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The Effectiveness of Self-Compassion on the Regulation of Excessive Hostility and Emotional Dysregulation in Mothers with Depressive Symptoms

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A B S T R A C T

Objective: The present study aimed to determine the effectiveness of self-compassion on regulating excessive hostility and emotional dysregulation in mothers with depressive symptoms.

Materials and Methods: This research employed a quasi-experimental method with a pretest-posttest design involving an experimental group and a control group. The statistical population included mothers of adolescents enrolled in middle and high school during the 2023–2024 academic year who exhibited depressive symptoms. A convenience sampling method was used to select 30 participants from the population, who were randomly assigned to two groups of 15. The research utilized the Spielberger Anger Questionnaire (1999) and the Toronto Alexithymia Scale (Bagby et al., 1996). The experimental group underwent training based on the self-compassion training protocol. Data were analyzed using univariate and multivariate covariance analysis methods.

Findings: The findings indicated that 44% of the individual differences in the anger dimension, 46% in the aggression and insult dimension, and 62% in the stubbornness and resentment dimension in the posttest phase were attributed to differences between groups or treatment effects. Similarly, 40% of individual differences in difficulty identifying emotions, 56% in difficulty describing emotions, and 63% in externally oriented thinking in the posttest phase were related to group differences or treatment effects ($p < .05$).

Conclusion: It can be concluded that self-compassion-based programs can significantly reduce excessive hostility and emotional dysregulation in mothers with depressive symptoms. These findings suggest that enhancing self-compassion can serve as an effective strategy for improving the psychological well-being of mothers suffering from depression and emotional difficulties.

Keywords: *Self-compassion training, excessive hostility regulation, emotional dysregulation, depression*

1. Introduction

Raising children and the numerous responsibilities placed on mothers can lead to stress, anxiety, and depression. The various challenges in the process of parenting may result in psychological pressures on mothers (Ede et al., 2023). These pressures can stem from changes in maternal roles and duties, financial concerns, balancing personal time and childcare, societal and familial expectations, family relationship conflicts, and more (Lathren et al., 2020).

Depressed mothers may struggle to effectively manage their emotions and often face difficulties in experiencing and expressing their feelings (Zitzmann et al., 2024). This issue can reduce their ability to connect with their children, potentially leading to behavioral and psychological problems in the children (Ferreira et al., 2024; Laslo-Roth et al., 2023). Emotional dysregulation in depressed mothers may hinder their ability to appropriately respond to their children's emotional needs, potentially resulting in feelings of insecurity and low self-esteem in the children (Li et al., 2023).

Furthermore, depressed mothers may experience negative feelings toward themselves or others for various reasons, which can lead to increased aggression and hostility. Excessive hostility regulation is an individual skill that involves controlling and reducing unreasonable and maladaptive violence and antagonism (Rice et al., 2020). This skill reflects an individual's ability to manage negative emotions and transform them into constructive and positive behaviors. Excessive violence and hostility can cause severe issues in personal and social relationships, negatively impacting an individual's mood and mental health (Lewis et al., 2014).

Self-compassion training is an important skill that can help depressed mothers cope more effectively with life challenges (Hong et al., 2022). Depressed mothers may feel hopelessness, stress, anxiety, or depression for various reasons and require support and guidance. The first step in self-compassion training for depressed mothers is understanding and accepting their current situation (Lathren et al., 2020). Mothers must recognize that feelings of hopelessness or depression are natural and should not evoke shame or self-blame. Awareness that negative emotions are universal and not indicative of weakness or incapacity can empower mothers to face these challenges with courage and self-compassion (Wang et al., 2023).

Depressed mothers often tend to prioritize their children's care over themselves, leading to increased stress and anxiety in their lives, which negatively affects their familial relationships and psychological well-being. Self-compassion training helps depressed mothers prioritize themselves and practice self-care. This training includes various skills that assist them in managing stress and anxiety, developing healthier relationships, and achieving emotional and psychological balance (Hong et al., 2022).

Given that maternal depression can lead to serious issues in child-rearing, conducting scientific research on self-compassion training for mothers is of significant importance. Such research can provide effective and evidence-based strategies to assist depressed mothers and play a crucial role in improving their psychological well-being. Therefore, this study aimed to investigate the effectiveness of self-compassion on the regulation of excessive hostility and emotional dysregulation in mothers with depressive symptoms.

2. Methods and Materials

2.1. Study design and Participant

The present study employed a quasi-experimental design with a pretest-posttest structure, including an experimental group and a control group. The statistical population consisted of mothers with adolescent children (aged 12–17) attending middle and high school during the 2023–2024 academic year, who exhibited depressive symptoms. Due to limited accessibility, convenience sampling was utilized. The sample size was determined using G*Power software to ensure sufficient power to detect a minimum difference of 1 unit in the dependent variables between the experimental and control groups. Assuming a Type I error rate of 5%, a Type II error rate of 20%, and a standard deviation of 0.9, the sample size was calculated as 15 participants per group. Consequently, 30 participants were selected from the population and randomly assigned to either the experimental or control group (15 participants each).

The procedure involved distributing the Spielberger Anger Inventory (1999) and the Toronto Alexithymia Scale (Bagby et al., 1997) to both groups prior to the intervention. The experimental group underwent an eight-session self-compassion training program (90 minutes per session, once a week), while the control group received no intervention. Posttests were administered to both groups after completing the program. To adhere to ethical standards, the self-

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compassion training was subsequently provided to the control group at the conclusion of the study.

Inclusion criteria included: (1) mothers exhibiting depressive symptoms diagnosed by a clinical psychologist through a clinical interview, (2) having adolescent children aged 12–17, (3) no use of antidepressant medication, (4) commitment to attending the sessions, and (5) a minimum educational level of high school diploma. Exclusion criteria included: (1) absence from more than three sessions, (2) noncompliance with group therapy rules, and (3) simultaneous participation in other therapeutic interventions.

2.2. Measures

2.2.1. Alexithymia

This scale is the Persian version of the Toronto Alexithymia Scale, a 20-item self-report questionnaire that provides a total score for emotional dysregulation and three subscale scores: difficulty identifying feelings, difficulty describing feelings, and externally oriented thinking. Items are rated on a Likert scale. The scale has demonstrated strong psychometric properties. The Cronbach's alpha coefficients for the Persian version were 0.82 for difficulty identifying feelings, 0.75 for difficulty describing feelings, and 0.72 for externally oriented thinking, indicating good reliability (Bagheri Sheykhangafshe et al., 2024).

2.2.2. Anger

This inventory is a paper-pencil scale designed for individuals aged 16–30 years. It comprises 57 items and six scales with five subscales, developed by Spielberger (1999). Items are organized into three sections, with the first section ("How I feel right now") assessing state anger using a four-point Likert scale ranging from "not at all = 1" to "very much = 4." The inventory measures state anger, trait anger, and methods of expressing and controlling anger. It was standardized for Iranian populations in 2010 by Asghari Moghadam, Moghadessin, and Dibajnia. The inventory includes 30 items, with three subscales: anger feelings (14 items), aggression and insult (8 items), and stubbornness and resentment (8 items). The subscales demonstrate strong reliability, with Cronbach's alpha coefficients of 0.93 for verbal expression of anger, 0.92 for physical expression of anger, 0.83 for external anger, 0.29 for internal anger, 0.02 for external anger control, and 0.64 for internal anger control (Lin et al., 2023).

2.3. Intervention

2.3.1. Self-Compassion Training

The self-compassion training program was based on Gilbert's (2014) therapeutic protocol and consisted of eight 90-minute sessions (Guo et al., 2020).

Session 1: Introduction and Conceptualization of Self-Compassion: This session focuses on building rapport with participants, introducing the structure of the sessions, and familiarizing them with the core principles of self-compassion therapy. Participants learn to differentiate between self-compassion and self-pity. The concept of self-compassion is explained in depth, providing a foundation for the therapeutic journey.

Session 2: Emotion Regulation Systems and the Compassionate Mind: The session begins with a recap of the previous meeting. Participants are introduced to the three emotion regulation systems (threat, drive, and soothing) and how they influence individual behavior and mental states. The distinction between a threat-focused mind and a compassionate mind is explained. Homework involves identifying which emotional regulation system is most active during distressing situations.

Session 3: The Brain and Mindfulness Practices: This session reviews the assigned homework and introduces participants to the "old brain" and "new brain" concepts, as well as the concept of the aware brain. Participants are taught soothing breathing exercises and mindful attention practices, such as mindful eating (e.g., the raisin exercise). Homework includes practicing soothing breathing and mindful eating in daily life.

Session 4: Characteristics of Compassion: Participants reflect on the previous session's practices and learn about the six core qualities of compassion: wisdom, strength, kindness, nonjudgment, responsibility, and openness. They explore the traits of a compassionate individual and understand the skills needed to embody compassion. Homework includes identifying examples of compassionate traits in their lives and assessing these qualities within themselves.

Session 5: Developing a Compassionate Self: This session begins with a review of the previous exercises. Participants practice soothing breathing rhythms and learn visualization techniques to create a compassionate self-image. They engage in exercises such as imagining their best self and practicing the "compassionate chair" technique to address self-criticism. Homework involves observing the effects of practicing self-compassion compared to

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rumination and using the compassionate chair technique to counteract self-criticism.

Session 6: Creating a Safe Place through Visualization: This session builds on previous practices by using soothing breathing and exploring the power of imagery. Participants practice visualizing a safe and soothing place and engage in compassionate coloring exercises. Homework involves using compassionate imagery when facing challenging emotions or distressing situations.

Session 7: Extending Compassion to Others: Participants review prior practices and begin each exercise with soothing breathing. They learn to extend compassion to others, receive compassion from others, and practice self-compassion in real-life interactions. Homework focuses on applying these exercises in their daily interactions to reinforce compassionate behaviors.

Session 8: Integration of Skills and Application: This final session emphasizes reviewing and practicing all the skills taught throughout the program. Participants are guided to understand the true meaning of compassionate behavior and encouraged to generate ideas for incorporating compassion into their daily lives. They practice writing a compassionate letter to themselves. The session concludes with a summary of the therapy and strategies for maintaining these skills in everyday situations.

Final Session: Post-Test and Closing: Participants complete the post-test to evaluate the outcomes of the intervention. The session concludes with expressions of gratitude and acknowledgment of their efforts, providing encouragement to continue applying the skills learned in their lives.

2.4. Data Analysis

Data analysis was conducted using descriptive and inferential statistics. Descriptive statistics included frequency, percentage, mean, and standard deviation. For inferential statistics, the Kolmogorov-Smirnov test was used to assess data normality, Levene's test was used for homogeneity of variances, and the homogeneity of regression slopes assumption was tested by examining the interaction effect of group and pretest scores in the regression model. Univariate covariance analysis (ANCOVA) was used for hypothesis testing. Additionally, independent t-tests were employed to compare mean age between groups, and chi-square tests were used to compare educational level distributions. Data analysis was performed using SPSS version 24, with a significance level of 0.05 for all tests.

3. Findings and Results

A total of 30 participants were included in this study. The mean age of the experimental group was 36.1 years (SD = 3.4), and the mean age of the control group was 37.8 years (SD = 3.5).

Table 1 presents the descriptive characteristics of emotional dysregulation and excessive hostility regulation scores, including their subscales, for the pretest and posttest phases. The table also highlights the mean differences between the two phases for both the experimental and control groups.

Table 1

Descriptive Characteristics of Variable Subscale Changes by Group

Variable	Stage	Experimental Group (M ± SD)	Control Group (M ± SD)
Difficulty Identifying Feelings	Pretest	7.2 ± 0.9	8.4 ± 0.8
	Posttest	5.8 ± 0.8	7.9 ± 1.1
Difficulty Describing Feelings	Pretest	17.8 ± 2.2	17.2 ± 2.5
	Posttest	15.5 ± 2.4	17.5 ± 2.6
Externally Oriented Thinking	Pretest	18.1 ± 2.9	19.3 ± 2.7
	Posttest	15.2 ± 2.8	18.8 ± 3.1
Anger	Pretest	25.1 ± 3.7	22.5 ± 3.4
	Posttest	22.1 ± 3.5	21.6 ± 3.9
Aggression and Insult	Pretest	15.7 ± 2.6	16.4 ± 2.5
	Posttest	13.2 ± 2.4	15.9 ± 2.1
Stubbornness and Resentment	Pretest	15.4 ± 2.7	15.4 ± 3.1
	Posttest	13.8 ± 1.5	15.0 ± 2.5

Before conducting the multivariate analysis of covariance (MANCOVA), the assumptions were verified using the Kolmogorov-Smirnov and Levene's tests. The Kolmogorov-Smirnov test for the posttest distribution of variables

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indicated that the normality assumption was not rejected ($p > .05$). Levene's test confirmed the homogeneity of error variances ($p > .05$). Additionally, the assumption of homogeneity of regression slopes, based on the non-significance of the group-pretest interaction effect, was also met ($p > .05$). Thus, the assumptions for conducting univariate analysis of covariance (ANCOVA) were satisfied.

The mean scores for emotional dysregulation and excessive hostility regulation variables in the experimental and control groups before and after the self-compassion intervention are presented in Table 2. As shown, the scores of participants in the experimental group improved significantly compared to the control group across both variables.

Table 2

ANCOVA Results for Subscales of Emotional Dysregulation and Excessive Hostility Regulation

Variable	Sum of Squares	df	Mean Square	F	Sig.	Effect Size	Power
Anger	27.8	1	27.8	21.7	.001	0.46	1.000
Aggression and Insult	30.4	1	30.4	42.2	.001	0.62	1.000
Stubbornness and Resentment	16.1	1	16.1	38.1	.001	0.60	1.000
Difficulty Identifying Feelings	13.1	1	13.1	16.7	.001	0.40	1.000
Difficulty Describing Feelings	30.1	1	30.1	32.5	.001	0.56	1.000
Externally Oriented Thinking	45.3	1	45.3	42.9	.001	0.63	1.000

According to the findings in Table 3, there was a significant difference in the posttest mean scores of emotional dysregulation and excessive hostility regulation between the experimental and control groups ($p < .001$). The results indicate that 40% of the individual differences in difficulty identifying feelings, 56% in difficulty describing feelings, 63% in externally oriented thinking, 44% in anger, 46% in aggression and insult, and 62% in stubbornness and resentment can be attributed to the differences between groups or the effects of the intervention.

4. Discussion and Conclusion

The objective of this study was to evaluate the effectiveness of self-compassion training in managing excessive hostility and emotional dysregulation in mothers exhibiting depressive symptoms.

The results of the ANCOVA test indicated that self-compassion training significantly improved scores related to excessive hostility regulation and emotional dysregulation in mothers with depressive symptoms. The study demonstrated a notable improvement in participants' ability to manage these variables compared to the beginning of the study ($p < .05$). These findings align with the prior studies (Guo et al., 2020; Hong et al., 2022; Kaihui et al., 2022; Kumar et al., 2023; Lathren et al., 2020; Oh & Kim, 2022; Psychogiou et al., 2016; Wang et al., 2023).

Mothers with depressive symptoms often face significant psychological and emotional pressures due to the demanding responsibilities of parenting, financial challenges, and societal expectations. These stressors can lead to heightened stress, anxiety, and, ultimately, depression. When mothers are unable to manage their emotions effectively, they may exhibit uncontrollable hostility and anger, which can affect family relationships and lead to behavioral problems in their children.

Self-compassionate mothers are less likely to criticize themselves harshly. Reducing self-criticism helps decrease negative emotions and hostility. By mitigating self-criticism, mothers can better manage their emotions and adopt more constructive ways to express their feelings rather than resorting to anger. Self-compassion training helps mothers identify and understand their emotions, enabling them to express negative emotions healthily rather than suppressing them. Enhanced emotional awareness allows mothers to respond constructively to stressful situations rather than reacting with hostility (Psychogiou et al., 2016).

The sense of shared humanity, a core element of self-compassion, helps mothers recognize that others face similar challenges. This understanding reduces feelings of loneliness and hostility. Empathy toward others enables mothers to replace anger with understanding and compassion during moments of negative emotions. Training in self-compassion significantly reduces hostility, leading to improved family relationships. Decreased hostility and increased kindness help mothers establish better emotional connections with their children and other family members, ultimately contributing to improved psychological and emotional well-being (Kumar et al., 2023).

In conclusion, self-compassion training can serve as an effective tool for managing hostility in mothers with

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depressive symptoms. By providing essential skills for self-care and emotional regulation, this intervention can enhance the quality of life and emotional relationships of these mothers. Ultimately, this intervention can improve mental health and overall family well-being.

Mothers with depressive symptoms are more vulnerable to emotional dysregulation due to emotional burdens and heavy responsibilities. Self-compassion training helps mothers better identify their emotions, allowing them to express negative feelings healthily. Increased emotional awareness enables mothers to manage their emotions effectively during stressful situations rather than suppressing them. Strategies such as deep breathing, meditation, and communication with others can be part of this management.

Self-compassion training teaches mothers to replace self-criticism with self-kindness. Reducing internal criticism decreases negative emotions and emotional dysregulation. With reduced self-criticism, mothers can express their emotions more positively and build confidence (Oh & Kim, 2022).

The training also fosters greater empathy toward others, improving social relationships and reducing feelings of loneliness. Positive relationships and social support help mothers feel more secure and calm when facing challenges. Support may come from friends, family, or support groups. Self-compassion training equips mothers with stress-management techniques such as meditation, yoga, and physical activity (Guo et al., 2020).

By reducing stress and increasing self-kindness, mothers can experience significant improvements in mental health, including reduced symptoms of depression and anxiety. Self-compassion training is expected to meaningfully decrease emotional dysregulation in mothers, improving their quality of life and family relationships. Increased kindness and empathy foster healthier relationships between mothers and their children and other family members, creating a more emotionally supportive family environment (Kaihui et al., 2022).

In conclusion, self-compassion training is a promising intervention for managing emotional dysregulation in mothers with depressive symptoms. By equipping mothers with essential self-care and emotional regulation skills, this intervention enhances their quality of life and emotional relationships. These changes benefit not only the mothers but also their children and other family members, fostering a healthier emotional environment within the family.

5. Limitations and Suggestions

This study had several limitations. The sample only included mothers with adolescent children and depressive symptoms, making it difficult to generalize the findings to other groups, such as mothers of younger children with depressive symptoms. Additionally, uncontrolled variables such as family conditions (e.g., socioeconomic status) may have influenced the results. Self-report measures may have led to data distortion due to response biases, including exaggeration or minimization of symptoms. The use of convenience sampling limits the generalizability of the findings.

Future researchers are recommended to include follow-up periods to assess the long-term effects of the intervention. It is also suggested that individuals with obsessive-compulsive disorders and clinical settings adopt this method to provide effective services to their clients.

Authors' Contributions

This article is derived from the doctoral dissertation of the first author, who conducted the research and wrote the manuscript. The second author supervised the study, and the third author provided consultation on the research process.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

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