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Research paper

Self-compassion is more effective than acceptance and reappraisal in decreasing depressed mood in currently and formerly depressed individuals☆

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ABSTRACT

Background: Self-compassion has recently been discussed as an effective affect regulation strategy for reducing negative affective states. The primary aim of the current study was to compare the efficacy of self-compassion to the more established strategies of acceptance and reappraisal.

Methods: For this purpose, we induced depressed mood in formerly, currently and never depressed individuals ($n = 30$ each) at four different time-points. Participants were instructed to regulate their emotions after each mood induction by either waiting, employing self-compassion, accepting their emotions or reappraising the situation. Level of depressed mood was assessed before and after each mood induction and regulation phase.

Results: Across groups, decreases in depressed mood were greater in the self-compassion compared to the waiting and acceptance conditions. In recovered and never depressed participants, self-compassion was also more effective than reappraisal.

Limitations: Our results rely solely on self-report data. *Conclusions:* Our finding that self-compassion is superior to acceptance and equally or more effective than reappraisal encourages future research on how self-compassion interventions can be used to enhance the efficacy and stability of current depression treatments.

1. Introduction

Major Depressive Disorder (MDD) is a highly recurrent disorder (Bockting et al., 2005). The risk for repeated episodes in individuals who have recovered from a depressive episode exceeds 80% (Boland and Keller, 2002) with patients experiencing an average of four major depressive episodes of 20 weeks duration each (Judd, 1997). The mechanisms of depression relapse and recurrence, however, have remained largely elusive (Beshai et al., 2011).

Throughout the past 20 years, deficits in affect regulation (AR) have gained increased attention as risk and maintenance factors for MDD (Ehring et al., 2010; Joormann and Siemer, 2014). AR refers to the extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying affective states in accordance with situational demands, biological needs, and individual goals (e.g., Eisenberg et al., 2004; Gratz and Roemer, 2008, Thompson, 1994). Following Gross (2014), affective states include undifferentiated psychophysiological arousal (e. g., tension, stress), moods (e. g., depressed mood, dysphoric mood), and emotions (e. g., anxiety, anger, sadness, shame, guilt). AR can thus be seen as an umbrella term including the concepts of emotion and mood regulation (Gross, 2014). Within this paper, a special emphasis was put on the regulation of depressed mood.

Cognitive theories of depression have suggested that negative affect cues cognitive processes that foster an escalation of negative mood which over time can culminate in a depressive episode (e.g., Teasdale, 1988). Many authors have argued that deficits in AR are not confined to acute episodes of depression but may be a more stable characteristic of depression vulnerability (Gross and Munoz, 1995; Kring and Werner, 2004; Rude and McCarthy, 2003). From this perspective, strategies that down-regulate negative affective states could potentially be used to prevent the onset, maintenance, or recurrence of depressive episodes. Two of the most widely studied AR skills are reappraisal (e.g., Gross and John, 2003) and acceptance (e.g., Berking and Whitley, 2014).

Several studies on healthy and clinical samples, including MDD

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participants, have supported negative associations between depressive symptoms and the use of reappraisal (Garnefski and Kraaij, 2006; Garnefski et al., 2004; Martin and Dahlen, 2005; Rood et al., 2012). At the same time, some authors have started to question the usefulness of reappraisal in down-regulating elevated negative mood states (e.g., Gotlib and Joormann, 2010). Reappraisal is a cognitively taxing task (Joormann and Siemer, 2014). Mood-congruent biases in basic cognitive processes such as attention, memory, and interpretation as well as deficits in cognitive flexibility and control may lead to inflexible and automatic appraisals and impede the use of reappraisal in MDD (Gotlib and Joormann, 2010; Joormann et al., 2010). Elevated levels of negative affect may further impede the use of reappraisal because alternative, more helpful, cognitions are incongruent with the experienced emotional and somatic states (Gotlib and Joormann, 2010; Joormann and Siemer, 2004). Consistent with this more critical evaluation of cognitive reappraisal, some studies have found habitual use of reappraisal to be unrelated to depressive symptoms or correlated with poorer outcomes (Garnefski et al., 2001; Nezlek and Kuppens, 2008).

Findings on associations between acceptance and depressive symptoms are also mixed (e.g., Garnefski and Kraaij, 2006; Garnefski et al., 2001; Martin and Dahlen, 2005). Previous experimental studies indicate a lack of short term relief (Campbell-Sills et al., 2006) or even temporary increases of experienced distress following acceptance (Liverant et al., 2008). Acceptance has been proposed to be a strategy that is difficult to apply without previous training and that may even activate feelings of hopelessness and resignation (Diedrich et al., 2014). It may be difficult to apply at elevated levels of negative affect (Diedrich et al., 2014; Shallcross et al., 2010). Limitations of reappraisal and acceptance clearly indicate the need for further research on adaptive AR strategies.

A strategy that has a long tradition in Buddhist approaches to enhance well-being (Gilbert et al., 2004) but has only recently gained the attention of mental health and well-being researchers is compassionate self-support (e.g., Neff, 2003). Self-compassion entails being kind, empathetic, supportive, and understanding toward oneself in instances of pain or failure rather than being harshly self-critical. It includes being open to and moved by one's experiences. Negative affect is not avoided. Instead, people take an external perspective on themselves (i.e., on the suffering self); they let arise a warm and strong feeling of empathy that is associated with the wish to help themselves in instances of pain and suffering (e.g., Berking and Whitley, 2014; Neff, 2003). Self-compassion is regarded as an effective AR strategy that helps create distance from suffering (i.e., the suffering self) and transforms negative affect (e.g., disgust, shame) into more positive self-referential affect (e.g., feelings of kindness and understanding; Berking and Whitley, 2014; Neff, 2003). As it directly builds on the experienced emotional and somatic states, it should require less cognitive flexibility and control than for example reappraisal (Gotlib and Joormann, 2010). Furthermore, as self- compassion directly builds on a person's suffering, it is proposed to be easily applied when facing extremely negative emotions (Berking and Whitley, 2014; Diedrich et al., 2014; Hein and Singer, 2008). Within the adaptive coping with emotions model (Berking and Whitley, 2014), self-compassion is also discussed as an effective mood stabilizing strategy that helps keep one's mood within an acceptable range and enhances motivation for effective AR (Berking and Whitley, 2014). Self-compassion may thus enable individuals to persistently utilize other adaptive skills such as reappraisal and acceptance, even if they are initially aversive (Berking and Whitley, 2014; Diedrich et al., 2014; Liverant et al., 2008). Previous cross-sectional and longitudinal studies using individuals from the general population (MacBeth and Gumley, 2012; Neff et al., 2007; Shapira and Mongrain, 2010) and a clinical inpatient sample (Berking et al., 2008a) have linked higher levels of habitual use of self-compassion to more positive emotions, less negative emotions, and fewer depressive symptoms. In a previous experimental study, self-compassion was more effective than a neutral waiting condition and equal to or, at elevated levels of depressed mood, more effective than reappraisal or acceptance in decreasing depressed mood in a MDD sample (Diedrich et al., 2014).

By comparing the effects of self-compassion on decreases in depressed mood to the more established AR strategies of acceptance and reappraisal, this study aimed to provide further support for self-compassion as an effective AR strategy in healthy and clinically diagnosed samples. Considering high rates of depression recurrence (e.g., Boland and Keller, 2002) and the likely importance of unregulated negative affect and deficits in AR (e.g., Teasdale and Cox, 2001) for depression relapse, this study, for the first time, aimed to test the effectiveness of self-compassion in formerly depressed individuals. Building on previous research and without previous training, we expected self-compassion to be more effective in reducing a previously induced negative mood state as (1) a neutral waiting condition, (2) emotional acceptance, (3) and cognitive reappraisal. Positive findings for self-compassion should hold across groups of currently, formerly and never depressed individuals.

2. Methods

2.1. Participants and procedures

Three groups of participants (n = 30 each) took part in the study: recovered depressed (RMD), currently depressed (MDD), and never depressed control (NC) participants. MDD participants were randomly selected out of 101 MDD patients enrolled in a treatment outcome study in two outpatient treatment centers in Germany using SPSS (Ehret et al., 2014). RMD and NC individuals were recruited to match these patients with regard to age, sex, and level of education (n = 30 each). RMD and NC participants were solicited in one of the two outpatient treatment centers as well as through advertisements posted in numerous locations within the local communities and in local newspapers. All individuals recruited in the outpatient clinic were willing to participate in the experiment. Individuals responding to the advertisements were excluded if they did not match the diagnostic criteria with regard to depression status, age, sex, and level of education

Participants were assigned to the groups on the basis of the Structured Clinical Interview for DSM-IV Axis I (SCID; German version: Wittchen et al., 1997). The diagnostic interview was administered by interviewers with Bachelor's degrees or above in clinical psychology. All raters received extensive training in using the SCID interview and were supervised by advanced students (i.e., psychologists with Master's degrees or above in psychology). Individuals in the MDD group were diagnosed with MDD as the primary diagnosis. Participants in the RMD group had experienced at least one major depressive episode in the past and had been remitted for at least two months prior to inclusion in this study. NC participants did not meet criteria for any mental disorder and had no history of MDD at the time of the study. Further inclusion criteria for all groups included age 18 or above and sufficient German language skills. Exclusion criteria included acute risk for suicide or comorbid psychotic, substance-related, bipolar disorders, organic brain or other severe medical disorders, and severe cognitive impairments. Other comorbid disorders in the MDD and RMD groups were allowed to increase validity of the study.

2.2. Material

2.2.1. Mood measures

Participants rated their level of depressed mood ("How depressed do you feel at the moment") on visual analog scales (VAS) at the beginning of the experiment (baseline rating), before, and after each of the four mood inductions and regulation instructions. Computer-based VAS were composed of two vertical lines anchored on one end by the words *"not at all"* (= 0) and on the other end by the word *"completely"* (= 100). Participants were asked to place a mark across the line at the point that best described their answer.