replicated. Replication by independent research groups is therefore needed to enhance the utility of study findings.

Research throughout the developmental spectrum. As indicated above, several studies controlled for age in their analyses and some revealed age differences in the relationship between self-compassion and depressive symptoms. Despite this, we have a limited understanding of how self-compassion initially develops and how its development relates to symptom onset from a young age. In addition, the ideal time within which to intervene and how to foster self-compassion in childhood remains unknown. Sophisticated longitudinal models are therefore needed to increase our understanding of the potentially bidirectional relationship between self-compassion, mood, and related pathology over time.

The need for research in clinical samples. Not one study to date has examined the link between self-compassion and depressive symptoms in a clinical sample of adolescents. Recent research in clinically depressed adults demonstrates that self-compassion predicts depressive symptoms over time (Krieger, Altenstein, Baettig, Doerig, & Holtforth, 2013; Krieger et al., 2016). Further research is needed to elucidate how self-compassion exerts its influence in clinically depressed youth and to determine whether self-compassion interventions are effective in reducing depressive symptoms and preventing depressive relapse in adolescents.

5. Conclusion

Despite the above-mentioned gaps in the literature, findings from 18 studies provide support for the instrumental role of self-compassion in adolescent depressive symptoms. Notably, a growing body of intervention research indicates that self-compassion is malleable and may lead to reductions in depressive symptoms over time. Future research would benefit from exploring the evolution of self-compassion and disentangling the effect of diversity variables in both community and clinical samples of adolescents. This would ultimately allow for the development and implementation of self-compassion interventions that are unequivocally evidence-based.

Declarations of interest

None.

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Appendix A. Supplementary data

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