Self-Compassion as a Predictor of Psychological Well-Being in Adults: A Cross-Sectional Study

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Abstract

Background. Self-compassion — the disposition to treat oneself with kindness, common humanity, and mindful equanimity in moments of personal failure or distress — has attracted considerable empirical attention as a protective psychological resource. However, studies examining its association with psychological well-being while controlling for sociodemographic variables in general adult samples remain comparatively limited. **Aim.** This cross-sectional study investigated whether self-compassion is associated with psychological well-being after controlling for age and gender in a community sample of adults. **Design and Sample.** N = 103 adults (M age = 34.8 years, SD = 10.0; 57.3% female, 42.7% male; 78.6% employed, 21.4% students) completed the Self-Compassion Scale–Short Form (SCS-SF; α = .93) and the WHO-5 Well-Being Index (α = .86) via anonymous online survey. **Main Results.** A bivariate correlation revealed a strong positive association between self-compassion and psychological well-being, $r(101) = .53$, $p < .001$. In a simultaneous multiple regression controlling for age and gender, self-compassion remained a significant predictor of well-being ($\beta = .53$, $t = 6.19$, $p < .001$), whereas age ($\beta = .06$, $p = .500$) and gender ($\beta = -.04$, $p = .614$) were non-significant. The overall model explained 29% of the variance ($R^2 = .29$, adjusted $R^2 = .27$, $F(3, 99) = 13.30$, $p < .001$). **Conclusion.** Self-compassion is a robust correlate of psychological well-being in adults, independent of age and gender. The effect is consistent with meta-analytic benchmarks. Given the cross-sectional design, causal inferences cannot be drawn; the findings may nonetheless inform the development of self-compassion-based interventions as a scalable approach to promoting population mental health.

Keywords: self-compassion, psychological well-being, adults, WHO-5, positive psychology

1. Introduction

Imagine a woman in her mid-thirties sitting alone on a Sunday evening, scrolling through the mental catalogue of the week's mistakes: the email she sent too hastily, the conversation she handled badly, the dietary resolve she abandoned by Wednesday. The inner monologue is familiar to most adults, but its register varies enormously between individuals. For some, the

voice is harsh, contemptuous, relentlessly critical — a running commentary that amplifies distress and diminishes the prospect of recovery. For others, it is more measured, even compassionate: acknowledging failure without catastrophising, extending to the self the same understanding one might offer a close friend. This difference — between harsh self-criticism and self-compassion — is, according to a substantial programme of psychological research, one of the more consequential individual-difference variables for human well-being. The present study examines the empirical relationship between self-compassion and psychological well-being in a sample of adults, testing this association while controlling for key sociodemographic variables.

Self-compassion was introduced as a formal psychological construct by Neff (2003a), who defined it as comprising three inter-related components: self-kindness (treating oneself with warmth and understanding rather than harsh judgement), common humanity (recognising that suffering and failure are part of the shared human experience), and mindfulness (holding painful thoughts and feelings in balanced awareness rather than over-identifying with them). The construct was theorised to provide a flexible, non-contingent form of self-regard that supports emotional regulation and facilitates adaptive coping with adversity. Since Neff's (2003a) seminal papers, self-compassion has become one of the most actively researched constructs in clinical and positive psychology, with hundreds of empirical studies accumulating across diverse populations and methodological designs.

At the population level, concerns about declining mental health, rising rates of depression and anxiety, and the erosion of psychological well-being have intensified the search for scalable, accessible psychological resources. The WHO-5 Well-Being Index provides a brief, validated measure of subjective psychological well-being widely used in epidemiological and clinical contexts (Topp et al., 2015). Population surveys employing the WHO-5 have documented substantial heterogeneity in well-being across demographic groups and identified modifiable psychological predictors as priority targets for intervention. Zessin et al.'s (2015) meta-analysis of self-compassion and well-being — analysing data from 79 studies with a combined N of over 16,000 — reported a mean effect size of r = .47 across well-being measures, establishing the robustness of the association and underscoring its practical significance.

Despite this wealth of evidence, several questions merit further empirical attention. Many studies examining self-compassion and well-being have employed student or clinical samples, limiting the generalisability of findings to community adults. Moreover, relatively few studies have tested the independence of the self-compassion–well-being relationship from sociodemographic factors such as age and gender, which are themselves associated with both constructs (Barnard & Curry, 2011; Leary et al., 2007). Gender differences in self-

compassion have been documented in some but not all studies, and the trajectory of self-compassion across adulthood remains incompletely understood. A study employing a diverse community sample and testing the self-compassion–well-being association while controlling for these factors therefore provides a useful, if incremental, contribution to the literature.

The present study is framed modestly. The existence of a positive self-compassion–well-being association is already well established meta-analytically (Zessin et al., 2015); the aim here is not to discover a novel effect but to test whether that association holds, with transparent measurement and simultaneous covariate control, in a community adult sample. If self-compassion is associated with well-being independently of age and gender, this strengthens the rationale for treating self-compassion as a candidate target in preventive mental health work — including mindful self-compassion (MSC) programmes (Germer & Neff, 2013), acceptance and commitment therapy (Hayes et al., 2012), and compassion-focused therapy (Gilbert, 2010) — while leaving questions of causal direction to subsequent experimental and longitudinal research.

2. Theoretical Background

2.1 Self-Compassion: Theory, Measurement, and Mechanisms

Neff's (2003a, 2003b) theoretical framework conceptualises self-compassion as a three-component construct: self-kindness versus self-judgement, common humanity versus isolation, and mindfulness versus over-identification. Each component represents a bipolar dimension, and self-compassion reflects the positive pole of all three simultaneously. Neff (2003b) positioned self-compassion as distinct from, though theoretically related to, constructs such as self-esteem, self-pity, and narcissism. Unlike self-esteem, which is contingent on success, performance, and social comparison, self-compassion is theorised to be non-contingent and relatively stable across fluctuations in performance and social evaluation. This non-contingency is proposed to be a key mechanism through which self-compassion confers its benefits: individuals high in self-compassion do not need to succeed or to be better than others in order to feel good about themselves, and are therefore less vulnerable to the emotional volatility associated with ego-threat.

The Self-Compassion Scale (SCS; Neff, 2003a) and its validated short form (SCS-SF; Raes et al., 2011) have become the most widely used instruments for assessing self-compassion. The SCS-SF comprises 12 items assessing the three positive components and their negative counterparts, yielding a total self-compassion score through reverse-scoring of the negatively keyed items and averaging. Psychometric studies across numerous languages and cultures have supported the factor structure, reliability, and validity of the instrument (Raes et al., 2011;

Zessin et al., 2015). In the present study the SCS-SF was employed for its brevity and psychometric quality, and demonstrated excellent internal consistency (α = .93).

The mechanisms through which self-compassion may promote well-being have been theorised at multiple levels. At the emotional level, self-compassion is theorised to deactivate the threat-based emotional system — the internal critic — and activate the soothing and affiliative system, resulting in reduced negative affect and increased positive affect (Gilbert, 2010). Fredrickson's (2001) broaden-and-build theory provides a compatible account: positive emotions generated by self-compassion broaden momentary thought–action repertoires and, over time, build enduring personal resources including resilience, optimism, and social connectedness, which in turn sustain psychological well-being. Empirical studies have associated self-compassion with positive affect, optimism, emotional resilience, and life satisfaction, and inversely with depression, anxiety, rumination, and experiential avoidance (Barnard & Curry, 2011).

Leary et al. (2007) demonstrated across laboratory and daily-diary studies that self-compassion attenuated the negative emotional impact of distressing events by reducing excessive self-identification with negative experiences, enhancing perspective-taking, and promoting adaptive cognitive reappraisal. Krieger et al. (2016) provided evidence that self-compassion is associated with reduced rumination and self-criticism — processes implicated in depression vulnerability. These findings situate self-compassion within an emotion-regulation framework, consistent with Gross's (2015) process model: self-compassionate individuals may attend to distress with mindful awareness rather than avoidance, and reappraise self-relevant failures through the lens of common humanity rather than isolation and self-blame. This regulatory function positions self-compassion as a potentially trainable emotional competence.

2.2 Psychological Well-Being: Definition and Assessment

Psychological well-being is a multifaceted construct encompassing hedonic elements (positive affect, life satisfaction, absence of negative affect) and eudaimonic elements (purpose, growth, autonomy, positive relationships; Ryff, 1989; Seligman, 2011). The WHO-5 Well-Being Index captures the hedonic component, assessing subjective experience of positive mood, vitality, and interest in life over the preceding two weeks. Despite its brevity, the WHO-5 has demonstrated robust psychometric properties including good internal consistency, convergent validity with longer well-being measures, and sensitivity to change in intervention studies (Topp et al., 2015). Its brevity makes it well suited to survey research in community samples, where instrument length is a key determinant of completion rates and data quality.

Seligman's (2011) PERMA model — positive emotion, engagement, relationships, meaning, and accomplishment — provides a broader conceptual backdrop. Self-compassion is theoretically relevant to multiple PERMA components: it may support positive-emotion regulation, facilitate engagement, enhance relational warmth, contribute to meaning by connecting personal experience to shared humanity, and sustain a sense of accomplishment by decoupling self-worth from performance. This theoretical convergence suggests that the association between self-compassion and well-being should be robust across operationalisations of the outcome, consistent with the effect sizes reported by Zessin et al. (2015).

Self-Determination Theory (SDT; Deci & Ryan, 2000) offers a further pathway. SDT identifies three basic psychological needs — autonomy, competence, and relatedness — whose satisfaction is held to be necessary for well-being. Self-compassion may support need satisfaction in each domain: by providing a stable, non-contingent self-regard it may support autonomy; by framing failure as a universal human experience rather than evidence of personal inadequacy it may support a realistic sense of competence; and by fostering common humanity it may support relatedness. The present study does not test these mechanistic pathways directly but is broadly consistent with the SDT expectation of a positive association between self-compassion and well-being.

2.3 Gender, Age, and Self-Compassion

Gender differences in self-compassion have been examined with mixed results. Some research has found that women score lower on self-compassion than men (Neff, 2003a; Neff et al., 2007), particularly on the self-kindness and isolation facets, potentially reflecting socialisation patterns that encourage self-criticism. However, more recent work indicates that gender differences are small when related variables are controlled, with modest meta-analytic effect sizes (Yarnell et al., 2015). The present study includes gender as a covariate to test whether the self-compassion–well-being association remains significant after accounting for gender-related variance. With respect to age, Neff and colleagues have reported slight increases in self-compassion across adulthood, consistent with theories of socioemotional development (Erikson, 1968). Age is likewise included as a covariate to ensure that any observed relationship reflects a genuine association rather than confounding by developmental factors.

2.4 Hypotheses

Drawing on the theoretical and empirical literature reviewed above, the present study advances two hypotheses:

H1: Self-compassion is positively and significantly associated with psychological well-being in a community sample of adults.

H2: Self-compassion significantly predicts psychological well-being after controlling for age and gender.

3. Method

3.1 Study Design

A cross-sectional correlational design was employed, consistent with standard practice in research examining self-compassion as a correlate of well-being outcomes (Neff, 2003a; Zessin et al., 2015). All variables were assessed at a single measurement occasion via self-report questionnaire. The study is best understood as the needs-assessment stage of an evidence-to-practice pipeline: it establishes, under naturalistic conditions in a community sample, the magnitude of the self-compassion–well-being association in order to inform the subsequent design and prioritisation of self-compassion-based interventions. No intervention, manipulation, or participatory component was implemented at this stage; accordingly, the present report makes no claims of an experimental or action-research outcome. The study was conducted in accordance with the Declaration of Helsinki (World Medical Association, 2013); given the anonymous, non-interventional nature of the survey, formal institutional review board approval was not required. Participants provided informed consent via a written pre-survey information screen.

3.2 Sample and Recruitment

Participants were recruited via anonymous online surveys distributed through multiple digital channels, including social-media platforms (Facebook and Instagram), university networks, and an online research-participation platform. Eligibility was restricted to adults aged 18 years or older. The final sample comprised N = 103 adults. Mean age was 34.8 years (SD = 10.0; range 18–62). Gender composition was 59 female (57.3%) and 44 male (42.7%); employment status was employed for 81 participants (78.6%) and student for 22 (21.4%). No exclusion criteria were applied beyond the minimum age requirement, and no compensation was provided. As a non-probability convenience sample, the data do not support claims of population representativeness (see Section 5.3).

3.3 Measures

Self-Compassion. Self-compassion was assessed using the Self-Compassion Scale–Short Form (SCS-SF; Raes et al., 2011), a 12-item instrument measuring three positive components

(self-kindness, common humanity, mindfulness) and their negative counterparts (self-judgement, isolation, over-identification). Items were rated on a five-point scale (1 = strongly disagree to 5 = strongly agree). The six negatively keyed items (items 1, 4, 8, 9, 11, and 12) were reverse-scored (6 − raw score), and a total self-compassion score was computed as the mean of all 12 items, with higher scores indicating greater self-compassion. The complete item set, response anchors, and scoring key are reproduced in Appendix A. The scale demonstrated excellent internal consistency in the present sample (α = .93; M = 3.54, SD = 0.81).

Psychological Well-Being. Psychological well-being was measured using the WHO-5 Well-Being Index (World Health Organization, 1998; Topp et al., 2015), a five-item scale assessing positive mood, vitality, and interest over the preceding two weeks. In the present study the WHO-5 was administered on a five-point response scale (1 = strongly disagree to 5 = strongly agree) in order to maintain a common response metric with the SCS-SF. This represents a deliberate deviation from the original six-point (0–5) WHO-5 response format. The items were further presented with agreement anchors (strongly disagree to strongly agree) in place of the instrument's validated frequency anchors (at no time to all of the time), a substitution adopted to give participants a single, uniform response format across both instruments and to minimise response-set switching, but one that departs from the conditions under which the WHO-5 was validated and may limit comparability with studies employing the original anchors. The original frequency anchors will be retained in future administrations. As a consequence, the conventional linear transformation to a 0–100 percentage score was not applicable, and the total score was computed as the mean of the five items, with higher scores indicating greater well-being. This adaptation precludes a robustness check based on the standard 0–100 scoring and is acknowledged as a limitation (see Section 5.3). The complete item set and anchors are reproduced in Appendix A. The scale demonstrated good internal consistency (α = .86; M = 3.62, SD = 0.91).

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3.4 Statistical Analysis

Data were analysed using IBM SPSS Statistics (Version 28) and independently verified in Python (statsmodels, pingouin). Descriptive statistics and internal-consistency coefficients (Cronbach's α) were computed for all study variables. A Pearson correlation assessed the bivariate association between self-compassion and well-being. A simultaneous multiple regression — with age, gender, and self-compassion entered together in a single block — was conducted to test whether self-compassion predicted well-being while controlling for age and gender; no hierarchical (stepwise block) entry was used. Regression assumptions — linearity, normality of residuals, homoscedasticity, and absence of multicollinearity — were formally

examined, and the results are reported in Section 4.3. Because all constructs were assessed via self-report, Harman's single-factor test was used to evaluate the potential for common-method variance (Podsakoff et al., 2003). Gender was coded 0 = male, 1 = female. All tests were two-tailed with α = .05.

4. Results

4.1 Descriptive Findings

Table 1 presents descriptive statistics for the study variables. Self-compassion scores ranged from 1.17 to 5.00 (M = 3.54, SD = 0.81), indicating moderately positive self-compassion across the sample. Well-being scores ranged from 1.40 to 5.00 (M = 3.62, SD = 0.91), reflecting moderate-to-good subjective well-being. Both instruments demonstrated good-to-excellent internal consistency (α = .93 for the SCS-SF; α = .86 for the WHO-5). Score distributions were approximately normal, with no transformations required.

Table 1

Descriptive Statistics for Study Variables

Scale	Items (n)	M	SD	α
Self-Compassion Scale–SF (SCS-SF)	12	3.54	0.81	.93
WHO-5 Well-Being Index	5	3.62	0.91	.86

Note. N = 103. M = mean; SD = standard deviation; α = Cronbach's alpha. Both scales used a 1–5 response format.

4.2 Correlational Findings

Table 2 presents the bivariate correlation between self-compassion and psychological well-being. Pearson's r(101) = .53, p < .001, indicating a strong positive association: participants with higher self-compassion reported substantially greater psychological well-being. This finding supports H1. The effect size of r = .53 is consistent with — and marginally above — the meta-analytic estimate of r = .47 reported by Zessin et al. (2015) and is conventionally characterised as large (Cohen, 1988).

Table 2

Correlations Among Study Variables

Variable	1	2
1. Self-Compassion (SCS-SF)	—	.53***
2. Well-Being (WHO-5)	.53***	—

Note. N = 103. *** p < .001 (two-tailed).

4.3 Main Analysis and Assumption Checks

A simultaneous multiple regression was conducted with psychological well-being as the criterion and age, gender, and self-compassion as predictors. The overall model was statistically significant, $F(3, 99) = 13.30$, $p < .001$, $R^2 = .29$, adjusted $R^2 = .27$, indicating that the three predictors collectively accounted for 29% of the variance in well-being. Self-compassion emerged as the only significant predictor ($B = 0.59$, $SE = 0.10$, $\beta = .53$, $t = 6.19$, $p < .001$). Age ($B = 0.01$, $SE = 0.01$, $\beta = .06$, $t = 0.68$, $p = .500$) and gender ($B = -.08$, $SE = 0.16$, $\beta = -.04$, $t = -.51$, $p = .614$) were non-significant. These results support H2. Table 3 presents the full regression results.

Table 3

Simultaneous Multiple Regression of Well-Being on Self-Compassion, Age, and Gender

Predictor	B	SE	β	t	p
Age	0.01	0.01	.06	0.68	.500
Gender	−.08	0.16	−.04	−.51	.614
Self-Compassion (SCS-SF)	0.59	0.10	.53	6.19	< .001

Note. N = 103. $R^2 = .29$, adjusted $R^2 = .27$, $F(3, 99) = 13.30$, $p < .001$. Gender coded 0 = male, 1 = female.

Assumption checks. Before interpretation, the regression assumptions were formally evaluated. Multicollinearity was negligible: all variance inflation factors were at or below 1.03 (tolerance ≥ .97). The normality of residuals was supported by a non-significant Shapiro–Wilk test, $W = .99$, $p = .38$, and by inspection of the normal P–P plot. Homoscedasticity was indicated by a non-significant Breusch–Pagan test, $\chi^2(3) = 1.67$, $p = .65$, and the residual-versus-fitted scatter revealed no systematic pattern, consistent with linearity. To address the potential for common-method variance arising from the exclusive use of self-report measures, Harman's single-factor test was conducted: an unrotated principal-components analysis of all 17 items yielded a first factor accounting for 47.8% of the variance, below the customary 50% threshold. This suggests that common-method bias is unlikely to fully account for the observed associations, although it cannot be entirely excluded (see Section 5.3).

5. Discussion

5.1 Summary and Theoretical Integration

The present study examined self-compassion as a correlate of psychological well-being in a community sample of adults. The findings were clear and consistent: self-compassion demonstrated a strong bivariate association with well-being ($r = .53$, $p < .001$) and remained a significant predictor after controlling for age and gender ($\beta = .53$, $p < .001$), with the overall model explaining 29% of the variance in well-being. Both hypotheses were supported. The magnitude of the association is consistent with, and marginally above, the mean effect reported in the Zessin et al. (2015) meta-analysis ($r = .47$). The contribution of the present study therefore lies less in the existence of the association — which is well established — than in its replication within a community adult sample, with simultaneous control for age and gender and with fully transparent, reproducible measurement.

From the perspective of Neff's (2003a, 2003b) self-compassion model, the pattern is readily interpretable. Participants who endorsed higher levels of self-kindness, common humanity, and mindfulness — and lower levels of their negative counterparts — also reported more positive mood, vitality, and interest in life. The mechanisms proposed by Neff, including deactivation of the inner critic, activation of affiliative self-soothing, and mindful present-moment awareness, are each theoretically linked to the dimensions captured by the WHO-5. The proposed non-contingency of self-compassionate self-regard — its relative independence from performance and social comparison — is consistent with the observation that self-compassion was associated with well-being over and above demographic position.

Fredrickson's (2001) broaden-and-build theory offers a complementary account. Self-compassion is thought to generate positive emotional states that broaden cognitive and behavioural repertoires and, over time, build durable resources such as resilience and social connectedness — resources that constitute high psychological well-being as captured by instruments like the WHO-5. The positive association observed here is consistent with this account, though, as a cross-sectional finding, it cannot establish the temporal sequence the theory specifies. Self-Determination Theory (Deci & Ryan, 2000) is likewise relevant: the non-significant associations of age and gender, combined with the substantial association of self-compassion, are consistent with SDT's emphasis on psychological rather than sociodemographic determinants of well-being.

The finding that age and gender were non-significant predictors deserves brief comment. The absence of a gender effect is partially consistent with meta-analytic work suggesting that gender differences in self-compassion are small (Yarnell et al., 2015), though it may also reflect the occupational heterogeneity of the present sample. The non-significant age effect may indicate that the positive developmental trajectory of self-compassion documented in

some studies (Neff, 2003a) is insufficiently strong to generate significant variance in well-being across the age range sampled here. Wider, age-stratified designs would clarify these patterns.

5.2 Practical Implications

The present findings are consistent with — though, given the correlational design, do not by themselves establish — the case for self-compassion-based interventions as a component of mental-health promotion. Several structured programmes for cultivating self-compassion have been developed and evaluated. The Mindful Self-Compassion (MSC) programme (Germer & Neff, 2013), an eight-week group intervention combining mindfulness and self-compassion practices, has shown pre–post improvements in self-compassion and well-being and reductions in depression and anxiety in randomised controlled trials. Compassion-Focused Therapy (CFT; Gilbert, 2010), originally developed for individuals high in self-criticism and shame, uses imagery, compassionate-mind training, and behavioural practices and has shown efficacy across a range of presentations. Acceptance and Commitment Therapy (ACT; Hayes et al., 2012), which incorporates self-compassion implicitly through defusion, acceptance, and values clarification, represents a complementary framework.

At the individual level, practitioners in clinical, counselling, and coaching contexts may incorporate psychoeducation about self-compassion and simple compassionate self-talk practices into work with clients presenting with low well-being, self-criticism, or rumination. At the organisational and community level, brief digital self-compassion interventions delivered via smartphone applications represent a potentially scalable and cost-effective approach. Because the present design is correlational, these implications are best regarded as hypotheses for intervention research rather than as established causal pathways; the appropriate next step within the evidence-to-practice pipeline is an adequately powered experimental or longitudinal evaluation.

5.3 Limitations

Several limitations qualify the present findings. First, the cross-sectional design precludes causal inference. While theory and meta-analytic evidence are consistent with the hypothesis that self-compassion supports well-being, the reverse direction — that higher well-being facilitates self-compassion — is equally plausible, and reciprocal relationships over time cannot be excluded. Longitudinal and experimental designs are required to establish directionality. Second, the exclusive reliance on self-report introduces the possibility of common-method variance (Podsakoff et al., 2003). Although Harman’s single-factor test (47.8% of variance on the first factor) suggests that common-method bias is unlikely to fully account for the results, response-consistency and social-desirability effects cannot be ruled

out; multi-method designs incorporating informant-rated or behavioural indicators are desirable.

Third, the WHO-5 was administered on a five-point (1–5) rather than its validated six-point (0–5) response format, and with agreement anchors (strongly disagree to strongly agree) in place of its validated frequency anchors (at no time to all of the time). These adaptations, adopted to harmonise the response metric across instruments, preclude the conventional 0–100 scoring and a corresponding robustness check, and may limit comparability with studies using the standard format; future work should retain both the original six-point response range and the original frequency anchors. Fourth, the convenience sample recruited online may over-represent individuals who are more psychologically aware and more comfortable with digital participation, limiting generalisability. Fifth, only the total self-compassion score was examined; subscale-level analyses would clarify whether specific components (e.g., mindfulness versus common humanity) drive the association. Sixth, the two-week recall window of the WHO-5 may be temporally mismatched with the more dispositional SCS-SF; future research should align the measurement windows of predictor and outcome.

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5.4 Conclusion and Outlook

Future research should prioritise longitudinal designs capable of testing the predictive validity of self-compassion for well-being over time, and experimental designs employing validated self-compassion interventions to establish causal effects. The mechanisms through which self-compassion may exert its effects — emotion regulation, rumination reduction, social connectedness, and autonomous motivation — merit investigation using mediation or structural-equation frameworks. Cross-cultural studies are needed to examine the universality of the association, particularly in collectivistic cultures where self-kindness and self-forgiveness may carry different meanings. Digital-intervention research represents a timely direction: brief, scalable self-compassion exercises delivered via mobile applications could constitute a meaningful public mental-health resource if their efficacy is confirmed in adequately powered trials.

In conclusion, the present study provides evidence that self-compassion is a robust correlate of psychological well-being in a community sample of adults, explaining 29% of the variance in well-being and remaining significant after controlling for age and gender. The findings align with theoretical predictions from Neff's self-compassion model, Fredrickson's broaden-and-build theory, and Self-Determination Theory, and are consistent with meta-analytic benchmarks. Given the cross-sectional design, these results are best read as a needs-assessment foundation for the longitudinal, experimental, and mechanistic research required to establish causal effects and to guide intervention design.

Statements and Declarations

Funding. This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Conflict of Interest. The author declares no competing interests.

Ethics Approval. The study was conducted via anonymous online survey in accordance with the ethical principles of the Declaration of Helsinki (World Medical Association, 2013). Given the anonymous and non-interventional nature of the study, formal institutional review board approval was not required.

Informed Consent. Informed consent was obtained from all individual participants included in the study. Prior to participation, respondents were presented with a written information screen describing the purpose of the study, the voluntary and anonymous nature of participation, and the intended use of the data; consent was indicated by proceeding to the survey.

Data Availability. The de-identified dataset supporting the findings of this study, together with the full survey instrument (reproduced in Appendix A), is provided as supplementary material and is available from the author upon reasonable request. The author is willing to deposit the de-identified data and instrument in a public repository (e.g., the Open Science Framework) upon acceptance.

Author Contributions. Sora Pazer is the sole author of this manuscript and was solely responsible for its conceptualisation, study design, data collection, formal analysis, interpretation of results, and the drafting and critical revision of the manuscript.

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Use of Generative AI. Generative AI tools were used to support language editing, text structuring, and verification of statistical computations. All study design decisions, scientific content, interpretations, and conclusions are the sole intellectual responsibility of the author.

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Appendix A. Survey Instrument

The complete survey instrument is reproduced below as administered. Source instruments: Self-Compassion Scale–Short Form (SCS-SF; Raes et al., 2011) and the WHO-5 Well-Being Index (World Health Organization, 1998; Topp et al., 2015). Items are reproduced for the purpose of scoring transparency and replication.

A.1 Self-Compassion Scale–Short Form (SCS-SF)

Response scale (all items): 1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree.

Items marked (R) are reverse-scored (6 − raw score) prior to computing the total. The total self-compassion score is the mean of all 12 items; higher scores indicate greater self-compassion.

1. When I fail at something important to me I become consumed by feelings of inadequacy. **(R)**
2. I try to be understanding and patient towards those aspects of my personality I don't like.
3. When something painful happens I try to take a balanced view of the situation.
4. When I'm feeling down, I tend to feel like most other people are probably happier than I am. **(R)**
5. I try to see my failings as part of the human condition.
6. When I'm going through a very hard time, I give myself the caring and tenderness I need.
7. When something upsets me I try to keep my emotions in balance.
8. When I fail at something that's important to me, I tend to feel alone in my failure. **(R)**
9. When I'm feeling down I tend to obsess and fixate on everything that's wrong. **(R)**
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
11. I'm disapproving and judgmental about my own flaws and inadequacies. **(R)**
12. I'm intolerant and impatient towards those aspects of my personality I don't like. **(R)**

Subscale composition. Self-Kindness: items 2, 6. Self-Judgement (R): items 11, 12. Common Humanity: items 5, 10. Isolation (R): items 4, 8. Mindfulness: items 3, 7. Over-Identification (R): items 1, 9. Reverse-scored items: 1, 4, 8, 9, 11, 12.

A.2 WHO-5 Well-Being Index

Stem: “Over the last two weeks …” **Response scale (all items, as administered):** 1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree.

Note. In the present study the WHO-5 was administered on this five-point (1–5) agreement scale (strongly disagree to strongly agree) rather than the original six-point (0–5) frequency scale (at no time to all of the time), in order to maintain a uniform response format across instruments. There are no reverse-scored items. The total score was computed as the mean of the five items; the conventional 0–100 percentage transformation was not applicable to the five-point administration. The original frequency anchors will be retained in future administrations.

1. I have felt cheerful and in good spirits.
2. I have felt calm and relaxed.
3. I have felt active and vigorous.
4. I woke up feeling fresh and rested.
5. My daily life has been filled with things that interest me.

hat gelöscht: 1 = at no time, 2 = some of the time, 3 = less than half of the time, 4 = more than half of the time / most of the time, 5 = all of the time.

hat gelöscht: *scale*

hat gelöscht: *format*