

## RESEARCH ARTICLE

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# The Self-Compassion Scale–Short Form: Psychometric evaluation in one non-clinical and two clinical Swedish samples

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## Abstract

**Background:** Self-compassion has been defined as the ability to be with one's feelings of suffering in a warm and caring way. Research has shown a negative association between self-compassion and mental illness, and that low self-compassion can make psychotherapeutic effects less likely. The ability to measure a patient's self-compassion in a fast and reliable way is therefore important in investigating effects of psychotherapies. The aim of the present study was to evaluate the psychometric properties of the Swedish version of the Self-Compassion Scale–Short Form (SCS-SF) in both non-clinical (NC) and clinical samples.

**Methods:** Cross-sectional data were gathered in a NC community sample ( $n = 1,089$ ), an eating disorder (ED) sample ( $n = 253$ ) and a borderline personality disorder (BPD) sample ( $n = 151$ ). All participants were asked to complete a number of questionnaires, including the SCS-SF, and 121 participants in the NC sample repeated the assessment after 2 weeks for test–retest analysis.

**Results:** Confirmatory factor analyses supported the first-order model suggested in previous research. Good internal consistency (Cronbach's  $\alpha = 0.78$ – $0.87$ ) and test–retest reliability (intra-class correlation =  $0.84$ ) were demonstrated for the entire scale. Results also showed good convergent validity, demonstrating moderate negative associations between self-compassion and mental illnesses, as expected, and acceptable divergent validity, demonstrating weak positive associations between self-compassion and quality of life and mindfulness.

**Discussion:** The correlations between the SCS-SF and the instruments used for validation were weaker in the clinical samples than the NC sample. This may be due to difficulties measuring these constructs or that the associations differ somewhat between different populations, which could warrant further research. The results added some support to the assumption that self-compassion may overlap with mindfulness yet still represents a distinct construct.

**Conclusions:** Analyses of the SCS-SF provided evidence of adequate to good psychometric properties, supporting use of the scale's total sum score and a first-order factor structure. This is in accordance with previous evaluations of the SCS-SF,

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suggesting that it is a reliable and time-efficient instrument for measuring a general level of self-compassion. This may be important when evaluating psychotherapy and investigating self-compassion and its influence on psychiatric illness.

#### KEYWORDS

borderline personality disorder, compassion-focused therapy, eating disorders, psychometric evaluation, self-compassion

## 1 | INTRODUCTION

*Compassion*, a concept that originated in Buddhism, has become increasingly accepted in psychology and psychotherapy. It refers to when a person recognizes suffering in himself or herself and others and wants and tries to alleviate and prevent it (Lama & Thupten, 1995). Two researchers and treatment developers who have contributed to this research area are Paul Gilbert and Kristin Neff. Gilbert developed Compassion-Focused Therapy after repeatedly observing how patients did not get better despite lengthy psychotherapeutic interventions, often struggling with high levels of shame, self-criticism and self-hatred (Gilbert, 2010). Gilbert described how shame and self-criticism could become aggravating factors in psychotherapy—for example, a patient could have a cognitive understanding of how to express compassion, but without showing a commensurate emotional experience, which could result in poor treatment outcomes (Gilbert, 2014).

Neff has focused her research on the concept of *self-compassion*, which she defines as the ability to be with one's feelings of suffering in a warm and caring way (Neff, 2003b). According to Neff, self-compassion consists of three dimensions, each including a positive and negative pole: (1) self-kindness, which refers to when people are kind and understanding towards themselves, especially in difficult times, instead of practising self-judgement; (2) common humanity, which is when a person's experience of difficulties is seen as an example of a common human experience rather than one of isolation; and (3) mindfulness, when a person pays attention to and is able to be with painful thoughts and feelings instead of over-identifying with them (Neff, 2003b). These three dimensions are separate, though they affect each other, and describe different ways of emotionally relating to pain. The ability to be emotionally present with pain can, for example, facilitate the ability to respond to oneself with warmth and kindness, which reduces feelings of over-identification with the experience (Neff, 2016). The opposite poles inherent to the concept have been proposed to activate the parasympathetic nervous system (self-compassion) or the sympathetic nervous system (self-criticism) (Costa et al., 2016). Unsurprisingly, several studies show a negative correlation between self-compassion and mental illnesses, such as anxiety, worry and depression (Körner et al., 2015; MacBeth & Gumley, 2012). There is also research that suggests a positive impact of self-compassion on levels of happiness and life satisfaction (Hollis-Walker & Colosimo, 2011), whereas higher levels of burnout are associated with lower levels of compassion and self-compassion (Conversano et al., 2020). Self-compassion has been reported to have

#### Key Practitioner Message

- The Self-Compassion Scale–Short Form (SCS-SF) was psychometrically evaluated in both non-clinical and clinical samples.
- The results suggest that the SCS-SF total score can be used as a measure of self-compassion.
- This study supports the use of the SCS-SF in clinical research and practice.

a positive correlation with mindfulness (McKay & Walker, 2021). The constructs of mindfulness and self-compassion overlap regarding how people relate to emotional distress, particularly in terms of mindful awareness of emotional distress, including an accepting and non-judgmental approach, but self-compassion also includes the ability to show kindness and support towards oneself and wanting to reduce suffering, yet accepting that it is part of the shared human experience. Self-compassion can be described as a distinct construct, according to research investigating its relationship with mindfulness and its association with patients' functional disability (Dahm et al., 2015). Research on compassion and self-compassion has also drawn attention to the importance of these variables in psychotherapy and their positive effects on, for example, psychological distress in various areas (Gilbert, 2020; Neff & Germer, 2022).

There is an ongoing discussion on how best to define and measure self-compassion, and there are different views on how compassion and self-compassion relate to each other. Proposals have been made on a common definition encompassing five parts: paying attention to suffering; understanding suffering as a universal human experience; feeling empathy for others in difficulty; tolerating feelings of discomfort that may arise when confronted with another person's suffering with continued openness and acceptance of the person's suffering; and acting to alleviate suffering (Strauss et al., 2016). However, the most common model for conceptualizing and measuring self-compassion was developed by Neff (2003b) and resulted in the Self-Compassion Scale (SCS), which has been widely used in research and clinical care. The SCS has, for example, been used to examine self-compassion in patients with eating disorder (ED) and borderline personality disorder (BPD)—two clinical groups where self-compassion has been suggested to be of great importance for treatment outcome and recovery (Feliu-Soler et al., 2017; Geller et al., 2019). The questionnaire consists of 26 items, where the person is asked to rate

different statements on a 5-point Likert scale. The SCS can be divided into six subscales corresponding to the central aspects of self-compassion according to Neff—self-kindness, self-judgement, common humanity, isolation, mindfulness and over-identification—and has shown good psychometric properties with high internal consistency ( $\alpha = 0.92$ ) and test–retest reliability ( $r = 0.93$ ) (Neff, 2003b). A confirmatory factor analysis provided some support for the theoretical division into six subscales that correlate according to a higher order model. A higher order model means that the variance in each item is affected by both an overall factor and a local factor. A global overall factor affects the latent (local) first-order factors, which each in turn directly affects the variance in one scale item (Neff, 2003a). However, the authors also found that positively and negatively worded items tended to load into different factors, suggesting a possible two-factor model.

Over the years, the SCS has received some criticism, including that it was developed using a non-clinical (NC) population and has not been validated to any greater extent in clinical populations (Williams et al., 2014). Psychometric studies regarding translations of the SCS into other languages have shown mixed results; some studies have found support for the higher order model (Castilho et al., 2015), while others have not (Costa et al., 2016; Williams et al., 2014). However, Neff (2016) has recommended that continued research on the SCS be based on a bifactor model, assuming that there is a general factor directly affecting the variance in all items and specific (local) factors affecting the variance in the items that belong to each factor. A bifactor model does not assume any hierarchical order in general or group factors but rather that they co-exist and shape the direct associations of the general factor and group factors with individual item responses. Self-compassion would be the general factor, and the six subscales would constitute the local factors. In a bifactor model, none of the local factors should correlate, as the connection between them is already explained by the general factor. An advantage of such a model is that it is possible to calculate how much of the variance in each item is explained by the general and local factor, respectively. Furthermore, Neff (2016) opposed a division based on a two-factor structure, which some researchers had suggested, and argued that a six-factor solution resonated well with her definition of self-compassion, where the six sub-components interact with how a person can relate to himself or herself with self-compassion. In a later study by Neff et al. (2019), the factor structure of 20 different samples from both clinical and NC populations was examined, and five different factor models were tested. The results showed support for using the SCS with six subscales and a total score (which represents overall self-compassion), and that the factors of the SCS can be explained based on a six-factor structure and a bifactor model. In contrast, Halamová et al. (2021) recently investigated the factor structure of the SCS in samples from 11 different countries and, like Costa et al. (2016), found support for a two-tier model of the scale with two dimensions: self-compassion and self-uncompassion. A two-tier model differs from a bifactor model in that it does not have a single general factor but instead two correlated general factors. Thus, the authors recommended that instead of summarizing the total score, the scale should measure two distinct,

but correlated, domains, namely, self-compassionate and self-uncompassionate (Halamová et al., 2021). Thus, there is an ongoing debate on how best to understand the concept of self-compassion and the factor structure of the SCS.

An abbreviated version of the SCS has also been developed, the Self-Compassion Scale–Short Form (SCS-SF), which consists of 12 of the original items, using the same Likert scale as the SCS (Raes et al., 2011). A high correlation has been found between total scores on the long and short versions of the scale ( $r = 0.93$ ), and good internal consistency was seen for the SCS-SF at the full-scale level ( $\alpha = 0.87$ ), though this was lower at the subscale levels. Furthermore, the original higher order model of the long (original) version with a general factor and six sub-factors, corresponding to the higher order model that Neff et al. suggested at the time, was confirmed to be an acceptable factor model for the SCS-SF. Based on this, it was recommended to use the total score of the SCS-SF as an efficient alternative for measuring self-compassion (Neff, 2016). Two later studies (Castilho et al., 2015; Garcia-Campayo et al., 2014) instead showed that a second-order structure was the best fit for the SCS-SF, but this solution showed lower internal consistency for the subscales. These results suggest that the short version of the questionnaire provides an overall assessment of self-compassion, while the longer version adds information about the various sub-components of the overall construct of self-compassion. However, in a more recent study by Kotera and Sheffield (2020), it was instead suggested that the two-factor structure suggested by Halamová et al. for the long version of the SCS was a better fit for the SCS-SF. The two-factor solution received further support in another study by Bratt and Fagerström (2020) with elderly participants, but the results were somewhat ambiguous, with a low level of internal consistency.

In summary, several studies have been conducted to evaluate the psychometric properties of the SCS and the SCS-SF, and while the overall psychometric properties of the instruments seem sound, results regarding the factor structure are mixed, and further research is needed, especially in different clinical populations. There is an ongoing debate on whether self-compassion consists of two distinct phenomena, corresponding to positive and negative aspects of self-compassion, or a single construct. Previous studies have shown that it is possible to measure the construct of self-compassion with the SCS across cultures, but there also seems to be culture-specific effects on a more detailed level regarding the exact structure of the concept (e.g., Birkett, 2014; Montero-Marín et al., 2018), and it is important to continue to assess the reliability and validity of the SCS in different cultural contexts. The purpose of this study was therefore to further investigate the psychometric properties of the SCS-SF with regard to factor structure, validity and reliability in data collected from a NC sample. Because the original scale has been criticized for lacking validation in a clinical sample, we also included two clinical samples in which self-compassion is seen as important for understanding treatment outcome: an ED and a BPD sample. These two clinical populations were chosen since self-compassion has been suggested to play important roles in their respective pathological conceptualizations and treatments (Turk & Waller, 2020; Wilson et al., 2019).

## 2 | METHOD

### 2.1 | Procedure and participants

All participants were recruited between 2016 and 2019. Participants in the NC sample were recruited via convenience sampling using a website specifically designed for gathering participants for scientific research, as well as advertisements on social media platforms and at Uppsala University. Interested participants signed up for more information and then received an e-mail with a link to more information about the study. Those who chose to participate were asked to sign an informed consent form, provide information on background variables and fill out a number of questionnaires online. Participants were offered remuneration in the form of a movie ticket voucher or lottery ticket for each assessment performed. All data were collected anonymously. In total, 1,304 people agreed to participate in the study. However, 25 never initiated participation, 191 interrupted participation during the study and 1 person was excluded for other reasons. Ultimately, a total of 1,089 adults with a mean age of 30.8 years ( $SD = 10.7$ ) completed the questionnaires (see Table 1), with a subsample ( $n = 121$ ) of 89 women and 32 men filling out the questionnaires a second time 2 weeks after the first assessment, for test-retest analysis.

Participants in the clinical samples were recruited at two sites: the eating disorder (ED) clinic and the dialectical behaviour therapy (DBT) clinic at Uppsala University in Sweden. The ED clinic treats all ED patients except those with binge-eating disorders, who are treated at a different clinic at Uppsala University Hospital, whereas the DBT clinic

treats patients with full or sub-threshold (fulfilling four diagnostic criteria) BPD. New patients undergoing an initial appointment with a psychiatrist or psychologist were routinely asked by the health professionals to participate in diagnostic interviews, as well as to fill out a standard battery of self-report questionnaires. Diagnosis was based on the Mini-International Neuropsychiatric Interview (Sheehan et al., 1998), the Eating Disorder Examination (Fairburn et al., 1993) and the Structured Clinical Interview for DSM-IV Axis II Personality Disorders, borderline criteria (First et al., 1997), conducted by co-rated psychologists. Patients were informed about the study during the diagnostic evaluation at the ED or DBT clinic. If patients chose to participate, they were asked to sign an informed consent form and then fill out about 15 questionnaires, including the SCS-SF, in a baseline assessment.

At the ED clinic, 520 persons were informed about the study, and 253 (48.7%) chose to participate. The participants were between 17 and 59 years old with a mean age of 25.7 years ( $SD = 7.5$ ). See Table 1 for other background variables. The mean BMI was 21.50 kg/m<sup>2</sup> ( $SD = 5.1$ ), and the most common ED diagnoses were bulimia nervosa ( $n = 76$ , 30.0%), anorexia nervosa ( $n = 75$ , 29.6%) and other specified feeding or eating disorder ( $n = 60$ , 23.7%). At the DBT clinic, 420 persons were informed about the study and 186 (44.3%) chose to participate. Of the 186 participants, 151 (81.2%) met the diagnostic criteria for BPD, while the remaining 35 (18.8%) participants met symptoms at the subclinical level for the diagnosis. In the statistical analyses for this study, only participants with a BPD diagnosis were included. The participants were between 18 and 59 years old, and the mean age was 26.6 years ( $SD = 7.0$ ). See Table 1 for other background variables.

	NC sample <i>n</i> (%)	ED sample <i>n</i> (%)	BPD sample <i>n</i> (%)
Gender			
Woman	832 (76.4)	241 (95.3)	133 (88.1)
Man	255 (23.4)	9 (3.6)	16 (10.6)
Other	1 (0.1)	3 (1.2)	2 (1.3)
Marital status			
Single	387 (35.5)	142 (56.1)	62 (41.1)
Married/cohabiting	512 (47.0)	58 (22.9)	56 (37.1)
Partner but not living together	111 (10.2)	32 (12.6)	18 (11.9)
Single with children	37 (3.4)	5 (2.0)	8 (5.3)
Other	42 (3.9)	16 (6.3)	7 (4.6)
Education			
Elementary	31 (2.8)	34 (13.4)	29 (19.2)
High school/college	382 (35.1)	137 (54.2)	90 (59.6)
University	658 (60.4)	79 (31.2)	31 (20.5)
Other	17 (1.6)	3 (1.2)	1 (0.7)
Occupation			
Working	465 (42.7)	86 (34.0)	44 (29.1)
Studying	473 (43.4)	109 (43.1)	34 (22.5)
Unemployed	41 (3.8)	3 (1.2)	9 (6.0)
Sick leave	44 (4.0)	43 (17.0)	54 (35.8)
Parental leave	29 (2.7)	3 (1.2)	1 (0.7)
Other	37 (3.4)	9 (3.6)	9 (6.0)

**TABLE 1** Background variables for the non-clinical (NC) community sample ( $n = 1,089$ ), the eating disorder (ED) sample ( $n = 253$ ) and borderline personality disorder (BPD) sample ( $n = 151$ )

## 2.2 | Instruments

The SCS-SF includes 12 items from the original version of the questionnaire (Raes et al., 2011). The answers are given on a 5-point Likert scale from *almost never* (1) to *almost always* (5). Thus, the maximum score on the questionnaire ranges from 12 to 60, with a higher score indicating a higher level of self-compassion. The SCS-SF has shown good internal consistency ( $\alpha = 0.87$ ) and a very high correlation with the long (original) version, at the full-scale level ( $r = 0.97$ ) (Raes et al., 2011). In accordance with suggestions from the developer of the questionnaire, the English version was translated from English into Swedish by bilingual translators and then back into English by an independent Swedish-language translator fluent in English. This was then compared with the original, and any differences were discussed with those responsible for the study until consensus was reached.

The Difficulties in Emotion Regulation Scale (DERS-16) (Bjoreberg et al., 2016) is a short version of the original self-report questionnaire (DERS-36) (Gratz & Roemer, 2004) and assesses difficulties in emotion regulation with 16 of the original 36 items. The answers are given on a 5-point Likert scale, ranging from *almost never* (1) to *almost always* (5), leading to a total score between 16 and 80, with higher scores indicating more severe problems with emotion regulation and control. Previous studies have shown that the DERS-16 has good psychometric properties with excellent internal consistency ( $\alpha = 0.92$ ), as well as strong correlation with the DERS-36 (Bjoreberg et al., 2016). In this study, the results showed that the Swedish version of the DERS-16 had high internal consistency (Cronbach's alpha = 0.94) when evaluating data from the NC sample ( $n = 1,089$ ).

The Hopkins Symptom Check-List (HSCL-25) was used as a measure for assessing symptoms of depression and anxiety. The instrument is divided into two subscales, one for depression and one for anxiety. Answers are given on a 4-point Likert scale ranging from *not at all* (1) to *very* (4), resulting in a total score between 25 and 100 (Tinghög & Carstensen, 2010). In studies on psychometric properties, the HSCL-25 has shown good validity as a measure of mental illness (Nettelbladt et al., 1993; Strand et al., 2003) and good internal consistency ( $\alpha = 0.94$ – $0.96$ ) (Tinghög & Carstensen, 2010). In this study, the Swedish version of the HSCL-25 had high internal consistency (Cronbach's alpha = 0.95) when evaluating data from the NC sample ( $n = 1,089$ ).

The Kentucky Inventory Mindfulness Scales (KIMS) was used for assessing mindfulness, i.e., the general ability to be consciously present in everyday life (Hansen et al., 2009). It consists of 39 items, and the answers are given on a 5-point Likert scale from *never true or very rare* (1) to *true very often or always* (5), leading to a score between 39 and 195, with a higher score indicating a greater ability to be mindful. The KIMS is divided into four subscales: Observing, Describing, Acting with awareness and Acceptance without judging. Previous factor analyses have supported the four-factor solution, which has also been confirmed with confirmatory factor analysis (Baer et al., 2004). Hansen et al. (2009) found that the KIMS has good internal consistency, and that intercorrelations with other instruments followed the

expected patterns. In this study, the internal consistency for each of the four subscales in the Swedish version of the KIMS was calculated when evaluating data from the NC sample ( $n = 1,089$ ) and ranged from acceptable to good: Observational ( $\alpha = 0.87$ ), Descriptive ( $\alpha = 0.88$ ), Acting with awareness ( $\alpha = 0.70$ ) and Acceptance without judging ( $\alpha = 0.92$ ).

The Borderline Symptom List–short version (BSL-23) assesses feelings and experiences typically reported by patients with BPD. It is a short version containing 23 of the 95 items included in the original questionnaire (BSL-95). The answers in the BSL-23 are given on a 5-point Likert scale ranging from *not at all* (0) to *very strong* (4), with the total of all items divided by the number of items, leading to a total mean score between 0.0 and 4.0. A higher score indicates more or stronger symptoms. The BSL-23 has shown good internal consistency ( $\alpha = 0.94$ – $0.97$ ) and distinguishes between patients with BPD and patients with other mental health problems (Bohus et al., 2009). The Swedish version of the BSL-23 used in this study was translated from German into Swedish and then back-translated at Uppsala University Hospital by authorized translators and is currently being evaluated. In this study, the results showed that the Swedish version of the BSL-23 had high internal consistency (Cronbach's alpha = 0.96) when evaluating data from the NC sample ( $N = 1,089$ ).

The Brunnsviken Brief Quality of life scale (BBQ) is a 12-item self-rating questionnaire for assessing self-experienced quality of life in six different life areas: leisure time, view of life, creativity, learning, friends and friendship, and view of self (Lindner et al., 2016). Responses are given on a 5-point Likert scale ranging from *strongly disagree* (0) to *strongly agree* (4), leading to a total score between 0 and 48, with a higher score indicating a higher level of quality of life. The Swedish version of the BBQ has shown satisfactory internal consistency, with a Cronbach's alpha of 0.76 in a previous Swedish sample (Lindner et al., 2016) and 0.75 in the current study.

## 2.3 | Statistical analyses

Visual inspection of data was performed to check distributions and identify outliers. If more than one item was missing from SCS-SF, the participant was excluded from the study. Three participants from the ED sample and two participants from the BPD sample were excluded on these grounds.

Based on previous conflicting research results regarding SCS-SF, confirmatory factor analyses were used to assess the latent variables of the SCS-SF. Four models were investigated based on previous research: a first-order model (Neff, 2019), a two-factor model (Kotera & Sheffield, 2020), a bifactor model (Neff, 2016) and a second-order model (Castilho et al., 2015). In the model assessment, commonly used goodness-of-fit indices were examined with their respective thresholds:  $\chi^2$ , the Comparative Fit Index ( $\geq 0.95$  for good and  $\geq 0.90$  for acceptable), the Tucker-Lewis index ( $\geq 0.95$  for good and  $\geq 0.90$  for acceptable), the Root-Mean-Square Error of Approximation ( $\leq 0.06$  for good and  $\leq 0.08$  for acceptable) and the Standardized Root Mean Square Residual ( $\leq 0.06$  for good and  $\leq 0.08$  for

acceptable). The internal consistency of the SCS-SF was analysed with Cronbach's alpha and its test-retest reliability with intra-class correlation (ICC).

Convergent validity was examined using Spearman's rank correlations by evaluating how strongly the SCS-SF correlated with measures assessing related or similar constructs and variables. Specifically, moderate to strong negative correlations were expected with measures of difficulties in emotion regulation (DERS-16), mental illness (HSCL-25) and borderline symptoms (BSL-23). Divergent validity was examined in a similar way, by investigating how strongly the SCS-SF correlated with measures of mindfulness (KIMS) and quality of life (BBQ)—concepts that may overlap with self-compassion but still represent distinct constructs. A moderate positive association between these variables was therefore expected. The statistical analyses were based on data from the NC sample (DERS-16 and HSCL-25) or the ED and BPD samples (DERS-16, HSCL-25, BSL-23, KIMS and BBQ).

Correlations of 0.2–0.39 were considered weak, 0.40–0.59 moderate, 0.6–0.79 strong and 0.8–1 very strong, but these are rather arbitrary cut-offs, and the context of the results should be considered. To compensate for multiple comparisons, the false discovery rate was investigated by comparing the *p* values with Benjamini-Hochberg adjusted *p* values, and results were reported as significant only if they did not reach the calculated threshold value (Thissen et al., 2002). Any differences in SCS-SF estimates between NC and clinical groups were examined using independent *t* tests. Effect sizes of differences between groups were estimated with Hodges *g*. Data processing was performed in IBM SPSS Statistics and R lavaan package.

This study was performed in line with the principles of the Declaration of Helsinki. The study was approved by the Regional Ethics Committee in Uppsala (Ref. Nos. 2013-156, 2014-252 and 2018-367).

## 3 | RESULTS

### 3.1 | Factor analyses

Confirmatory factor analyses for the investigated models were performed using pooled data from the three samples, and the resulting fit indices are presented in Table 2.

The first-order model provided adequate model fit indices, whereas the two-factor, bifactor and second-order models had

inadequate fit indices. The first-order model mimicked the two-tier model for the SCS-SF originally reported in Raes (2011) with the exception that the isolation (ISO) and Over-identification (OI) latent variables were highly correlated. Therefore, a modified first-order model with these two variables collapsed into a single latent variable was also investigated and provided marginally improved fit indices compared with the original first-order model; see Figure 1. The latent variables' standardized factor loadings for the first-order and modified first-order models are presented in Supporting Information S1.

The factor structures were also investigated in each sample separately, but the fit indices showed the same overall patterns as for the merged data, despite the inadequate sample sizes, and are therefore not reported here. The mean scores and standard deviations for each instrument and subscale in each sample are presented in Table 3.

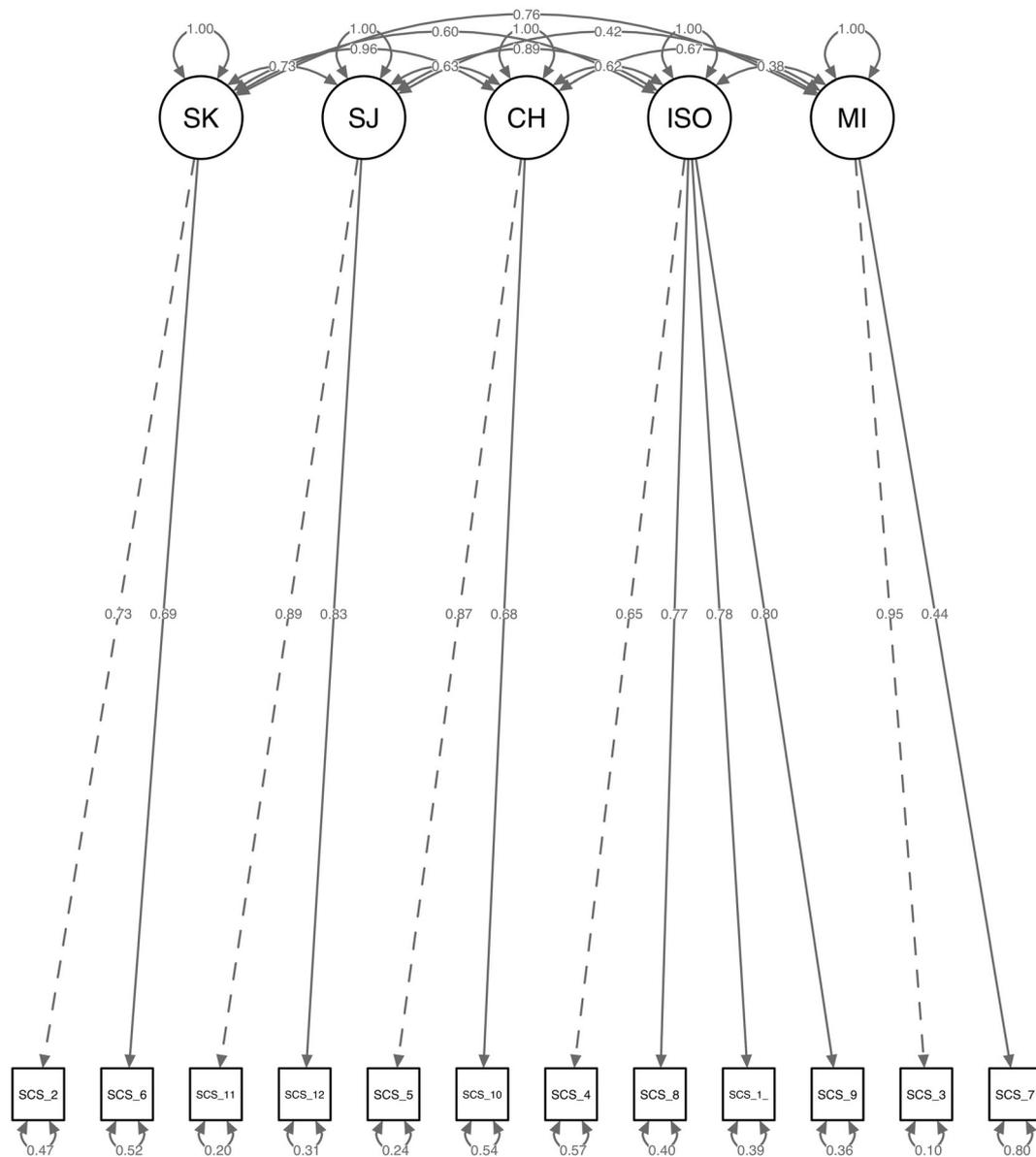
### 3.2 | Validity

The SCS-SF mean value in the NC sample was significantly higher than those in the ED sample ( $t [1,338] = 14.70, p < 0.001, g = 1.03$ ) and the BPD sample ( $t [1,218] = 18.18, p < 0.001, g = 1.58$ ). A statistically significant difference in mean value ( $t [380] = 5.39, p < 0.001, g = 0.58$ ) was also found between the ED sample and the BPD sample. The KIMS mean value in the NC sample was significantly higher than those in the ED sample ( $t [1,338] = 7.87, p < 0.001, g = 0.55$ ) and the BPD sample ( $t [1,218] = 12.66, p < 0.001, g = 1.11$ ). A statistically significant difference in mean value ( $t [380] = 4.67, p < 0.001, g = 0.48$ ) was also found between the ED sample and the BPD sample. In summary, effect sizes were larger for the SCS-SF than for the KIMS when comparing NC and clinical samples. Correlation analyses showed a moderate negative relationship between self-compassion and difficulties in emotion regulation (DERS-16) in both the NC sample and the clinical sample (see Table 4). Furthermore, moderate negative associations were found between self-compassion and symptoms of depression and anxiety (HSCL-25) in both the NC sample and the ED sample. The associations between self-compassion and depression and anxiety, respectively, were weaker in the BPD sample. The SCS-SF was moderately positively correlated with the KIMS total score and weakly to moderately correlated with each subscale of the KIMS, except the Observe subscale, which was not significantly correlated with the SCS-SF in any sample, and the Describe subscale, which was not significantly correlated with the SCS-SF in the BPD sample. The

Model	$\chi^2$	CFI	TLI	RMSEA (90% CI)	SRMR
First-order	293.66	0.966	0.943	0.072 (0.064–0.080)	0.044
Modified first-order	311.36	0.962	0.943	0.063 (0.057–0.069)	0.044
Two-factor	635.26	0.917	0.896	0.085 (0.080–0.091)	0.059
Bifactor	779.61	0.958	0.943	0.100 (0.094–0.106)	0.086
Second-order	1419.02	0.923	0.905	0.129 (0.123–0.125)	0.116

**TABLE 2** Fit indices for each model in the confirmatory factor analyses ( $n = 1,508$ )

Abbreviations: CFI, Comparative Fit Index; CI, confidence interval; RMSEA, Root Mean Square Error of Approximation; SRMR, Standardized Root Mean Square Residual; TLI, Tucker–Lewis Index.



**FIGURE 1** Path diagram for the modified first-order model. CH, common humanity; ISO, isolation; MI, mindfulness; SJ, self-judgement; SK, self-kindness

SCS-SF was weakly negatively correlated with the BSL-23 in the NC sample and weakly positively correlated with the BBQ in the clinical samples.

correlations can be found in Supporting Information S2. The ICC for the SCS-SF total scores between test and retest was 0.84 in the NC sample ( $n = 121$ ).

### 3.3 | Internal consistency and test-retest reliability

The internal reliability of the SCS-SF was good in both the NC sample ( $\alpha = 0.86$ ) and the ED sample ( $\alpha = 0.87$ ), while analysis in the DBT sample showed acceptable internal reliability ( $\alpha = 0.78$ ). Inter-item correlations were  $-0.11$  to  $0.72$  in the NC sample,  $-0.12$  to  $0.59$  in the DBT sample and  $-0.04$  to  $0.66$  in the ED sample. Excluding any item did not significantly increase the internal consistency of the scale in any of the samples. All individual inter-item

## 4 | DISCUSSION

The aim of this study was to explore and evaluate the psychometric properties of the Swedish version of the SCS-SF in a NC sample and two clinical samples (ED and BPD), including an investigation of the factor structure. In accordance with earlier psychometric evaluations, the SCS-SF showed acceptable to good internal consistency and test-retest reliability with significantly higher levels of self-compassion in the NC sample than in the clinical samples (Tóth-Király & Neff, 2021).

**TABLE 3** Mean scores and standard deviations for each instrument in each study sample

	NC sample (n = 1,089) m (SD)	ED sample (n = 250) m (SD)	BPD sample (n = 149) m (SD)
SCS-SF	35.86 (8.60)	27.09 (8.17)	22.56 (7.04)
DERS-16	38.21 (13.02)	48.78 (15.64)	64.83 (9.89)
HSCL-25 depression	1.87 (0.63)	2.55 (0.68)	2.87 (0.54)
HSCL-25 anxiety	1.77 (0.56)	2.36 (0.66)	2.67 (0.53)
KIMS total score	121.36 (14.57)	113.06 (16.96)	105.13 (15.44)
Observe	3.06 (0.71)	3.18 (0.71)	2.99 (0.82)
Describe	3.27 (0.77)	3.16 (0.89)	3.05 (0.97)
Act	2.89 (0.51)	2.58 (0.63)	2.38 (0.59)
Accept	3.29 (0.90)	2.65 (0.84)	2.35 (0.85)
BSL-23	0.80 (0.76)	n/a	n/a
BBQ	n/a	30.76 (6.79)	27.70 (7.07)

Abbreviations: BBQ, Brunnsvikens Brief Quality of Life Inventory; BPD, borderline personality disorder; BSL-23, Borderline Symptom List - short version; DERS-16, Difficulties in Emotion Regulation Scale-16; ED, eating disorder; HSCL, Hopkins Symptom Check-List; KIMS, Kentucky Inventory Mindfulness Scales; NC, non-clinical; SCS-SF, Self-Compassion Scale-Short Form.

	NC sample rho	ED sample rho	BPD sample rho
DERS-16	-0.62*	-0.51*	-0.44*
HSCL-25 depression	-0.61*	-0.49*	-0.30*
HSCL-25 anxiety	-0.52*	-0.44*	-0.21*
KIMS	0.51*	0.38*	0.34*
Observe	-0.07	0.05	0.11
Describe	0.25*	0.24*	0.15
Act	0.38*	0.21*	0.27*
Accept	0.58*	0.40*	0.20*
BSL-23	-0.53*	n/a	n/a
BBQ	n/a	0.41*	0.29*

**TABLE 4** Correlations between the SCS-SF and the other instruments in the three samples

Abbreviations: BBQ, Brunnsvikens Brief Quality of Life Inventory; BPD, borderline personality disorder; BSL-23, Borderline Symptom List - short version; DERS-16, Difficulties in Emotion Regulation Scale-16; ED, eating disorder; HSCL, Hopkins Symptom Check-List; KIMS, Kentucky Inventory Mindfulness Scales; NC, non-clinical; SCS-SF, Self-Compassion Scale-Short Form.

\* $p < .001$ .

This is in line with expectations, since it is common that psychiatric patients judge themselves, ruminate and experience negative emotions instead of showing a compassionate approach to themselves (Castilho et al., 2015). In fact, self-criticism has been suggested to be a transdiagnostic feature in clinical populations (Schanche, 2013).

#### 4.1 | Factor structure

The factor structure of the SCS-SF has been debated, and in this study, the confirmatory factor analysis resulted in adequate fit indices only for the first-order factor structure, as suggested by Neff (2019) for the full-length SCS. This has also been supported in studies of the SCS-SF (Garcia-Campayo et al., 2014). The results thus support Neff's suggestion that the SCS measures one construct with six latent

variables. Halamová et al. (2021) and others (Babenco & Guo, 2019; Hayes et al., 2016) have argued for a two-factor model for the SCS, assessing both a self-compassionate and a self-uncompassionate approach. For example, Halamová et al. (2021) suggest that a person can receive a higher score on self-compassionate attitudes after a treatment, but unchanged scores in terms of self-uncompassionate responses, which would mean that a total score would give a misleading picture. Such a two-factor solution did not receive adequate support in the present study, but since this is a consistent finding, it may need further investigation. Instead, two of the latent variables correlated highly in the present study, and collapsing these two into a single latent variable improved the fit indices marginally. As this finding has not been reported previously, it should be interpreted with caution and needs to be investigated in further studies. Notably, another recent study found support for a three-factor solution not previously

identified and indicated that the results regarding the SCS-SF validity measures were inadequate (Meng et al., 2019). In the most recent study of the SCS by Tóth-Király and Neff (2021), strong support was reported for combining exploratory structural equation modelling (ESEM) with the bifactor approach, i.e., using the bifactor-ESEM model in investigations of self-compassion. Thus, the results of previous studies regarding the SCS and its short form are mixed and may be highly influenced by factors such as research population and contextual factors (Muris & Otgaar, 2020).

## 4.2 | Construct validity

Regarding the construct validity of the scale, the associations between the SCS-SF and the other self-report instruments were all in the hypothesized directions. The negative associations between self-compassion and depression and anxiety found in this study confirmed the results reported in previous studies (Hayes et al., 2016; Raes, 2011). Furthermore, the results confirmed the negative association already found between self-compassion and borderline symptoms (Carreiras et al., 2021), as well as between self-compassion and difficulties in emotion regulation (Gouveia et al., 2019). Interestingly, the correlations with difficulties in emotion regulation, depression and anxiety were weaker in the clinical samples than in the NC sample. In other words, self-compassion seems to have a weaker influence on the level of these variables in clinical samples than in NC samples. Another observation was that the participants in the BPD sample reported the lowest levels of self-compassion and the highest levels of emotion regulation difficulties, anxiety and depression. Indeed, BPD patients are known to have a lower level of self-compassion than ED patients (Costa et al., 2016). In addition, patients at the DBT clinic could have been a selected and more severe group of psychiatric patients compared with the ED sample since less severe BPD patients are often not referred to the DBT clinic. Further research is needed to specifically investigate these differences between NC and clinical populations, but the results provide some support for the general assumption that an improved ability to be compassionate towards oneself may be valuable in psychotherapeutic interventions to reduce psychiatric problems.

A positive correlation between self-compassion and mindfulness was expected since mindfulness is conceptualized as a part of self-compassion and has been reported in several research studies (e.g., Hollis-Walker & Colosimo, 2011). Although our results confirmed this association with a moderate positive correlation between the overall score for mindfulness and the level of self-compassion in the NC sample, the results also provide support for the suggestion that, in spite of a partial overlap, these two concepts represent distinct constructs. The strongest association was found between self-compassion and the accepting aspect of a mindful approach, whereas associations were much weaker between self-compassion and the observing and acting aspect of a mindful approach. The relative weakness of the association seen between mindfulness and self-compassion in this study could also be explained by the fact that the

KIMS captures a more general experience of mindfulness than the individual items found in the SCS-SF. According to Neff (Neff, 2003a, 2003b), self-conscious mindfulness means that we can notice that we are feeling something painful and that we can stay with the emotion without over-identifying with it and respond with warmth and kindness. In other words, mindfulness in the context of self-compassion means not only allowing oneself to have a feeling but also to embrace it with understanding and warmth (Neff, 2003b). In contrast, the KIMS intends, among other things, to measure the ability to describe an experience and the level of acceptance without judging (Hansen et al., 2009). Neff and Dahm (2015) has previously pointed out that difficulties in generalizing from the original version can also arise due to translation or studying it in a new cultural context. Indeed, the Swedish translation may have a problem in differentiating between 'balancing emotions' (item 7) and 'controlling emotions'. It is possible that patients thought that different dysfunctional strategies and behaviours such as restrictive eating behaviours or self-harm would be examples of 'controlling emotions' or 'observing emotions'. Lastly, the effect sizes showed that there were much larger differences in the SCS-SF than in the KIMS when comparing NC and clinical samples. In other words, patients who suffer from psychiatric symptoms seem to demonstrate a certain level of mindfulness but have a harder time being compassionate towards themselves.

Previous studies have shown a negative association between symptoms of mental illness and levels of self-compassion (e.g., MacBeth & Gumley, 2012), which indicates that self-compassion may be important in developing well-being. Several studies report results in accordance with this assumption (Lluch-Sanz et al., 2022; Zessin et al., 2015). The present study adds some support for this, given that there is a positive correlation between self-compassion and quality of life and assuming that well-being and a high quality of life are more likely when a person shows a compassionate approach towards themselves and others. However, quality of life was only measured in the clinical samples, not in the NC sample, and since the association was weak, it is likely that there are other factors that contribute to if a person with mental illness experiences a high quality of life. A problem with investigating the association between self-compassion and quality of life is that the conceptualization of psychological well-being and quality of life is not uniform, which makes it difficult to compare results between studies using different rating scales. It is conceivable that the BBQ, used in this study, does not measure the quality of life based on the same construct as those previously shown to have a stronger association with self-compassion. Another problem is that psychological well-being has in some cases been explained as a lack of mental illness or a low degree of burnout. It is important to distinguish between these concepts and to measure them in different ways (Lindner et al., 2016).

## 4.3 | Study limitations

It should be noted that the majority of the participants in all three samples were women. This may affect the generalizability of the

results. Since previous research has suggested possible differences in self-compassion between men and women, it is important to include a more gender-balanced sample in future research. In addition, the clinical samples were quite small. Therefore, it was not possible to perform factor analyses on each separate sample. Instead, merged data from the three samples were used in the factor analyses. This analytical strategy was chosen since previous studies including several samples have demonstrated a high degree of invariance in the factor structure of the SCS across population types, gender, age and language (Tóth-Király & Neff, 2021).

#### 4.4 | Future research

Although plenty of research has been conducted on the SCS internationally, results are mixed, and there is a particular need for further research of the short version of the instrument. Given the value that the instrument has in clinical work and research, continued psychometric evaluation of the scale is important, especially of its factor model and in larger clinical samples. The question of possible age differences would also be valuable to explore further, both in samples from several age groups and by following individuals over time. Furthermore, it is desirable to investigate threshold scores for the SCS-SF to describe low, medium and high levels of self-compassion in both clinical and NC samples. It has also been suggested that qualitative methods could add valuable information about the difference between self-compassion and selfishness/self-indulgence (Tóth-Király & Neff, 2021). Lastly, the ability to measure a change in self-compassion over time, such as before and after treatment (the scale's sensitivity to change), should be investigated. In particular, it has been suggested to combine this with training of mindfulness and compassion (Conversano et al., 2020). While further research may be needed to better understand the small but significant differences in construct and structure found in different evaluations of the SCS and its short form, it is important to underscore that the research on the SCS so far support the use of the instrument for measuring the concept of self-compassion and that it may be used as a clinical tool for both assessment, evaluation and for measuring important change processes in treatments.

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#### CONFLICT OF INTEREST

The authors declare that they have no conflict of interest.

#### ETHICS STATEMENT

This study was performed in line with the principles of the Declaration of Helsinki. The study was approved by the Regional Ethics Committee in Uppsala (Ref. Nos. 2013-156, 2014-252 and 2018-367). Informed consent was obtained from all participants included in the study. Patients gave written informed consent regarding publication of their data.

#### AUTHOR CONTRIBUTIONS

All authors contributed substantially to each part of the manuscript. All authors read and approved the final manuscript.

#### DATA AVAILABILITY STATEMENT

Data will not be made publicly available due to confidentiality but can be made available upon reasonable request to the corresponding author.

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## SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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