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Self-compassion and mental health help-seeking: A systematic review and meta-analysis

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Abstract

Objectives

To synthesise evidence on the association between self-compassion and mental health help-seeking attitudes, intentions, behaviours, and barriers, and to assess heterogeneity and risk of bias.

Methods

This systematic review and meta-analysis followed PRISMA 2020 and was prospectively registered with PROSPERO (CRD420261411461). MEDLINE, Embase, PsycINFO, and Scopus were searched from inception to 10 July 2026. Observational studies reporting quantitative associations between self-compassion and mental health help-seeking outcomes were eligible. Random-effects meta-analyses pooled Fisher's *z*-transformed correlations, which were back-transformed to Pearson's *r*. Risk of bias was assessed using an adapted Joanna Briggs Institute checklist.

Results

Twenty-one cross-sectional studies involving 18,535 participants were included. Seven studies (N = 2,414) were pooled for help-seeking attitudes, yielding a small positive association, r = .22, 95% CI [.12, .32], p = .002, with high heterogeneity (I^2 = 79.55%). Eight studies (N = 3,790) were pooled for help-seeking intentions, also showing a small positive association, r = .20, 95% CI [.13, .27], p < .001, with substantial heterogeneity (I^2 = 72.17%). Findings remained significant after excluding high-risk studies and in leave-one-study-out analyses. Evidence was insufficient to meta-analyse help-seeking behaviours or barriers. Six studies were rated low risk of bias, six moderate, and nine high.

Conclusions

Greater self-compassion is associated with more favourable help-seeking attitudes and stronger help-seeking intentions, although effects are small and heterogeneous. Prospective, cross-cultural studies using consistent and validated measures are needed, particularly for actual help-seeking behaviour and barriers.

Introduction

Mental disorders are among the leading causes of disability worldwide, affecting approximately 970 million people and contributing substantially to reduced quality of life, impaired social and occupational functioning, and premature mortality (GBD 2019 Mental Disorders Collaborators, 2022; World Health Organization, 2022). Although effective psychological and pharmacological interventions are available for many mental health conditions, a large proportion of those who could benefit from care do not access services. Data from the World Mental Health Surveys indicate that only approximately one third of individuals with mental disorders in low- and middle-income countries and fewer than half in high income countries receive treatment within a given year (Thornicroft et al., 2017). Even when treatment is eventually sought, delays between symptom onset and treatment initiation commonly extend for years (Wang et al., 2007). Reducing this treatment gap remains one of the major challenges in global mental health (Kotera et al., 2023).

elp-seeking is not a single decision but a dynamic, often non-linear process involving awareness of symptoms, recognition and articulation of a problem, appraisal of the need for assistance, identification of appropriate sources of support, and willingness and ability to engage with those resources (Rickwood et al., 2005). Individuals may move back and forth between these stages or become delayed at particular points, for example by recognising distress without being able to articulate it, or by perceiving a need for support while doubting that available help will be effective or trustworthy. Help-seeking may involve informal support from family members, friends, peers, or community members, as well as formal support from mental health, primary care, educational, or occupational services (Henderson et al., 2026). Attitudes towards seeking help, intentions to seek help, and actual help-seeking behaviours are related but conceptually distinct (Kotera & Maughan, 2020). Favourable attitudes may not translate into intentions, and intentions may not result in behaviour when practical, social, or emotional barriers intervene. Consequently, psychological factors may operate differently at different stages of the help-seeking process.

A substantial body of research has demonstrated that help-seeking is shaped by interacting psychological, social, cultural, and structural influences. Systematic reviews consistently identify stigma, self-stigma, shame, fear of negative evaluation, low mental health literacy, concerns about confidentiality, and preferences for self-reliance as important barriers to seeking professional support (Clement et al., 2015; Gulliver et al., 2010). Service availability, affordability, accessibility, and perceived cultural appropriateness also influence whether willingness to seek help can be converted into service use. Notably, however, several commonly reported barriers concern how individuals interpret and respond to their own distress. People who have come to respond to suffering with self-criticism, shame, isolation, or avoidance may find it difficult to acknowledge psychological difficulties, disclose them to others, or accept that they deserve care (Kotera, 2021; Kotera et al., 2022). Understanding psychological processes that support a more accepting and constructive response to personal distress may therefore complement structural and public health approaches to improving engagement with mental health care.

One construct that may be particularly relevant to mental health help-seeking is self-compassion. Self-compassion refers to responding to personal suffering with kindness and understanding, recognising difficulty as part of the shared human experience, and maintaining balanced awareness of painful thoughts and emotions (Neff, 2003). According to Neff's model, self-compassion comprises three interacting pairs: self-kindness rather than self-judgement, common humanity rather than isolation, and mindfulness rather than over-identification (K. D. Neff, 2003). Self-kindness involves offering oneself warmth and support instead of harsh criticism. Common humanity places personal difficulty within the broader experience of human imperfection and suffering, rather than

interpreting it as evidence that one is uniquely deficient. Mindfulness involves holding distressing experiences in balanced awareness without suppressing them or becoming consumed by them.

Self-compassion is therefore distinct from self-pity, self-indulgence, or avoidance of responsibility (Neff, 2022). Whereas self-pity can intensify a sense of isolation and immersion in distress, common humanity situates suffering within a wider social context. Likewise, responding kindly to oneself does not require minimising problems or avoiding corrective action. A compassionate response may instead make it psychologically safer to recognise difficulty accurately and take steps to alleviate it. Self-compassion also differs conceptually from self-esteem because it does not depend on favourable self-evaluation, comparison with others, or evidence of competence. These distinctions are particularly relevant to help-seeking, which often requires individuals to acknowledge vulnerability without construing that acknowledgement as evidence of personal failure (Kotera et al., 2022).

Over the past two decades, self-compassion has become a major focus within clinical, counselling, and health psychology because of its consistent associations with psychological functioning. Meta-analytic evidence consistently links self-compassion with better psychological functioning. Notably, self-compassion has demonstrated a large negative association with psychopathology, primarily depression, anxiety, and stress ($r = -.54$) (MacBeth & Gumley, 2012), and a substantial positive association with psychological wellbeing ($r = .47$) (Zessin et al., 2015). Further meta-analyses have associated higher self-compassion with lower psychological distress and self-criticism, as well as greater resilience and adaptive coping (Ferrari et al., 2019; Marsh et al., 2018). Interventions designed to cultivate self-compassion, including Mindful Self-Compassion and Compassion-Focused Therapy, have also demonstrated beneficial effects across clinical and non-clinical populations (Kirby et al., 2017; Wilson et al., 2019). Together, this evidence suggests that self-compassion is a modifiable psychological resource with broad relevance to mental health.

Beyond its associations with mental health outcomes, self-compassion may also be relevant to treatment engagement. By reducing shame and harsh self-judgement, self-compassion may make it easier for individuals to acknowledge psychological distress without interpreting it as evidence of weakness or personal failure (Clement et al., 2015; Kotera et al., 2021). Its emphasis on common humanity may reduce feelings of isolation, while mindful awareness may support the recognition and articulation of distress without avoidance or over-identification. Together, these processes may influence whether individuals perceive their difficulties as legitimate, disclose them to others, regard themselves as deserving of support, and take steps towards seeking care. Self-compassion may therefore function as a psychological facilitator of mental health help-seeking, although its role should not be interpreted as causal on the basis of correlational evidence.

Several theoretical pathways support an association between self-compassion and help-seeking. First, self-compassion may reduce shame and self-stigma, both of which are consistently identified as barriers to professional support (Clement et al., 2015; Vogel et al., 2007). A person who responds to psychological difficulty with understanding rather than self-condemnation may be more able to acknowledge vulnerability without interpreting the need for help as weakness or inadequacy. This may be particularly important when symptoms conflict with personal or cultural expectations concerning independence, emotional control, competence, or social responsibility.

Second, the mindfulness component of self-compassion may promote clearer recognition of distress. Balanced attention to painful thoughts and emotions may reduce denial, suppression, and over-identification, allowing individuals to notice both the presence and seriousness of a problem (Hayes et al., 2006; Neff, 2022). Recognising one's distress as significant and potentially requiring support is often an important early stage of help-seeking, because individuals may be less likely to seek assistance for experiences that they minimise, normalise excessively, or avoid examining. Mindful awareness may also help individuals distinguish transient discomfort from distress that may warrant external support.

Third, common humanity may counter beliefs that one is alone, abnormal, or uniquely flawed (Kotera et al., 2022). Psychological difficulties are frequently accompanied by perceptions of social difference and disconnection. By placing suffering within the broader human experience, common humanity may reduce anticipated judgement and make disclosure to professionals, relatives, friends, or peers feel less threatening. It may also encourage individuals to perceive receiving support as a normal interpersonal response to difficulty rather than as evidence of personal inadequacy.

Fourth, self-kindness may support the belief that one deserves care and relief (Neff, 2011). Help-seeking frequently involves practical and emotional demands, including identifying services, discussing distress with unfamiliar people, tolerating uncertainty, and continuing after delays or unsatisfactory initial encounters. A supportive internal response may strengthen motivation to undertake these steps and persist when accessing care is difficult. In contrast, self-judgement may contribute to beliefs that suffering is deserved, insufficiently serious, or attributable to personal weakness, thereby discouraging engagement.

Compassion-focused theory provides a related account of these processes. Harsh self-criticism and shame are understood as expressions of a threat-focused mode of responding, whereas compassion can activate feelings of safeness, soothing, and affiliation (Gilbert, 2010). Seeking help necessarily involves approaching another person or service while tolerating vulnerability, dependence, uncertainty, and possible evaluation. A stronger capacity for self-reassurance may make the shame and perceived interpersonal threat associated with help-seeking more manageable (Kotera et al., 2019a; 2019b). Self-compassion may also support adaptive agency. Rather than eliminating personal responsibility, it can create an internal context in which difficulties can be evaluated without defensive avoidance and appropriate action can be taken.

The relationship between self-compassion and help-seeking may nevertheless be more complex than a uniformly positive association. Self-compassion could reduce psychological distress and therefore lower the perceived need for formal care. Some individuals may respond to distress through self-help or informal support rather than professional services, and favourable attitudes or intentions do not necessarily translate into actual service use (Nagai, 2015; Rickwood & Thomas, 2012). Self-compassion might therefore facilitate adaptive responses to distress without necessarily resulting in professional help-seeking in every circumstance.

Different components of self-compassion may relate differently to help-seeking. In a large sample of university students, compassionate self-responding was associated with stronger intentions to seek professional support, whereas self-coldness, comprising self-judgement, isolation, and over-identification, was associated with weaker intentions (Dschaak et al., 2021). Particular components may also operate at different stages of the help-seeking process. Conceptually, isolation may discourage disclosure of distress, whereas mindful awareness may facilitate problem recognition, although these pathways require direct empirical examination. Associations may additionally vary according to symptom severity, previous treatment experience, age, gender, and cultural context. Moreover, favourable attitudes or intentions cannot result in service use when care is unavailable, unaffordable, inaccessible, or perceived as culturally inappropriate (Rickwood & Thomas, 2012). It is therefore important to distinguish psychological willingness to seek help from realised help-seeking behaviour.

Empirical research examining self-compassion and help-seeking has been conducted in varied populations, including university students and counselling professionals (Aruta et al., 2023; Dschaak et al., 2021). However, the evidence remains fragmented, with studies focusing on different aspects of help-seeking, such as self-stigma and disclosure risk, professional help-seeking intentions, and professional or informal help-seeking behaviour (Min et al., 2022). Studies have examined attitudes towards professional psychological help, intentions to seek support, previous or current service use, disclosure, and perceived barriers to help-seeking. These outcomes represent distinct stages and forms of the help-seeking process and may not be equally associated with self-compassion (Nagai, 2015; Rickwood & Thomas, 2012). Studies also differ in whether they assess global self-compassion, individual components, or related constructs, as well as in their sampling, measurement, and analytical approaches. Consequently, the overall magnitude, consistency, and boundary conditions of the association remain unclear.

A comprehensive synthesis is important for theoretical and practical reasons. Theoretically, it could clarify whether self-compassion is consistently related to treatment engagement and whether associations vary across stages of help-seeking. It may also indicate which dimensions of self-compassion and which help-seeking outcomes should receive greater attention in longitudinal and experimental research. Practically, self-compassion is amenable to intervention (Kotera & Van Gordon, 2021) and may represent a complementary target within efforts to reduce treatment gaps (Kotera et al., 2022). Existing initiatives commonly emphasise service availability, mental health literacy, and reductions in public stigma. These remain essential, but interventions that help people recognise and respond more compassionately to their own suffering may address an additional intrapersonal barrier to engagement. Such implications require caution, however, because evidence of association alone would not establish that increasing self-compassion causes greater help-seeking.

To our knowledge, no systematic review and meta-analysis has quantitatively synthesised evidence on the association between self-compassion and mental health help-seeking outcomes. The present review therefore aimed to systematically examine and meta-analyse this association. Four research questions (RQs) were established:

RQ1. What is the overall association between self-compassion and help-seeking outcomes? RQ2. Does the strength of association differ across help-seeking attitudes, intentions, behaviours, and barriers?

RQ3. Where sufficient data are available, which study or sample characteristics explain heterogeneity?

RQ4. What is the methodological quality and risk of bias of the existing evidence?

By clarifying the magnitude, consistency, and quality of the evidence, this review seeks to advance understanding of self-compassion as a potential transdiagnostic correlate of treatment engagement and to inform future longitudinal and intervention research aimed at reducing mental health treatment gaps.

Methods

Protocol and Registration

This systematic review and meta-analysis was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA 2020) guidelines (Page et al., 2021) (see Online Resource 1 for the completed checklist). The review protocol was prospectively registered with the International Prospective Register of Systematic Reviews (PROSPERO; registration number: CRD420261411461).

Eligibility Criteria

Eligibility criteria were defined using the Population—Exposure—Outcome (PEO) framework.

Population

Studies involving human participants of any age, gender, nationality, or clinical status were eligible. Studies conducted in community, educational, occupational, healthcare, or clinical settings were included.

Exposure

The exposure of interest was self-compassion, assessed using validated self-report measures (e.g., Self-Compassion Scale (Neff, 2003), Self-Compassion Scale–Short Form (Raes et al., 2011)) or conceptually equivalent measures explicitly designed to assess self-compassion.

Outcomes

Drawing on established conceptualisations of mental health help-seeking and its barriers (Clement et al., 2015; Rickwood et al., 2005; Rickwood & Thomas, 2012), help-seeking-related variables were grouped into four categories: (a) help-seeking attitudes, such as attitudes towards seeking professional psychological help; (b) help-seeking intentions, such as willingness or intention to seek support in the future; (c) help-seeking behaviours, such as actual use of mental health services or other support resources; and (d) help-seeking barriers, such as self-stigma, shame, perceived obstacles, or reluctance to seek help. Because barriers are generally conceptualised as antecedents to help-seeking rather than as help-seeking outcomes themselves (Clement et al., 2015; Vogel et al., 2007), the term help-seeking-related outcomes is used here as an umbrella term for all variables included in the synthesis.

Study Design

Observational quantitative studies, including cross-sectional and longitudinal studies, were eligible. Experimental studies and intervention trials were excluded unless they reported eligible observational data that could be extracted independently of the intervention, such as associations measured at baseline or before the intervention commenced. Qualitative studies, reviews, editorials, conference abstracts, protocols, dissertations, and case reports were excluded.

Information Sources and Search Strategy

A comprehensive literature search was conducted in MEDLINE, Embase, and PsycINFO via Ovid, and in Scopus, from database inception to the latest database coverage available at the time of searching (10 July 2026). The search strategy was developed by the review team with support from a subject librarian and was refined to maximise sensitivity. Database-specific subject headings were used where available, including MeSH terms in MEDLINE and APA Thesaurus terms in PsycINFO, alongside free-text terms searched in title, abstract, keyword, and relevant heading fields. The search combined terms relating to self-compassion or closely related self-directed constructs with terms relating to help-seeking, service use, counselling, psychotherapy, treatment barriers, and perceived barriers. For MEDLINE, Embase, and PsycINFO, a third concept was added to identify observational, cross-sectional, longitudinal, cohort, case-control, survey, questionnaire, correlational, or association studies. For Scopus, which does not support controlled vocabulary searching, the strategy was limited to title, abstract, and author keyword fields; the study-design concept was not included because it substantially reduced retrieval and risked lowering search sensitivity. No restrictions were applied regarding publication date, language, geographical location, or participant characteristics. The full search strategies are provided in Online Resource 2.

Study Selection and Supplementary Searching

For title and abstract screening, YK and JA independently screened the same randomly selected 10% of records to assess concordance. Disagreements were discussed, and the eligibility criteria were clarified where necessary, with CL available to provide an additional judgement when consensus could not be reached. YK then screened the remaining records independently.

For full text screening, YK and DAO independently assessed the eligibility. Disagreements were resolved through discussion, with CL providing an additional judgement when consensus could not be reached.

CL conducted backward citation searching of the reference lists of all included studies and two recent systematic reviews relevant to self-compassion and mental-health help-seeking (Anthes & Dreisoerner, 2026; Conde et al., 2026). CL also conducted forward citation searching for each of the 21 included studies using the “Cited by” function in Scopus and screened the titles and abstracts of citing records against the review eligibility criteria. The initial list of eligible studies was subsequently reviewed for completeness by MA, who has expertise in the self-compassion literature. The final set of included studies was reviewed and agreed by all authors.

The study selection process was documented using a PRISMA flow diagram.

Data Extraction

Data were extracted by YK, and verified by KM, DBP, LMG, CECV, MDH, and ACT using a standardised extraction form. Following established guidance for systematic review data collection and reporting (Higgins et al., 2024; Page et al., 2021), eight categories of information were extracted from each study: author and year of publication; country; study design; population and sample size; setting; self-compassion measure; help-seeking outcome and measure; and key findings. Data for meta-analysis, such as data required to calculate effect sizes and covariates included in adjusted analyses were retrieved by YK and verified by SF (Online Resources 4). For the correlation meta-analyses, zero-order associations were used to maximise comparability across studies. Adjusted odds ratios and multinomial regression coefficients were retained in their originally reported metrics and synthesised narratively because they were not directly comparable with unadjusted correlations. Corresponding authors were contacted when an exact or compatible effect estimate was unavailable. Studies without sufficient numerical information were retained in the narrative synthesis but omitted from quantitative pooling.

Risk of Bias Assessment

Risk of bias was assessed using an adapted version of the Joanna Briggs Institute Critical Appraisal Checklist for Analytical Cross-Sectional Studies (Barker et al., 2026) by YK, and verified by KM, DBP, LMG, CECV, MDH, and ACT. Eight domains were evaluated: clarity of the sample inclusion criteria; use of objective, standard criteria where a condition was used to define the sample; valid and reliable measurement of self-compassion; valid and reliable measurement of the relevant help-seeking outcome; identification of potential confounding factors; strategies for addressing confounding; appropriateness of the statistical analysis; and adequate description of the participants and setting. The item concerning objective criteria for defining a condition was rated

not applicable when eligibility was not based on a physical or mental health condition. Each item was rated Yes, No, Unclear, or Not applicable. Where a study reported more than one eligible help-seeking outcome, risk of bias was assessed separately for each outcome.

Overall risk of bias was classified using a prespecified decision rule. Studies were rated as having low risk of bias when all applicable core items were rated Yes and no material methodological concerns were identified. Moderate risk of bias was assigned when there was no rating of No for self-compassion measurement, help-seeking measurement, or statistical analysis, but one or more items were rated Unclear or there was an isolated concern relating to confounding. Studies were rated as having high risk of bias when: (a) self-compassion measurement, help-seeking measurement, or statistical analysis was rated No; (b) both identification and management of confounding were rated No; or (c) the relevant self-compassion–help-seeking result was unavailable or insufficiently reported.

Data Synthesis

A narrative synthesis was conducted for all included studies. A meta-analysis was undertaken when at least three independent studies reported sufficiently comparable outcomes. Separate meta-analyses were planned for help-seeking attitudes, intentions, behaviours, and barriers.

Pearson's correlation coefficient (r) was the primary effect-size metric. Spearman rank correlations were converted to approximate Pearson correlations using $r \approx 2\sin(\pi\rho_s/6)$ before inclusion in the primary analysis. This conversion was treated as approximate and examined through sensitivity analysis. Adjusted odds ratios and multinomial regression coefficients were not converted to correlations. Correlations were transformed to Fisher's z values before pooling, with sampling variance calculated as $1/(N - 3)$, and pooled estimates were back-transformed to r for presentation (Borenstein et al., 2009; Rupinski & Dunlap, 1996).

Where a study reported multiple dependent effects within the same outcome category, the effects were averaged on the Fisher's z scale to produce one study-level estimate. The variance of the combined estimate was calculated assuming a correlation of .50 between the dependent outcomes. Where estimates were reported for mutually exclusive participant subgroups, subgroup estimates were combined using inverse-variance weighting before entry into the meta-analysis.

Random-effects models were fitted using restricted maximum likelihood estimation, with the Knapp–Hartung adjustment applied to confidence intervals and significance tests (Knapp & Hartung, 2003). Analyses were conducted in R version 4.1.2 using the metafor package version 5.0–1 (Viechtbauer, 2010).

Assessment of Heterogeneity

Statistical heterogeneity was assessed using Cochran's Q, τ^2, and I^2. I^2 values of approximately 25%, 50%, and 75% were interpreted as indicating low, moderate, and high heterogeneity, respectively, while recognising that these thresholds are approximate and should be considered alongside the magnitude and direction of effects (Higgins et al., 2003). Ninety-five per cent prediction intervals were calculated and back-transformed to the correlation scale to describe the range of effects expected across comparable settings. Subgroup analyses were planned to examine participant age, clinical status, geographical region, and self-compassion measurement instrument when sufficient studies and adequate variation across moderator categories were available. Meta-regression was to be undertaken only when at least ten studies were available for the relevant analysis (Deeks et al., 2024).

Sensitivity Analyses

Prespecified sensitivity analyses excluded studies judged to be at high risk of bias and examined the influence of each study through leave-one-study-out analyses. For the meta-analysis of help-seeking intentions, additional sensitivity analyses excluded studies reporting Spearman rather than Pearson correlations and varied the assumed correlation between dependent within-study outcomes from 0 to 1.

Missing Results and Small-Study Effects

Potential bias arising from missing or selectively unreported results was assessed by identifying studies that measured both self-compassion and an eligible help-seeking outcome but did not report the direct association. Corresponding authors were contacted when the missing estimate was required for quantitative synthesis. Potential small-study effects were to be assessed using funnel plots and Egger's regression test when at least ten studies were available within a meta-analysis (Egger et al., 1997). Where funnel-plot asymmetry was identified, the trim-and-fill method was planned as a sensitivity analysis to assess its possible influence on the pooled estimate (Duval & Tweedie, 2000).

Results

The database searches identified 2,736 records: 1,205 from Embase, 735 from MEDLINE, 504 from PsycINFO, and 292 from Scopus. After removal of 816 duplicates, 1,920 records underwent title and abstract screening, of which 1,890 were excluded. Two reviewers independently screened a subset of 203 titles and abstracts, achieving 97.5% agreement; disagreements were resolved through discussion. Thirty reports proceeded to full-text screening. Nine were excluded because they did not assess help-seeking (n = 8), and did not assess self-compassion (n = 1) (Online Resource 3). Twenty-one studies were therefore included in the review. Forward and backward citation searching and consultation with experts identified no additional eligible studies. Figure 1 presents the PRISMA flowchart.

Study Characteristics

The 21 included studies were published between 2017 and 2026 and comprised 18,535 participants, with individual sample sizes ranging from 158 to 9,349. All studies used cross-sectional designs. Fifteen administered surveys online, one used mixed online and in-person data collection, four used on-site or paper-based surveys, and one did not report the survey mode. Seven studies were conducted in the United States, six in China, two in the United Kingdom,

and one each in Australia, Canada, the Philippines, Romania, and Türkiye. One study recruited German-speaking participants from Austria, Germany, and Italy. The evidence represented 11 countries but was concentrated primarily in the United States and China.

Most studies examined young people in educational settings. Fourteen recruited exclusively from secondary-school, university, medical-student, postgraduate, or collegiate-athlete populations, and one included both university students and other adults. Other populations comprised athletes, counselling professionals, combat-wounded veterans, community adults, and attendees of a focused music-listening event. Where reported, mean age ranged from 18.03 to 45.60 years. Gender composition varied considerably: several studies recruited predominantly women, whereas three focused exclusively or almost exclusively on men. Reporting and analytical inclusion of non-binary and other gender identities were inconsistent across studies.

Self-compassion was generally measured using established instruments. Sixteen studies used the Self-Compassion Scale–Short Form or selected items from it, although two substantially modified the scale by using only two items or the six positively worded items. Four studies used the full Self-Compassion Scale, and one assessed state self-compassion using the State Self-Compassion Scale–Short Form. Most studies reported acceptable or good internal consistency, although one reported a score range inconsistent with standard Self-Compassion Scale–Short Form scoring.

The operationalisation of help-seeking was more heterogeneous. Eight studies assessed attitudes towards professional help-seeking, and 11 assessed intentions to seek formal, informal, professional, or general support; two of these examined both attitudes and intentions. Other outcomes included actual help-seeking, perceived barriers to psychological treatment, willingness to participate in mental health treatment, and general support-seeking. Established measures included the Attitudes Toward Seeking Professional Psychological Help Scale–Short Form, General Help-Seeking Questionnaire, Inventory of Attitudes Toward Seeking Mental Health Services, Mental Help-Seeking Attitudes Scale, and Mental Help-Seeking Intention Scale. However, twelve studies used adapted, shortened, single-item, or author-developed measures, and formal and informal help sources were sometimes combined into a single score.

Table 1. Study characteristics (*n*=21)

Study ID	Study	Country	Design
1	Harker and Petrie (2026)	United States	Cross-sectional online survey
2	Liu et al. (2026)	China	On-site cross-sectional survey
3	McClymont and Krause (2026)	Australia	Cross-sectional post-event online survey
4	Sun et al. (2026)	China	Cross-sectional online survey
5	Chira and Nedelcea (2025)	Romania	Cross-sectional psychometric adaptation and validation study using onl
6	Lu et al. (2025)	China	Cross-sectional survey (online or paper was unreported)
7	Gorczynski and Sims-Schouten (2024)	United States	Cross-sectional online survey
8	Kantar and Yalçın (2024),	Türkiye	Cross-sectional online survey
9	Lu et al. (2024)	China	Cross-sectional survey administered at school
10	Mateer et al. (2024)	United States	Cross-sectional online survey
11	Aruta et al. (2023).	Philippines	Cross-sectional paper survey
12	Komlenac et al. (2023)	Germany, Austria, and Italy	Cross-sectional online survey
13	Kim et al. (2022)	United States	Cross-sectional online survey
14	Min et al. (2022).	China	Cross-sectional online survey
15	Dschaak et al. (2021).	United States	Cross-sectional online survey
16	Gorczynski et al. (2020)	United Kingdom	Cross-sectional online survey
17	Wu et al. (2020)	China	Cross-sectional online survey
18	Bravo et al. (2019)	United States	Cross-sectional online survey
19	Hilliard et al. (2019)	United States	Cross-sectional mixed-mode survey (online and in person)
20	Wasylkiw and Clairo (2018)	Canada	Cross-sectional paper-and-pencil survey
21	Sydenham et al. (2017)	United Kingdom	Cross-sectional online survey

Abbreviations: AHSQ, Actual Help-Seeking Questionnaire; ATSPH-SF, Attitudes Toward Seeking Psychological Help Scale–Short Form; ATSPPH-SF, Attitudes Toward Seeking Professional Psychological Help Scale–Short Form; BSSS, Berlin Social Support Scales; GHSQ, General Help-Seeking Questionnaire; HS, help-seeking; IASMHS, Inventory of Attitudes Toward Seeking Mental Health Services; ISCI, Intentions to Seek Counseling Inventory; IPV, intimate partner violence; MHSAS, Mental Help-Seeking Attitudes Scale; MHSIS, Mental Help-Seeking Intention Scale; PBPT, Perceived Barriers to Psychological Treatments; PHQ-9, nine-item Patient Health Questionnaire; SC, self-compassion; SCS, Self-Compassion Scale; SCS-SF, Self-Compassion Scale–Short Form; SSCS-S, State Self-Compassion Scale–Short Form; UK, United Kingdom; US, United States; VA, United States Department of Veterans Affairs.

Statistical notation: α, Cronbach's alpha; *B*, unstandardized regression coefficient; β, standardized regression coefficient; CI, confidence interval; *M*, mean; *n*, sample size; OR, odds ratio; *p*, probability value; *r*, Pearson correlation coefficient; SD, standard deviation; ρ, Spearman's rank-order correlation coefficient.

Narrative synthesis of help-seeking outcomes

Across the 21 included studies, 16 reported at least one association in which greater self-compassion corresponded to more favourable help-seeking attitudes or intentions, greater help-seeking, or fewer perceived barriers. Associations were generally small to moderate. Findings differed according to the outcome and source of help. Min et al. (2022) found that self-compassion was positively associated with total help-seeking, r = .134, and non-professional help-seeking, r = .141, but not professional help-seeking, r = -.070. Wu et al. (2020) found that greater self-compassion was associated with lower likelihood of belonging to attitudinal/availability-barrier and high-barrier profiles. In contrast to the predominant pattern, Bravo et al. (2019) found that greater self-compassion was associated with lower willingness to participate in general, Department of Veterans Affairs-based, and online mindfulness treatment. Three studies did not report an exact direct association suitable for quantitative synthesis: Gorczynski et al. (2020) and Hilliard et al. (2019) described the relevant associations as nonsignificant without reporting the coefficients, whereas Sydenham et al. (2017) did not report the direct self-compassion—support-seeking association.

Risk of bias assessment

The risk-of-bias assessments for individual studies are presented in Online Resource 5. At the study level, six studies were rated as having low risk of bias, six as having moderate risk, and nine as having high risk. Studies reporting multiple eligible help-seeking outcomes received the same overall risk-of-bias classification across outcomes.

Measurement of self-compassion was generally methodologically strong. Nineteen studies used a self-compassion measure judged to be valid and reliable, while measurement validity was unclear in two studies that used selected items or reported non-standard scoring. In comparison, the quality of help-seeking measurement was more variable. Help-seeking measurement was rated Yes in 11 studies, Unclear in eight, and No in two. Unclear ratings commonly reflected the use of adapted, shortened, single-item, or insufficiently validated help-seeking measures.

Confounding was a prominent source of bias. Seven studies neither clearly identified potential confounding factors nor reported strategies to address them. Statistical analysis was judged appropriate in 18 studies and unclear in three, principally because the relevant self-compassion–help-seeking association was not reported sufficiently for assessment. The participants and settings were described adequately in 19 studies and unclearly in two.

Overall, high risk-of-bias ratings were primarily attributable to unvalidated help-seeking measures, failure to identify and address confounding, and unavailable or insufficiently reported self-compassion–help-seeking results. Moderate ratings were largely associated with uncertainty about the validity of adapted or single-item help-seeking measures rather than clearly inappropriate measurement or analysis.

Meta-analysis

Of the four planned outcome categories, help-seeking attitudes and intentions met the threshold for quantitative synthesis. Fewer than three studies reported sufficiently comparable effects for help-seeking behaviours or barriers. The primary and sensitivity analyses are summarised in Table 2.

Table 2. Primary and sensitivity analyses

Outcome	Analysis	*k*	*N*	Pooled *r* (95% CI)	*p*	I^2 (%)	τ^2	95% prediction interval
Attitudes	Primary analysis	7	2414	0.22 [0.12, 0.32]	0.002	79.55	0.0119	[-0.06, 0.47]
Attitudes	Excluding high-risk studies	5	1678	0.26 [0.13, 0.39]	0.006	75.98	0.0101	[-0.04, 0.52]
Intentions	Primary analysis	8	3790	0.20 [0.13, 0.27]	< .001	72.17	0.0051	[0.02, 0.37]
Intentions	Pearson correlations only	6	2821	0.19 [0.08, 0.30]	0.007	81.18	0.0085	[-0.07, 0.43]
Intentions	Excluding high-risk studies	5	2555	0.19 [0.06, 0.31]	0.017	82.43	0.0088	[-0.10, 0.45]

Note. k = number of independent studies; N = combined analytic sample size. Random-effects models used restricted maximum likelihood estimation with the Knapp-Hartung adjustment. Correlations were analysed after Fisher's z transformation and back-transformed to r for presentation. τ^2 is reported on the Fisher's z scale. For the primary intentions analysis, Spearman correlations were approximately converted to Pearson correlations. Multiple dependent estimates from the same sample were combined into one study-level effect.

Help-seeking attitudes

Seven studies comprising 2,414 participants were included in the meta-analysis of help-seeking attitudes. As shown in Figure 2, all study-level estimates were positive, although their magnitude varied considerably. The random-effects model indicated a significant positive association between self-compassion and favourable help-seeking attitudes, r = .22, 95% CI [.12, .32], p = .002. Heterogeneity was high, $Q(6)$ = 39.61, p < .001, I^2= 79.55%, and τ^2= .0119. The 95% prediction interval ranged from r = −.06 to .47.

Individual study estimates are presented as correlation coefficients with 95% confidence intervals. Confidence intervals were calculated from the reported correlation and analytic sample size when not provided by the original study. The diamond represents the pooled random-effects estimate obtained using restricted maximum likelihood estimation with the Knapp-Hartung adjustment. Correlations were analysed after Fisher's z transformation and back-transformed to Pearson's r for presentation.

Chira and Nedelcea (2025) reported r = .08, N = 578, and p < .01. Because the reported significance level appeared inconsistent with the effect estimate and sample size, the reported correlation was retained, while its sampling variance and confidence interval were calculated from the reported r and N using the same procedure applied to the other studies.

Excluding two studies judged to be at high risk of bias did not weaken the pooled association. The resulting estimate was r = .26, 95% CI [.13, .39], p = .006, with continued high heterogeneity, I^2 = 75.98%. The 95% prediction interval ranged from −.04 to .52.

Leave-one-study-out estimates ranged from r = .18 to .25, and every confidence interval excluded zero. Omitting Kantar and Yalçın (2024), which reported the largest association, reduced the pooled estimate to r = .18, 95% CI [.10, .26], and reduced heterogeneity to I^2 = 51.78%. No individual study materially altered the conclusion.

Help-seeking intentions

Eight studies comprising 3,790 participants were included in the meta-analysis of help-seeking intentions. The random-effects model indicated a significant positive association between self-compassion and help-seeking intentions, r = .20, 95% CI [.13, .27], p < .001 (Figure 3). Heterogeneity was substantial, $Q(7)$ = 21.79, p = .003, I^2 = 72.17%, and τ^2 = .0051. The 95% prediction interval ranged from r = .02 to .37.

Individual study estimates are presented as correlation coefficients with 95% confidence intervals. Multiple dependent estimates reported within the same sample were combined into one study-level effect, and estimates from independent participant subgroups were combined using inverse-variance weighting. Spearman correlations were approximately converted to Pearson correlations for the primary analysis. The diamond represents the pooled random-effects estimate obtained using restricted maximum likelihood estimation with the Knapp-Hartung adjustment. Effects were analysed after Fisher's z transformation and back-transformed to Pearson's r for presentation.

Excluding three studies judged to be at high risk of bias produced a similar pooled estimate, r = .19, 95% CI [.06, .31], p = .017. Heterogeneity remained high, I^2 = 82.43%, and the 95% prediction interval ranged from −.10 to .45.

Leave-one-study-out estimates ranged from r = .19 to .22, with all confidence intervals excluding zero. Omitting McClymont and Krause (2026), which reported a near-null association, reduced heterogeneity from I^2 = 72.17% to 45.96%, while the pooled association remained significant, r = .22, 95% CI [.17, .27]. No individual study materially altered the pooled conclusion.

In an additional sensitivity analysis excluding the two studies that reported Spearman rather than Pearson correlations, the pooled association remained similar, r = .19, 95% CI [.08, .30], p = .007. Heterogeneity remained high, $Q(5)$ = 21.23, p < .001, I^2 = 81.18%, and τ^2 = .0085. The 95% prediction interval ranged from −.07 to .43.

Varying the assumed correlation between dependent within-study outcomes from 0 to 1 produced virtually identical pooled estimates (r = .201 throughout; 95% CI lower limits, .126—.127; upper limits, .273 throughout). The result was therefore insensitive to the assumed degree of within-study dependence.

Analyses not undertaken

Meta-analyses were not undertaken for help-seeking behaviours or barriers because fewer than three studies reported sufficiently comparable effect estimates. Subgroup analyses were not conducted because the number of studies was small and the proposed moderator categories were sparsely represented. Meta-regression, funnel plots, Egger's regression test, and trim-and-fill analyses were not undertaken because neither meta-analysis included at least ten studies.

Discussion

This review found that greater self-compassion was associated with more favourable help-seeking attitudes and stronger help-seeking intentions, with similar small positive pooled associations across these two outcomes. Although heterogeneity was substantial, the small number of studies precluded the planned subgroup analyses and meta-regression, so the study and sample characteristics underlying this variation could not be established. The methodological quality of the evidence was mixed, with six studies rated as low risk of bias, six as moderate risk, and nine as high risk; nevertheless, excluding high-risk studies did not materially change the pooled findings.

Regarding the overall association between self-compassion and help-seeking (RQ1), this review found consistent evidence that greater self-compassion was associated with more favourable help-seeking attitudes and stronger help-seeking intentions. The pooled associations were small but statistically significant for both attitudes (r = .22), and intentions (r = .20). These findings remained significant after excluding studies at high risk of bias, and were not materially altered by leave-one-study-out analyses or alternative decisions concerning the treatment of Spearman correlations and dependent outcomes. The findings therefore suggest that self-compassion may be relevant to how people evaluate and contemplate seeking support. Though the causal direction of this relationship cannot be established, greater self-compassion may facilitate help-seeking, help-seeking experiences may strengthen self-compassion, or both may reflect other individual or contextual factors.

No clear differences across help-seeking outcomes (RQ2) were found: the pooled associations for help-seeking attitudes and intentions were numerically similar. This apparent similarity should not, however, be interpreted as evidence of statistical equivalence because the two pooled estimates were not formally compared. Insufficient comparable data were available to meta-analyse help-seeking behaviours or barriers, preventing a comprehensive comparison across all four outcome categories. The narrative synthesis further suggested that the association may depend on how help-seeking is

operationalised. Self-compassion was positively associated with total and non-professional help-seeking but not professional help-seeking in Min et al. (2022), whereas Bravo et al. (2019) found inverse associations with willingness to participate in three forms of mindfulness treatment. These contrasting findings indicate that actual help-seeking, the source of help, and willingness to undertake a specific treatment should not be treated as interchangeable outcomes.

The available evidence could not identify which study or sample characteristics explained heterogeneity (RQ3). Considerable heterogeneity was observed in both meta-analyses, but the small number of studies precluded the prespecified subgroup analyses and meta-regression. It was therefore not possible to determine statistically whether age, clinical status, geographical region, cultural context, or self-compassion measurement explained variation in effect sizes. Leave-one-study-out analyses indicated that Kantar and Yalçın (2024) contributed substantially to heterogeneity in attitudes, whereas McClymont and Krause (2026) contributed substantially to heterogeneity in intentions, although removing either study did not alter the overall conclusion.

Descriptively, positive associations were reported across several national and regional settings, indicating that the relationship was not confined to one country. Nevertheless, null, mixed, and inverse findings were also observed. These differences cannot be attributed specifically to culture because country was confounded with participant population, outcome definition, measurement instrument, and service context, and the evidence was concentrated largely in the United States and China. Future research should therefore measure cultural orientations at participant level and use comparable help-seeking outcomes across countries rather than relying on country as a proxy for culture. One potentially useful framework is worth orientation, referring to culturally shaped assumptions about how personal worth is established and whether care must be earned (Kotera, 2026b). In contribution- or achievement-based orientations, seeking psychological help may threaten worth by signalling weakness, dependency, failure, or reduced social contribution (Kotera, 2026a). Self-compassion may be especially relevant in such contexts because it can loosen the connection between worth and performance, allowing distress to be viewed as a legitimate basis for receiving care. By contrast, in dignity- or inherent-worth orientations, care may be regarded as something to which people are entitled by virtue of being human, making help-seeking less threatening to personal worth. Future cross-cultural studies should examine whether contribution-based and inherent-worth orientations moderate the association between self-compassion and professional, informal, and behavioural help-seeking.

The methodological quality of the evidence was mixed (RQ4): six studies were rated as having low risk of bias, six as moderate risk, and nine as high risk. The main concerns were the use of adapted, shortened, single-item, or insufficiently validated help-seeking measures; inadequate identification and management of confounding; and incomplete reporting of the focal self-compassion—help-seeking association. Self-compassion measurement was generally stronger than help-seeking measurement, although two studies (Dschaak et al., 2021; Lu et al., 2024) used selected items from established self-compassion instruments. Importantly, excluding high-risk studies did not materially change the pooled associations for either attitudes or intentions. This supports the robustness of the overall pattern, but it does not remove the limitations created by cross-sectional designs, residual confounding, measurement heterogeneity, and selective non-reporting.

Clinical implications

The findings suggest that self-compassion may be a relevant, although modest, target when seeking to improve openness towards mental-health support. Interventions that reduce self-criticism, shame, and perceptions of personal failure may help some individuals view seeking assistance as a legitimate form of self-care rather than as evidence of weakness (Uneno et al., 2024). Self-compassion components could therefore be incorporated into psychoeducation, stigma-reduction programmes, university mental-health initiatives, athlete support programmes (Kotera et al., 2024), and preparatory interventions for people who are hesitant to engage with services (Dupasquier et al., 2018).

The small effect sizes and observational nature of the evidence mean that self-compassion should not be regarded as a stand-alone solution to limited help-seeking. Service accessibility, cost, confidentiality, availability, previous treatment experiences, discrimination, social norms, and trust in professionals may exert stronger influences on actual behaviour (Henderson et al., 2026). Moreover, the meaning of compassionate self-care and appropriate help-seeking may differ across cultural and relational contexts (Neff et al., 2008). Interventions should therefore be culturally responsive and should recognise that seeking support from family members, peers, community figures, or professionals may carry different meanings and consequences across populations.

Future research

Several priorities emerge from this review. Self-compassion and help-seeking should be examined as a primary research focus, with greater attention to actual help-seeking behaviour and perceived barriers, which remain under-studied relative to attitudes and intentions. Prospective and longitudinal designs are needed to clarify temporal relationships and determine whether self-compassion operates differently across stages of the help-seeking process. Greater methodological consistency, including the use of validated and clearly defined help-seeking measures, would improve comparability across studies. Research in clinical populations and culturally diverse, particularly non-WEIRD, settings is also needed to establish the generalisability and boundary conditions of the observed associations.

Strengths and limitations

A principal strength of this review is its novel integration of two important but previously disconnected areas of research. To our knowledge, no previous systematic review or meta-analysis has synthesised the association between self-compassion and mental-health help-seeking. This is important because self-compassion has been linked with a broad range of mental health outcomes (MacBeth & Gumley, 2012), while help-seeking has become increasingly prominent in global mental health research and practice (van den Broek et al., 2023). By examining whether self-compassion is associated with attitudes, intentions, behaviours, and barriers to seeking help, the review addresses a clinically and conceptually important gap. Methodological strengths further support the credibility of the findings. The review was prospectively registered, followed PRISMA guidance, applied broad eligibility criteria without date, language, or geographical restrictions, and searched four major databases using a strategy developed with a subject librarian. Citation searching and expert consultation were used to identify additional studies. Data extraction and risk-of-bias judgements were independently verified, and attitudes, intentions,

behaviours, and barriers were treated as conceptually distinct outcomes. The meta-analysis maintained statistical independence by combining dependent effects within studies, used random-effects models with the Knapp-Hartung adjustment, reported prediction intervals, and included multiple sensitivity and influence analyses.

Several limitations should also be acknowledged. All included studies were cross-sectional, precluding causal or temporal conclusions. The evidence was concentrated in the United States and China and was dominated by young people and educational populations, limiting generalisability to older adults, clinical populations, and underrepresented regions. Only seven attitude studies and eight intention studies could be pooled, preventing adequately powered moderator analyses, including the planned examination of culture and geographical region. Behaviour and barrier outcomes could not be meta-analysed, and formal assessment of small-study effects was not possible. Help-seeking was measured inconsistently, with several studies using adapted, shortened, single-item, or author-developed instruments. Some potentially eligible associations were incompletely reported, and the descriptive comparison of national settings cannot distinguish cultural influences from differences in samples, measures, services, and study design. Finally, although sensitivity analyses excluding high-risk studies supported the findings, the pooled estimates remain dependent on an evidence base with substantial heterogeneity and mixed methodological quality.

Conclusion

Greater self-compassion was associated with more favourable help-seeking attitudes and stronger intentions to seek help, with small positive pooled associations that remained robust across sensitivity analyses. Evidence concerning actual help-seeking behaviour and perceived barriers was too limited for quantitative synthesis. Substantial heterogeneity indicates that the strength of the association is likely to vary across populations and settings, but the available evidence was insufficient to identify cultural or other moderators. Prospective and cross-cultural studies using consistent, validated measures are needed to establish temporal relationships, examine actual help-seeking behaviour, and determine when, how, and for whom self-compassion may facilitate engagement with mental health support.

Declarations

Author Contribution

Conceptualisation: Y.K.Methodology: Y.K.Formal analysis: Y.K.Data curation: Y.K., D.A.O., and J.A.Project administration: Y.K.Investigation: Y.K., C.L., K.M., D.A.O., D.P., M.A., L.G.-K., C.C.V., S.F., M.H., and J.A.Validation: Y.K., C.L., K.M., D.A.O., D.P., M.A., L.G.-K., C.C.V., S.F., M.H., and J.A.Writing—original draft: Y.K.Writing—review and editing: all authors.

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Figures

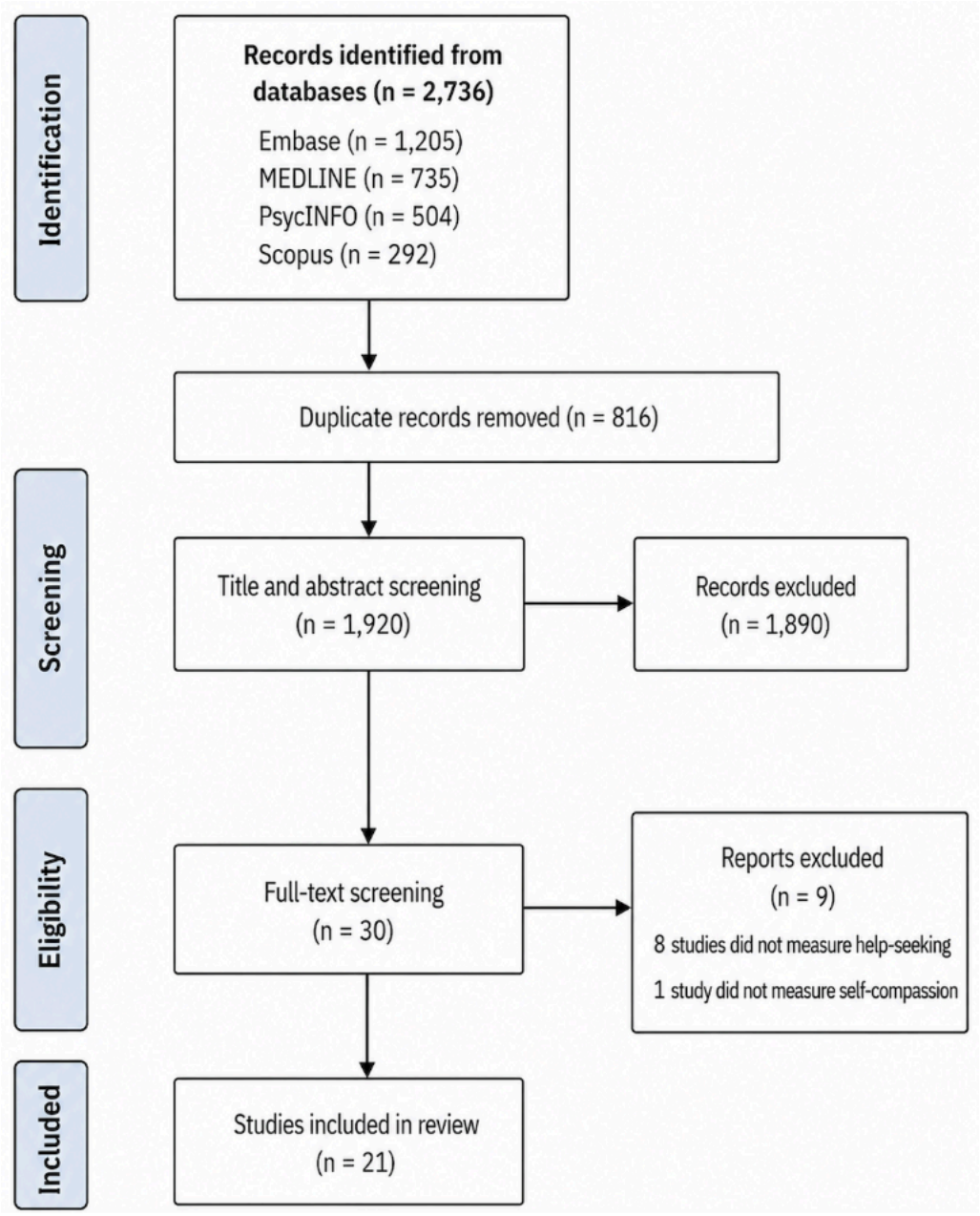


Figure 1

PRISMA flowchart of study identification and selection

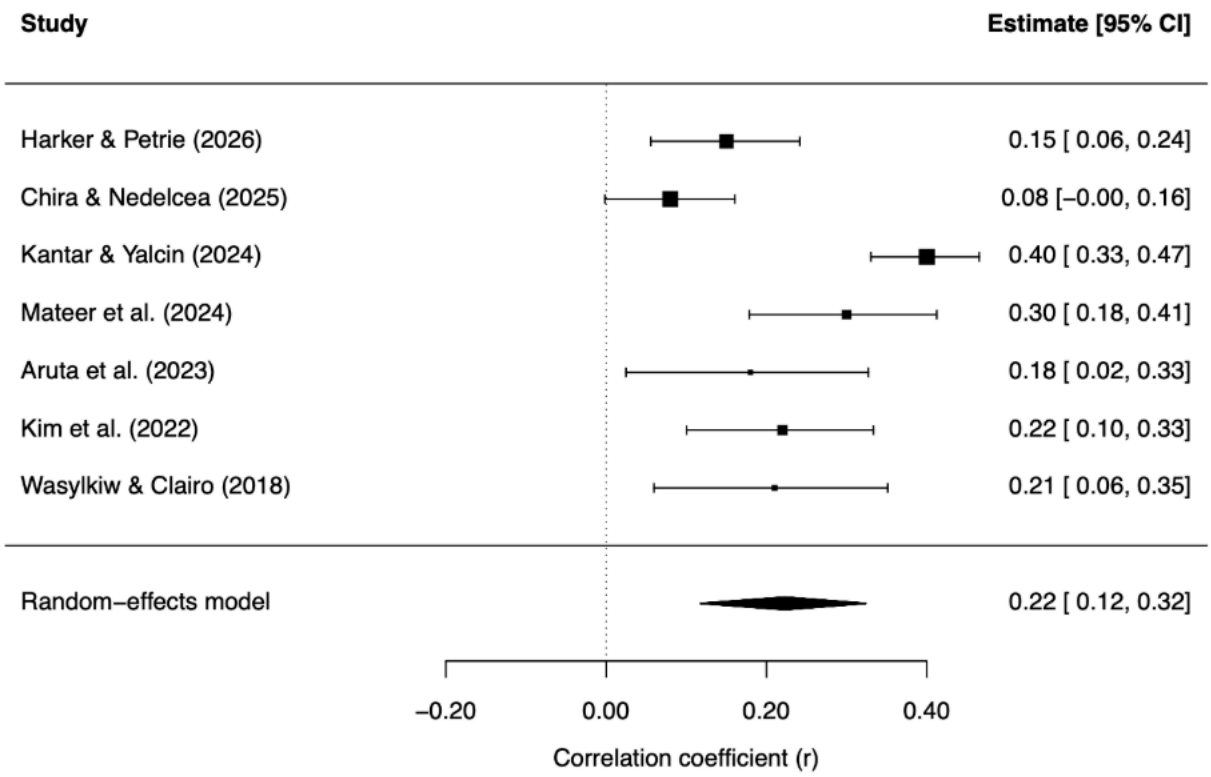


Figure 2

Forest plot of the association between self-compassion and help-seeking attitudes

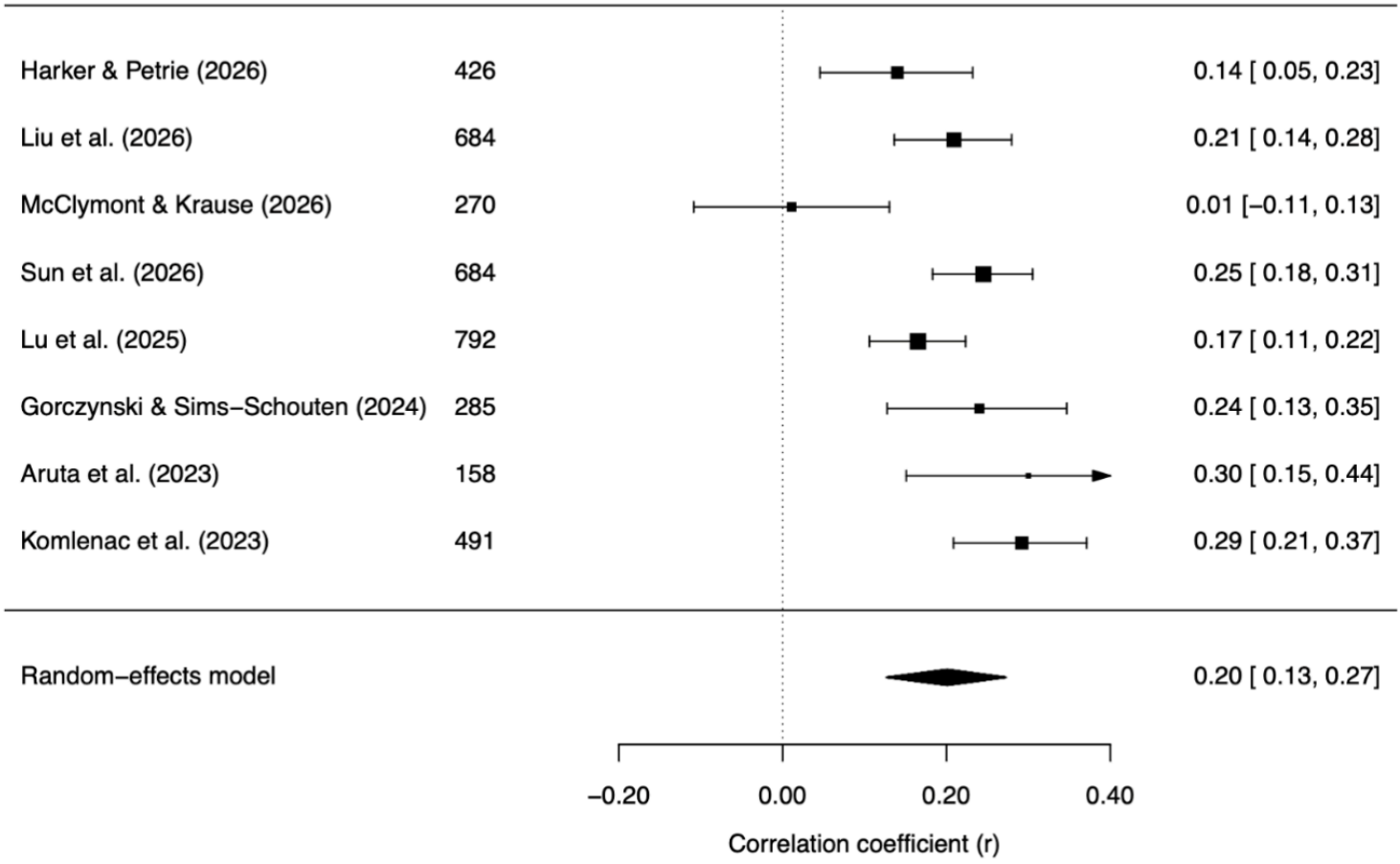


Figure 3

Forest plot of the association between self-compassion and help-seeking intentions

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