ENCEPHALOS 63, 83-94, 2026

Self-Compassion, Psychological Distress and Family History of Major Mental Illness: A Cross-Sectional Study in the Greek General Population

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Summary

Self-compassion is a significant factor in psychological well-being and a notable characteristic of human thought and behavior, appearing to be negatively associated with the development of psychopathology. The aim of this cross-sectional study, concerning the Greek general population, is to investigate the relationship between self-compassion and variables of psychological distress, as well as the presence of a positive family history of mental illness, using the PHQ-9, DASS-21, and Self-Compassion Scale (SCS) questionnaires. Multiple linear regression, mediation analysis, and the non-parametric Mann-Whitney U method were used for statistical analysis. The results revealed a negative relationship between depression and anxiety with self-compassion (β = -0.048 and β = -0.011 respectively) , and a positive relationship between family history of mental illness and self-compassion (p < 0.005). Furthermore, the relationship between family history and psychological distress variables is partially mediated by self-compassion levels, while no correlation was found between self-compassion and age or gender. Limitations of the study include the convenience sampling method and the measurement of anxiety, depression, and stress using self-report scales to assess distress. This study demonstrates the importance of self-compassion as an indicator of psychological resilience and the benefit of interventions focusing on its enhancement.

Keywords: discharge; transitions; stroke; checklist; after-stroke care

Introduction

Self-Compassion is defined as a person's ability to show compassion and understanding to themselves when they are facing difficult situations and psychologically adverse events. It is theorized to be a productive way of processing thoughts and emotions that can cause dysphoria and that can threaten physical and mental health (Neff, 2023). Self-Compassion is a new subject of research for the international scientific community in the west, with over 4000 studies already referring to it. Western philosophy had been historically involved with the subject of compassion towards others. Self-Compassion is a term from Buddhist philosophical thought and is introduced to the western literature of psychology from Dr. Neff (Neff, 2003). Based on Buddhism, the dichotomy between compassion towards the self and the others creates a false dissociation between a person and their environment. Based on Dr. Neff, Self Compassion consists of three basic terms. The first one is a person's ability to show goodness toward themselves without judging them, the second one is that a person recognizes that wrongdoing in their daily living is a normal part of human nature and the third one is the self-recognition of the negative content of mental thoughts and feelings instead of trying to suppress them or self-identifying with them. In simple terms, Self Compassion is a psychological term-human ability through which goodness towards the self prevails over negative self-thinking, as well as acceptance of human nature over its suppression, and positive self-consciousness over evading negative situations (Barnard & Curry, 2011). The experienced reader of Buddhist philosophy and theology can easily comprehend the similarity of Dr. Neff's theory and eastern thought.

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Though in the scientific fields of psychology and psychiatry that term is not being used solely for its philosophical meaning, but also for its practical qualities as an aspect of human thinking and behavior. Socioeconomic factors seem to attenuate the levels of Self Compassion, as ethnicity, where Greece seems to belong to the countries with the lowest levels, religion, gender, with men having the highest levels, and there are observations that Self Compassion is positively associated with age. (Neff, 2003). It is worth mentioning that the term Self Compassion doesn't imply any quality of 'spiritual' content, denying that way any cartesian type of interpretation of the term, but instead had indications of its impact on a psychophysiological level. In lab studies with stressors, it is also mentioned that there is a negative association between Self Compassion and cortisol blood levels, blood pressure and interleukin-6. Natural stress biomarkers that are associated with physical pain or psychological dysphoria were significantly reduced in persons with high Self Compassion levels in contrast with persons who had lower levels.

Although such studies may not have a robust sample capacity or they may be in their initial phase, they indicate that there are scientifically grounded connections between Self Compassion and improved stress response. Through that way a new thematic for the study of neurobiology and behavior is opened, from the level of thought (so the CNS) to the organic response to it (Handbook of Self-Compassion, 2023). It is worth referring to the fact that Self Compassion is correlated with changes in brain activity.

It is observed that activation of the medial Prefrontal Cortex (mPFC), an area correlated with self-referential thinking, endoscopic thought and emotional regulation. People with high Self Compassion had elevated activation of medial Prefrontal Cortex, during processing of negative information for the self, indicating more adaptive emotional responses. In fact, the Amygdala, known for its role in fear and anxiety response, is less activated in people with elevated Self Compassion when they receive negative judgement (Longe et al., 2010).

Since the initiation of the usage of the term Self Compassion new research questions have emerged. In that aspect the relation between Self Compassion and different population teams is being studied worldwide, as well as its relationship with specific occupations, its effect on the emotional and cognitive human condition and its relationship with psychopathology. It is indicated from studies that Self Compassion is positively correlated with positive emotion and negatively correlated with negative emotion (Leary et al., 2007; Neff et al., 2007; Neff & Vonk, 2009). In a study with Christian clerics a negative correlation between Self Compassion and Emotional exhaustion was found, as well as negative correlation with the feeling of guilt, positive with the feeling of satisfaction with religious liturgy, and no correlation with the feeling of guilt was found (Barnard & Curry, 2011).

Emotional exhaustion has been defined as exhaustion, irritability, sadness, cynicism and social aversion. Satisfaction with religious liturgy is defined as positive work with positive impact towards others. In other Studies Self Compassion is negatively correlated with anxiety and depression (Neff et al., 2007) where anxiety and depression symptoms were evaluated in a student population, in addition to the effect of self-negative thinking and its modulating role between Self Compassion, anxiety and depression (Neff et al., 2005). Also, Self Compassion is positively correlated with a person's ability to live positively, with the feeling of purpose in life, self-control, low stress levels and less negative affect and high life satisfaction ("well-being") (Neely et al., 2009). Self-compassion is also positively correlated in studies with the feeling of optimism in life, feeling of happiness and self-acceptance (Neff & Vonk, 2009).

Self-Compassion is also related to elevated emotional intelligence, meaning the ability of a person to understand feelings of themselves and others and to regulate theirs (Neff, 2003). It is also found that people with high Self Compassion tend to accept their negative emotions more and use more efficient mechanisms of coping with negative emotions (Neff et al., 2005). Self-Compassion seems to play a specific role in the psychological growth of teenagers. Studies have found that Self Compassion is lower in adolescents and is related with aspects of narcissism and lower self-confidence (Bengtsson et al., 2015). Higher levels of Self Compassion tend to be related to greater psychological resistance to situations of disappointment, higher empathy, and more efficient emotional regulation (Talwar et al., 2022). Regarding the human cognitive spectrum, it is indicated that Self Compassion correlates with specific cognitive constructs. It is correlated negatively with the rumination of negative thoughts for the self and with evading strategies and the suppression of negative thoughts (Neff et al., 2005). Procrastination and maladaptive perfectionism are also negatively related to Self-Compassion (Williams et al., 2008) and in contrast to that, the self-perception of competition is positively related to it (Neff et al., 2005). Agreeableness is indicated to be connected positively to Self-Compassion (Neff et al., 2007) and self-perception of belonging to a social circle as well. Summarily, information collected from the literature about the relation between the cognitive and emotional human condition and Self Compassion have been indicated, with important pointers for its use in the field of science and also for practice in psychology and psychiatry.

Nowadays a new field of psychotherapy is being practiced: Compassion Focused Therapy. This field of psychotherapy is part of the broader field of cognitive and behavioral therapy and has been constructed to help people who are usually harsh to themselves and express negative self judgement, resulting in chronic psychological adversities such as depression and feeling of shame. The basis of the therapy is the creation of an accepting therapeutic relation with safety and cooperation. Psychoeducation about the functions of the mind, emotions and their experiences is a primary aspect of Compassion Focused Therapy. Through that process a person can understand their difficulties as a part of the universal human condition, and they acquire new ways of

managing them (Gilbert ,2010). Functional Magnetic Resonance studies suggest that self-education about Self Compassion attenuates brain connectivity and reduces activity in areas related to self judgement and threat (Kim et al., 2020). Compassion Focused Therapy is also used in multiple experimental and semi-experimental models in populations of interest studying Self Compassion, thoughts and actions. Specifically, it is studied in male prisoners, where a reduction of crime thought after eight psychotherapy sessions was found (Rezapour-Mirsaleh et al., 2020). In a double-blind study in women with substance abuse there was found a significant reduction of drug use seeking behaviors after sessions of Compassion Focused Therapy, indicating its positive role in rehabilitation programs (Abdoli et al., 2020). Regarding food intake disorders, the latter psychotherapy increases positive image about the body and the self in patients with eating disorders in parallel to a reduction in anxiety and depression symptoms (Goss & Allan, 2010).

Dr Neff has created the first scale for Self-Compassion ("Self Compassion Scale"), which has a self-questionnaire structure with 26 questions for all the primary aspects of the term: Self Kindness, common humanity and conscientiousness. The Self Compassion Scale has been evaluated by Dr. Neff for its validity and reliability in 2003 in a sample of 391 male and female students. In that study Confirmatory Factor Analysis was conducted and also its complete internal reliability was acceptable (0.92). The total internal consistency of its subscales had a range from 0.75 to 0.81. In a latter study in 232 people, it was found that the scale had a good test-retest reliability (0.85- 0.93), in a three-week space between its repetition. Regarding the construct validity, it was initially evaluated in male and female students. People who had a higher scale score also had higher scores in other self-evaluation tests of kindness towards self and others. Buddhists who were practicing Self Compassion with specific customs also had higher Self Compassion scores than the students (Neff, 2003). Though because it is a mostly new scale, its components are still being thoroughly studied and evaluated on their connection to the definition of Self Compassion and its understanding from different cultural groups. There are some critics form the literature about its use. The fact that the scale consists of both positive and negative components which do not measure exactly the presence of Self Compassion but also its loss is under question. For example, self judgement subscale can refer to characteristics contrary to Self-Compassion. That matter has led researchers to suggest that the use of the sum of the score could be misleading, because it connects different dimensions (Muris et al., 2016). Also, the validity of the scale in non-westerners and generally in less individualistic societies is under question, with some studies indicating that the construct of Self Compassion is different in distinct cultures (Zeng et al., 2016).

Self-Compassion scale is nowadays used to populous studies that explore psychological aspects and psychopathology in the general population. In matter of psychological attachment theory, in 2010 the modulatory effect of self-compassion in attachment anxiety in males and females and their subjective well-being were studied. In that study, it was found that Self Compassion is negatively related with attachment anxiety, suggesting that people with such anxiety tend to judge themselves negatively and feel overwhelmed by their negative feelings (Wei et. Al, 2010). The use of Self Compassion scale showed that its term is a predictive factor of mental health and its elevation through psychotherapy can alleviate anxiety and depression symptoms. Such is indicated in a population study of people with mental disorders under psychotherapy (Van Dam et al., 2011). In addition, it is worth mentioning that the use of the scale in geriatric populations shows a positive correlation with the feeling of wellbeing (Allen et al., 2012; Phillips, W. J., & Ferguson, S. J. ,2012). Self-Compassion is not only restricted to mental health improvement but also to the betterment of the quality of life of people with chronic bodily health conditions. Specifically, it is suggested that Self Compassion is positively related to less adverse health behaviors and less functional decline to people with chronic conditions. People with diabetes, cancer or chronic pain seem to benefit from Self Compassion enhancement. That can happen because they show more treatment adherence, less pain and more acceptance of help and care from others (Finlay-Jones et al., 2023).

In terms of the relation between Self Compassion and psychopathology, it is indicated that more Self Compassion couples with reduced psychiatric symptoms. A meta-analysis of the use of the scale shows negative correlation between Self Compassion and psychopathology with an index of r=–0.54 (95% CI=–0.57 to −0.51; Z=−34.02; pb.0001) (MacBeth, A., & Gumley, A. ,2012). In a study of patients with schizophrenia, it was found that self-compassion correlates with reduced symptoms both positive and negative type (Eicher A.C. et al., 2013). In other study in people with psychotic spectrum disorders with delusional thoughts the emotional dysphoria caused by the content of the delusions correlates negatively with the level of Self Compassion (Scheunemann et al., 2018). Similar findings were shown by other Self Compassion study in people with bipolar disorder (Doessing et al., 2015). Self-compassion also seems to improve symptomatology of generalized anxiety, post-traumatic stress disorder, depression and eating disorders through psychotherapy (Brown et al., 2014; Costa et al., 2016; Kelly et al., 2014; Körner et al.,2015; Zeller et al., 2014). In other metanalysis actions using Self Compassion seem to benefit eleven distinct psychosocial fields, with a large effect size for eating behavior, rumination, a medium one for compassion, stress, depression, conscientiousness, self judgement and anxiety (Ferrari et al.,2019). Caretakers of elder patients with higher Self Compassion tend to overcome better the problems of the latter's' care (Murfield et al., 2020).

In conclusion, the positive effect of Self Compassion in the human mental condition is imminent. It is worth suggesting that there is not extended literature about the Self Compassion levels in people who have relatives with mental disorders. There are many indications that those people suffer from stressors, due to their important role as caretakers of the mental health patients and the serious psychologically pressuring events that they may encounter. Compassion and exhaustion towards others is studied in

such relatives and seems to be higher than the general population. Though Compassion towards the self is not known if it follows the same or a different norm (Pompili, 2014; Upasen & Saengpanya, 2021).

METHODS

Study design, participants and procedure

The present study is a cross-sectional study, a method used due to its low financial and time requirements, as well as the possibility of studying multiple variables in relation to self-compassion. The reference population is the general population, and a convenience sampling method was followed, choices that further contribute to low cost and reduced completion time. For the data collection process, questionnaires were administered individually online during the months of April to June of the year 2025. The estimated sample size was 70 individuals, which emerged after a power analysis described below. The study population consisted of individuals who chose to participate following a request from researchers received either in person or online through social media posts. All participants gave informed consent for their participation and were able to use the internet to answer the questions. The snowball method was used to collect further data, as participants approached in person were asked to forward the questionnaire to people in their social circle. Due to the convenience sampling method, adjustment for potential confounding factors was done through statistical analysis. Inclusion criteria were sufficient understanding and reading of the Greek language, age over 18 years, and ability to use the internet to complete questionnaires. Exclusion criteria were the existence of active psychotic symptoms or cognitive function disorders to the point of making it impossible to understand the questionnaire items or rendering the person incapable of giving informed consent, as well as disturbance of consciousness making perception of the environment impossible.

Statistical Analysis

For all statistical tests, the statistical package SPSS 30.0.0 (IBM Corp, NY, USA) was used. To investigate the correlation of all measured variables with self-compassion, aiming to answer the main and the majority of secondary research questions, and additionally to control for potential confounding effects, multiple linear regression analysis will be used, treating self-compassion measured by the SCS as a quantitative dependent variable. The level of statistical significance was set at 0.05. Additionally, Cronbach's alpha internal consistency index was calculated for all scales and subscales used, Spearman's rho for correlation of non-normally distributed quantitative variables, Mann-Whitney U analysis for investigating relationships between non-normally distributed quantitative variables and binary qualitative variables, and finally mediation analysis. The sample size necessary to detect at least a moderate effect size (0.15) with sufficient power (80%) using multiple linear regression was calculated using SPSS 30.0.0, resulting in a minimum necessary sample size of 66 individuals.

RESULTS

Demographic and clinical characteristics

Table 1 presents the demographic characteristics and clinical data for the total sample, which consists of 125 individuals.

Table 1

Descriptive statistics for demographic characteristics, family history of mental illness, PHQ-9 score, and DASS-21 score for the total sample (N=125).

Variable	*Mean ± SD or f (%)*	*Alpha (α)*
Gender		
Men	45 (36.0)	
Women	80 (64.0)	
Years of Education		
<12	19 (15.2)	
≥12	106 (84.8)	
Age (years)	30.49 ± 9.78	
≤29 years	72 (57.6)	
30-45 years	40 (32.0)	
>45 years	12 (9.6)	
Occupation		
Healthcare Professional	28 (22.4)	
Other	97 (77.6)	

Family History of Mental Illness		
Negative (No)	87 (69.6)	
Positive (Yes)	38 (30.4)	
Total PHQ-9 Score	8.57 ± 6.30	0.88
Total Self-Compassion Score (SCS)	2.98 ± 0.67	0.91
DASS-21		0.95
Stress	17.39 ± 10.88	0.87
Anxiety	11.84 ± 10.93	0.88
Depression	13.87 ± 10.60	0.87

Note: Data are presented as Mean ± Standard Deviation (M ± SD) for quantitative variables, and as Frequency (Relative Frequency) f (%) for qualitative variables. N=125.

Psychometric Properties of Questionnaries

Internal consistency indices (Cronbach's alpha) for each questionnaire and their subscales are recorded in Table 1. The total DASS21 scale showed Cronbach's alpha=0.947, a value that possibly indicates excessive sample homogeneity or similarity between items.

Construct validity for the PHQ-9 and DASS21 questionnaires was examined based on the convergent validity of the two scales. Spearman's rho revealed a statistically significant high correlation [rho=0.68, p<0.001, 95% CI (0.569, 0.767)], indicating convergent validity of the two scales in our sample.

Self-compassion in Relation to Clinical and Demographic Characteristics

The results of the backward multiple linear regression with self-compassion as the dependent variable are presented in Table 2. The following independent variables were initially entered: gender, age, years of education, occupation, depression levels (PHQ-9), stress levels (DASS21–Stress), anxiety levels (DASS21–Anxiety), and family psychiatric history. Age was treated as a categorical variable (<29, 30-45, and >45 years). The PHQ-9 was selected over the DASS21-Depression subscale due to its superior internal consistency and established utility as a screening tool in the general population.

The final multivariate model included depression levels (PHQ-9), anxiety levels (DASS21-Anxiety), and age. The model explains 37.50% of the variance in self-compassion scores (R2 = 0.375). A negative correlation was found between depression and self-compassion (beta = -0.048), independent of anxiety and age (p < 0.001). Anxiety also showed a negative correlation with self-compassion (beta = -0.011), while holding other variables constant (p = 0.006).

Table 2

Multiple linear regression analysis for the estimation of self-compassion (SCSG) (N=125).

Explanatory Factors	***Coefficient β***	***p-value***	***95% Confidence Interval***
Depression (PHQ-9)	-0.048	<0.001*	[-0.078, -0.048]
Anxiety (DASS21-Anxiety)	-0.011	0.006*	[-0.022, 0.000]
Age			
≤29 years (Ref)	-	-	-
30-45 years	0.014	0.965	[-0.202, 0.230]
>45 years	0.288	0.082	[-0.037, 0.613]

F = 25.57, p < 0.001, R2= 0.375. (*): Statistically significant.

Family History and Distress Comparison

The results from the Mann-Whitney-U test for the comparison of depression, anxiety, and stress with a family history of major mental illness are shown in Table 3. This statistical method was chosen due to the non-normal distribution of scores for the DASS-21-Stress, DASS-21-Anxiety, and PHQ-9 scales in the sample.

Median levels of stress, anxiety, and depression were found to be significantly higher in individuals with a positive family history of major mental illness. The significance level was set

at alpha = 0.017 following Bonferroni correction for multiple (3) comparisons.

Scale	*Positive History Median [IQR]*	*Negative History Median [IQR]*	*U-value*	*p-value*
Depression (PHQ-9)	10 [6, 16.50]	6 [3, 11]	2203.50	0.001*
Anxiety (DASS21)	16 [5, 32]	6 [2, 18]	2164.50	0.002*
Stress (DASS21)	24 [12, 30]	14 [8, 22]	2194.50	0.001*

Effect of Self-Compassion on the Relationship between Family History of Major Mental Illness and Distress

The results of the mediation analyses for the effect of self-compassion on the relationship between family history of major mental illness and depression, anxiety, and stress are shown in Figures 1-6. A statistically significant total effect model was observed in all analyses (Depression: F=12.95, p<0.001; Anxiety: F=14.95, p<0.001; Stress: F=11.62, p<0.001).

In all models, self-compassion was found to partially mediate the relationship between depression, anxiety, stress, and a positive family history of major mental illness.

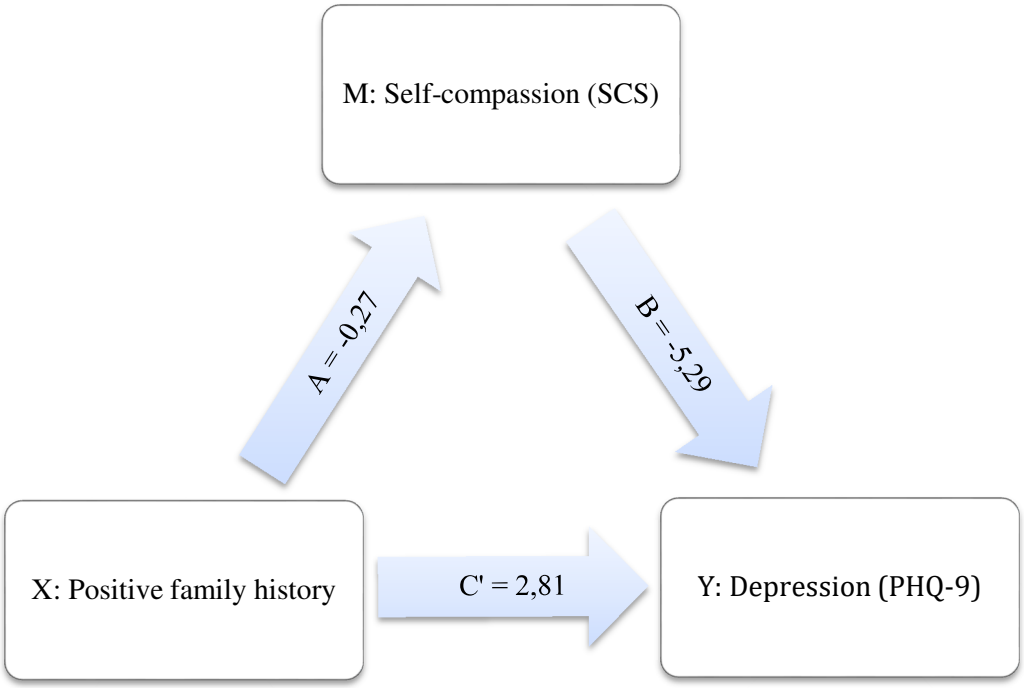
The statistically significant indirect effects were 1.40 [95% CI (0.12, 2.86)], 1.91 [95% CI (0.09, 4.01)], and 1.89 [95% CI (0.15, 4.02)], respectively. The total mediation percentages for the relationships between depression, anxiety, stress, and family history were 33.25%, 24.52%, and 27.31%.

Table 3

Median values, Interquartile Range (IQR), and U-test for distress scales based on family history.

Figure 1. Total effect model of family history of major mental illness on depression. F = 12.95, p < 0.001.

Figure 2. Simple mediation model of self-compassion in the relationship between family history of major mental illness and depression. PA = 0.004, pB < 0.001, pC' < 0.001. Indirect effect (A * B) = 1.40, 95% CI



(0.12, 2.86)

Figure 3. Total effect model of family history of major mental illness on anxiety. F = 14.95, p < 0.001.

Figure 4. Simple mediation model of self-compassion in the relationship between family history of major mental illness and anxiety. pA = 0.004$, pB < 0.001$, pC' < 0.001. Indirect effect (A * B) = 1.91, 95% CI (0.09, 4.01).

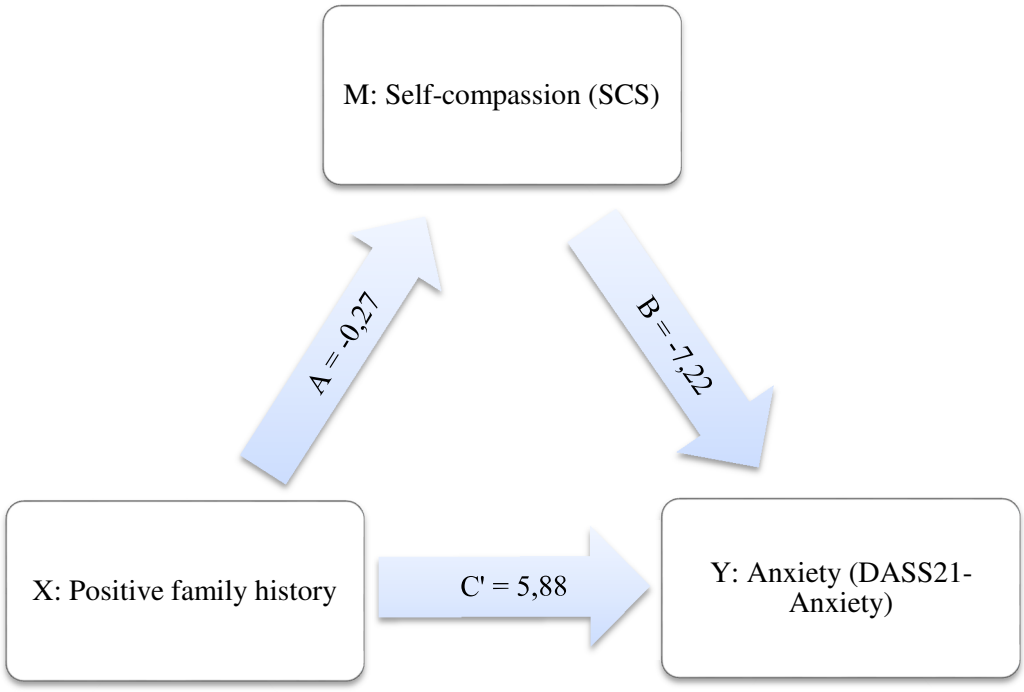
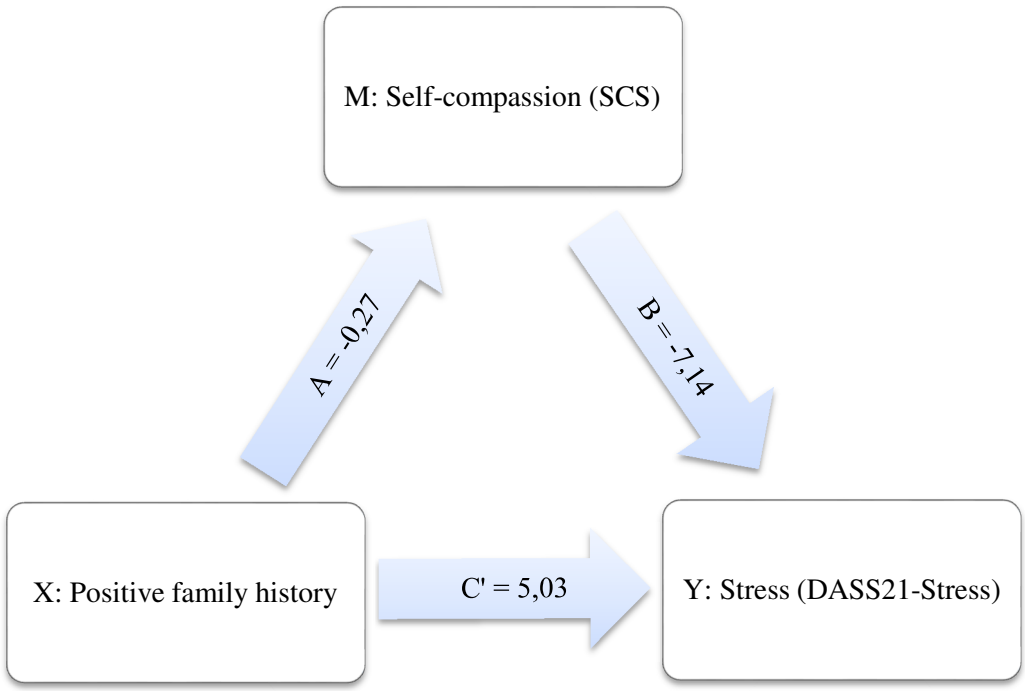


Figure 5. Total effect model of family history of major mental illness on stress. F = 11.62, p < 0.001.

Figure 6. Simple mediation model of self-compassion in the relationship between family history of major mental illness and stress. pA = 0.004, pB < 0.001, pC' = 0.01. Indirect effect (A*B) = 1.89$, 95% CI (0.15, 4.02).



DISCUSSION

The study findings attempt to contribute to a better understanding of the role of self-compassion in the general population and specifically in subgroups with increased risk of manifesting psychological distress, such as individuals with a positive family psychiatric history. No statistically significant sociodemographic differences emerged, contrary to Neff's (2023) study which showed increased self-compassion associated with increasing age and male gender. As expected, individuals reporting a positive family history of major mental illness presented significantly higher levels of distress in depression, anxiety, and stress markers. Simultaneously, results showed that self-compassion is strongly and negatively correlated with levels of depression and anxiety, consistent with recent meta-analyses.

Family history of major mental illness may be related to increased psychological burden, either due to genetic predisposition or through the experience of the caregiver role. The mediation analysis highlighted the role of self-compassion as a partial mediator in the relationship between positive family psychiatric history and psychological distress. This implies that reduced self-compassion constitutes an intermediate mechanism—creating conditions of vulnerability—through which family exposure to mental illness negatively affects an individual 's mental state. Thus, self-compassion could be considered to function as a protective mechanism against psychological burden. Extending this, the question arises whether self-compassion can function effectively as a factor enhancing resilience. Recent reviews confirm that characteristics like hope, self-esteem, and self-compassion function protectively regarding the maintenance of positive affect that enhances resilience. Interventions like Compassion Focused Therapy (CFT) and Mindfulness-Based Cognitive Therapy (MBCT) enhance self-compassion and aid in emotional self-regulation, reducing distress. The limitations are: Non-randomized sampling may limit generalizability, the sample was geographically limited, the cross-sectional design does not allow for causal conclusions, the study only examined gender as men/women.

The present study examined the association between self-compassion and psychological distress, operationalized as symptoms of depression, anxiety, and stress, as well as the

mediating role of self-compassion in the relationship between family history of major mental illness and psychological distress. Overall, the findings support theoretical and empirical literature suggesting that self-compassion constitutes an important protective psychological factor.

Consistent with previous research (MacBeth & Gumley, 2012; Neff, 2003), self-compassion was found to be significantly and negatively associated with depressive and anxiety symptoms. Individuals reporting higher levels of self-compassion experienced lower levels of psychological distress, supporting the view that self-compassion facilitates adaptive emotional regulation and reduces maladaptive self-evaluative processes such as self-criticism and rumination. These findings reinforce the conceptualization of self-compassion as a mechanism that promotes psychological well-being by fostering self-acceptance and emotional balance in the face of distress.

As hypothesized, participants with a positive family history of major mental illness reported significantly higher levels of depression, anxiety, and stress. This result is consistent with prior studies indicating that familial exposure to mental illness may increase psychological vulnerability through genetic liability, environmental stressors, or caregiving burden (Murfield et al., 2020; Lök & Bademli, 2024). Importantly, mediation analyses demonstrated that self-compassion partially mediated the relationship between family psychiatric history and psychological distress. This suggests that reduced self-compassion may function as an intermediate mechanism through which familial mental illness exerts its negative impact on individual psychological functioning.

Contrary to findings reported by Neff (2023), the present study did not identify significant associations between self-compassion and sociodemographic variables such as age and gender. This discrepancy may be attributable to sample characteristics, including limited age variability, cultural context, and the homogeneity of the study population, as well as methodological differences between studies.

Collectively, the findings suggest that self-compassion may operate both as a protective factor against psychological distress and as a resilience-related construct that mitigates the adverse psychological effects associated with a family history of mental illness. This interpretation is further supported by recent evidence highlighting the role of self-compassion, alongside constructs such as hope and self-esteem, in promoting psychological resilience and sustained positive affect (Egan et al., 2024).

From a clinical perspective, the present findings have important implications for prevention and intervention efforts. Psychotherapeutic approaches that explicitly target self-compassion, such as Compassion Focused Therapy (CFT) and Mindfulness-Based Cognitive Therapy (MBCT), have demonstrated effectiveness in enhancing self-compassion and reducing symptoms of depression and anxiety across diverse clinical populations (Kurebayashi & Sugimoto, 2022; Millard et al., 2023; Stutts et al., 2022). Interventions aimed at strengthening self-compassion may be particularly beneficial for individuals with a positive family psychiatric history, who appear to be at increased risk for psychological distress.

LIMITATIONS AND FUTURE DIRECTIONS

Despite the contributions of the present study, several limitations should be acknowledged. First, the study employed a convenience sampling method, as data were collected within the context of a postgraduate semester project with limited time resources. Participants were recruited based on accessibility and willingness to participate, either in person or online. As a result, the sample was not randomly selected, which may limit the generalizability of the findings. Certain social groups (e.g., mental health professionals or individuals with higher psychological literacy) may be overrepresented or underrepresented. Additionally, the sample was relatively homogeneous in terms of age, social status, and geographic location.

Second, the cross-sectional design of the study constitutes a significant limitation. Although statistically significant associations were identified among self-compassion, family psychiatric history, and psychological distress, the single-time-point assessment precludes causal inferences. It cannot be determined whether low self-compassion contributes to the development of psychological distress, whether psychological distress undermines self-compassion, or whether both are influenced by unmeasured third variables, such as early life adversity, trauma exposure, or personality traits. Longitudinal and prospective study designs are therefore recommended to clarify the directionality and temporal dynamics of these relationships.

Third, the study relied exclusively on self-report measures, including the Self-Compassion Scale (SCS), the Patient Health Questionnaire-9 (PHQ-9), and the Depression Anxiety Stress Scales-21 (DASS-21). While these instruments are widely used and psychometrically sound, self-report data are inherently subject to response biases, such as social desirability, recall bias, and mood-congruent responding. Even in anonymous surveys, participants may hesitate to disclose sensitive psychological information, potentially leading to underreporting or superficial responses. Future research would benefit from incorporating multi-method approaches, including clinician-rated assessments, behavioral measures, or qualitative interviews.

Furthermore, although participants were given the option to self-identify beyond binary gender categories, all respondents identified as either male or female. Consequently, the present study was unable to examine differences related to non-binary or gender-diverse identities. Future research should aim to include more diverse samples to explore the role of self-compassion across a broader spectrum of gender identities.

Finally, the study focused exclusively on depression, anxiety, and stress as indicators of psychological distress. Other

forms of psychopathology, such as post-traumatic stress disorder (PTSD), obsessive–compulsive disorder (OCD), or personality disorders, were not assessed. The exclusion of additional diagnostic domains may limit a comprehensive understanding of the role of self-compassion across different forms of psychological dysfunction. Future studies should examine whether the protective and mediating role of self-compassion extends to a wider range of clinical conditions.

CONCLUSION

The present study contributes to the growing literature on self-compassion by demonstrating its significant association with reduced psychological distress and its partial mediating role in the relationship between family history of major mental illness and psychological burden. Individuals with higher levels of self-compassion reported lower symptoms of depression and anxiety, while those with a positive family psychiatric history exhibited greater psychological distress. Importantly, self-compassion emerged as an intermediate mechanism through which familial exposure to mental illness may influence individual mental health outcomes.

These findings support the conceptualization of self-compassion as a resilience-related psychological resource that may buffer vulnerability in at-risk populations. From a clinical and preventive standpoint, interventions aimed at enhancing self-compassion—such as Compassion Focused Therapy and Mindfulness-Based Cognitive Therapy—appear particularly promising, especially for individuals with elevated familial risk. Future longitudinal and intervention-based research is needed to further clarify the causal pathways involved and to determine whether strengthening self-compassion may not only alleviate distress but also contribute to the prevention of mental health disorders.

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