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Self-Compassion as a Moderator of the Relationship Between Emotion Dysregulation and Borderline Personality Disorder Symptoms

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SELF-COMPASSION AS A MODERATOR OF THE RELATIONSHIP BETWEEN EMOTION DYSREGULATION AND BORDERLINE PERSONALITY DISORDER SYMPTOMS

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A core feature of borderline personality disorder (BPD) is emotion dysregulation (American Psychiatric Association, 2013). Such dysregulation leads to emotions spiraling out of control, hindering reason, and leading to out-of-control maladaptive behaviors (Conklin, Bradley, Westen, 2006). Invalidating environments, coupled with biologically based emotional vulnerability, are thought to account for the development of BPD (Linehan, 1993). Self-compassion (SC) is in contrast to some common symptoms related to BPD, such as self-hatred, intense shame, and negative self-schemas. SC was tested as a potential moderating mechanism in the relationship between emotion dysregulation and BPD symptoms among a sample of college students. SC consists of self-kindness, an understanding of common humanity, and mindfulness (Neff, 2003a). It was hypothesized that SC would moderate the relationship of emotion dysregulation and BPD characteristics in a college sample, such that those with higher levels of SC will have lower BPD characteristics. Results from multiple regression analyses supported this hypothesis. Implications for this study include the incorporation of teaching self-compassion into treatments for individuals with emotion dysregulation and/or BPD.

Self-Compassion as a Moderator of the Relationship Between Emotion Dysregulation and Borderline Personality Disorder Symptoms

Borderline Personality Disorder

According the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM) (2013), a personality disorder consists of enduring, pervasive, and inflexible patterns of thoughts, behaviors, and attitudes that deviate from the norm of one's culture, and that cause considerable distress. Most often the disorder arises in adolescence or early in adulthood. Borderline personality disorder has garnered much attention in research and within the health-care system in part because of its high association with self-injurious behavior, suicide attempts, and completed suicides, and because of the high level of mental health resources utilized by this population. Although BPD is often difficult to treat successfully, treatments with demonstrated effectiveness have been developed; however, these treatments do not work for everyone and thus there is a need to continue to advance interventions for BPD.

BPD affects about 2% of the general population, and is seen in 10% of outpatients and 20% of inpatients (5th ed.; *DSM–5*; American Psychiatric Association, 2013). It is a disorder in which an individual has a pattern of instability in interpersonal relationships, self-image, emotional experience, and has marked impulsivity (APA, 2013). To be diagnosed with BPD, one needs to meet five or more of nine criteria within the DSM-5 (APA, 2013). Criteria include:

> (1) frantic efforts to avoid real or imagined abandonment… (2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation (3) identity disturbance: markedly and persistently unstable self-image or sense of self (4) impulsivity in at least two areas that are potentially self-damaging…(5) recurrent suicidal behavior, gestures, or threats, or self-mutilating

behavior (6) affective instability due to a marked reactivity of mood…(7) chronic feelings of emptiness…(8) inappropriate, intense anger or difficulty controlling anger… (9) transient, stress-related paranoid ideation or severe dissociative symptoms (APA, 2013).

Because of the criteria requirements, any one individual may present with BPD in 256 different ways, thus there is much heterogeneity in this population. The symptom most commonly associated with BPD, however, is lability in mood (Linehan, 1993).

Gunderson (2011) has grouped together BPD symptoms into categories affecting the following types of functioning: affective, impulsive, interpersonal, and other. Criteria six, seven, and eight are included in the affective domain. Criteria four and five are included in the impulsive domain. Examples of criterion four (impulsivity) may include impulsive spending, sex, substance abuse, reckless driving, and binge eating (APA, 2013). Criteria one and two are included in the interpersonal domain. Criteria three and nine are included in the "other" domain (Gunderson, 2011).

Linehan (1993) presented a reorganization of the existing criteria for BPD as it appears in the DSM-5 into five categories. Each category represents dysregulation or dysfunction in five domains: emotional, interpersonal, behavioral, cognitive, and self. The first category reflects emotional dysregulation and includes criterions six and eight. Emotional responses tend to be highly reactive and can lead to various negative emotional experiences and expressions such as depression, anxiety, and anger. Linehan's (1993) second category describes interpersonal dysregulation; this includes DSM criterions one and two. Although relationships are marked by intensity and difficulty, the individual goes to great lengths to prevent them from ending. Linehan's (1993) third category includes dysregulation in the behavioral domain; it reflects DSM

criterions four and five. Individuals engage in impulsive, self-injurious behaviors in attempts to harm oneself or die. Linehan's (1993) fourth category includes dysregulation in cognitions and reflects DSM criterion nine. This can be seen as episodes of thought dysregulation in response to stressful events. The final category includes dysfunction in self; this encapsulates DSM criterions three and seven. The individual may feel emptiness or have little or no stable sense of self (Linehan, 1993).

Emotion Regulation

Development of emotion regulation. A defining feature of BPD is emotion dysregulation: the inability to efficiently regulate emotions. Emotion dysregulation, or affective instability as it is referred to in the DSM-5, is "due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)" (APA, 2013, p. 663). Emotion dysregulation is the inability to handle affect such that emotions spiral out of control, show frequent lability, are intensified, and hinder reason (Conklin, Bradley, Westen, 2006).

Linehan's (1993) biosocial theory proposes that emotional vulnerability coupled with a pervasively or severely invalidating environment results in the development of BPD. Emotional vulnerability coupled with the inability to regulate emotions leads to emotion dysregulation, a defining feature of BPD (Linehan, 1993). Emotional vulnerability includes high sensitivity to emotional stimuli, intense emotional experience, and a slow return to emotional baseline. An individual with high sensitivity is quick to react, and reacts to cues or events that less vulnerable individuals do not. For example, a close friend's departure for a weekend trip may elicit a deep emotional response from an emotionally vulnerable individual, and little or no response from a less vulnerable individual. Intense emotionality includes extremes in feelings and expressions of

emotions. Those with BPD tend to have much more intense emotional experiences compared to a person without BPD. For example, what may cause mild embarrassment for a person without BPD may cause deep shame and humiliation in the person with BPD (Linehan, 1993). At the same time, Linehan suggests that individuals with BPD may experience positive experiences intensely as well. Others (Levine, Marziali, & Hood, 1997), however, have found that those with BPD experience similar intensity of positive emotions as those without BPD. A slow return to baseline refers to the idea that emotional reactions tend to be long-lasting. This in turn can affect a number of cognitive processes that can often reactivate emotional states. For example, interpretations and social judgments may be biased by emotional states (Linehan, 1993).

Linehan (1993) describes four characteristics of emotional arousal that are challenging for individuals with BPD. The first is that these individuals have difficulty regulating the entire response set in an emotional experience. Such a set includes components that are physiological, experiential, cognitive, and expressive in nature. The second characteristic that poses difficulty is that emotional states can hinder adaptive behaviors. Highly arousing states can interfere with healthy, adaptive strategies, and in turn can lead to maladaptive strategies, such as dichotomous thinking and avoidance, both of which are characteristic of BPD (Linehan, 1993). The third characteristic is that the inability to regulate high arousal leads to a sense of unpredictability. Emotional responses are at times handled with success and at others not, making it difficult for the person to anticipate how he or she will be able to function. Fourth, the lack of control in emotional experiences leads to the development of fears of certain events that then exacerbate emotional vulnerability further (Linehan, 1993).

An invalidating environment is "one in which communication of private experiences is met by erratic, inappropriate, and extreme responses" (Linehan, 1993, p. 49). Rather than being

validated, emotions, reactions, and experiences are punished, trivialized, or ignored. Additionally, invalidating environments may attribute the individual's responses and behaviors to socially unacceptable characteristics such as being unmotivated, lazy, mentally ill, overly sensitive, manipulative, and the like. Linehan (1993) describes invalidating families as those who have intolerance for the expression of negative emotions, and thus respond negatively to the emotionally vulnerable family member. They overemphasize controlling emotional expressiveness, and oversimplify problem solving. Such invalidation causes the individual to believe the messages communicated by the invalidating environment, including that a) his or her reactions and emotions are "wrong" or inappropriate and, b) he or she possesses the socially unacceptable characteristics the family has communicated.

Dimensions of emotion dysregulation. The concept of emotion dysregulation is increasingly being studied outside the context of BPD. For example, Gratz and Roemer (2004) have conceptualized difficulties in emotion regulation via six dimensions: 1) lack of awareness of emotional responses, 2) lack of clarity of emotional responses, 3) nonacceptance of emotional responses, 4) limited access to effective emotion regulation strategies, 5) difficulties controlling impulses during negative emotional experiences, and 6) difficulties engaging in goal-directed behaviors during negative emotional experiences. These dimensions are captured by Gratz and Roemer's (2004) development of the Difficulties in Emotion Regulation scale (DERS).

Emotion dysregulation research in BPD. To explore whether emotion dysregulation is a core feature of BPD, Conklin, Bradley, and Westen (2006) compared the nature of affect and affect regulation in those with BPD to those with dysthymic disorder (DD). In general, those with BPD showed more emotional dysregulation, as indicated by the strategies and coping styles used to regulate emotions, but did not experience more or less negative and positive affect in general.

Both groups, however, had similarly high levels of negative affect, and similarly low levels of positive affect. Conklin et al. (2006) found that those with BPD often employ four different maladaptive emotion regulation strategies that they classified as internalized, externalized, avoidance, and disorganized; those with BPD, in contrast to those with DD, tended to use externalized and disorganized strategies more often. An externalized strategy would be one in which the individual blames another for his or her own mistakes. A disorganized strategy is one where the individual often engages in self-destructive behaviors. Emotional avoidance would be, for example, thinking about upsetting ideas without the accompanying emotions. Internalizing strategies would direct negative emotions inwardly instead of to the appropriate external source (Conklin et al., 2006).

Many have tried to examine how emotion dysregulation affects the features of BPD. To examine this question, Salsman and Linehan (2012) studied the effects of difficulties in emotion regulation on features of BPD when accounting for both negative affect intensity and reactivity independently. Results supported a model in which negative affect intensity mediated the relationship between emotion dysregulation components of lack of emotional clarity and limited access to emotion regulation strategies, and BPD features, as measured by the Borderline Symptom List (BSL). The results also supported a model in which negative affect reactivity mediated the relationship between the emotion dysregulation components of limited access to emotion regulation strategies and difficulty engaging in goal directed behavior, and features of BPD. These results suggest that a lack of emotion regulation strategies in the context of emotional reactivity and intensity may have an effect on features of BPD, and thus the teaching of such skills may be particularly useful in treatment (Salsman and Linehan, 2012).

The end result of having emotional difficulties and problems with regulating emotions is that the individual, as Linehan (1993) describes, is the "psychological equivalent of third-degree burn patient" (p. 69). Any minor infraction can cause immense pain and suffering. Because early environments are often invalidating, individuals tend to become self-invalidating of their own emotional experience and ability to solve problems.

In addition to emotion dysregulation, two other forms of emotional functioning are prominent in BPD: experiential avoidance and low distress tolerance (Iverson, Follette, Pistorello, & Fruzzetti, 2012). Experiential avoidance can be thought of as an unwillingness to experience uncomfortable emotions, thoughts, sensations, memories, and the like. Instead, the person avoids them in a variety of ways. Distress tolerance can be defined as the "actual or perceived ability to withstand negative emotional states" (Iverson et al., 2012, p.416). Using step-wise linear regression analyses, Iverson et al. (2012) found that experiential avoidance was a unique contributor to BPD severity. Distress tolerance was not found to predict BPD severity.

Affect intensity. Larsen and Diener (1987) have conceptualized affect intensity as "stable individual differences in the strength with which individuals experience their emotions" (p. 2). It refers to the strength of the emotional experience, regardless of the content, over time. Larsen and Diener (1987) developed the Affect Intensity Measure (AIM), which measures the strength of everyday emotional experiences. Through factor analysis, Bryant, Yarnold, and Grimm (1996) identified positive intensity, negative intensity, and negative reactivity as three factors of the AIM that represent "affect intensity" the best. In general, those with BPD tend to experience greater emotional intensity compared to those without psychological disorders (Bland, Williams, Scharer, & Manning, 2004). Yen, Zlotnick, and Costello (2002) found affect intensity to be significantly associated with number of BPD criteria in a group of women with BPD features.

Rosenthal, Ahn, and Geiger (2011) compared the emotional reactivity in individuals with BPD to healthy control participants. Participants were primed and asked to provide examples of bothersome stimuli. They were then asked to rate how bothersome they found statements that reflected stimuli that would be noxious to the five senses. For example, the participants rated the following statement: "compared to other people, are you bothered by car horns?" (Rosenthal et al., 2011, p. 717). Those with BPD reported higher reactivity to stimuli of the five senses, with auditory responses being the most pronounced. This research on affect intensity and reactivity fit with Linehan's (1993) two components of emotional vulnerability: emotional intensity and high sensitivity to emotional stimuli.

Self-Compassion

Self-compassion has been defined by one prominent researcher as "being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness" (Neff, 2003a, p. 87). It also "involves offering nonjudgmental understanding to one's pain, inadequacies and failures, so that one's experience is seen as part of the larger human experience" (Neff, 2003a, p. 87). Rather than leading to self-centeredness, self-compassion leads to compassion and concern for others as well, which can promote feelings of inter-connectedness.

According to Neff's theory, there are three components to self-compassion: 1) self-kindness, 2) common humanity, and 3) mindfulness. The first component, self-kindness, consists of extending gentleness and support to oneself, instead of being self-critical and harsh. Rather than being self-punitive in the face of failures and setbacks, one views them in terms of understanding and warmth, and accepts the self as imperfect (Neff, 2011). The second component, common humanity, consists of seeing one's experiences as part of the human

condition, rather than as isolating or shameful (Neff, 2011). Mistakes made do not reflect individual failure, but rather one component of the process of what it means to be human. The third component, mindfulness, consists of experiencing painful thoughts as they are, not exaggerating nor avoiding them. It also consists of being in the present with openness and non-judgmentalness. Painful thoughts are acknowledged and held in awareness, and are neither suppressed nor exaggerated (Neff, 2011).

Neff (2003a) promotes the idea of self-compassion as a state in which the individual pursues any means necessary, even if painful, to achieve a state of well-being. This often means no longer engaging in previously harmful behaviors, such as self-condemnation. Self-compassion could potentially buffer against self-harm and suicidal behaviors that often stem from self-condemnation. This is particularly relevant for individuals with BPD who tend to employ internalizing emotion regulation strategies (Conklin et al., 2006).

Neff (2003a) proposes that self-compassion is related to clarity and accuracy of self-appraisals. When engaging in self-compassion, one does not have to hide shortcomings in order to avoid self-judgment. Neff (2003a) proposes that instead these shortcomings are acknowledged and understood with kindness. Such kindness allows one to formulate effective plans of action due to a more positive state. Neff (2003a) also proposes that self-compassion is related to self-regulation and the ability to cope with stress. Specifically, those who engage in self-compassion have higher levels of emotional approach coping. This form of coping includes identifying, understanding, and expressing emotions in a psychologically adaptive way. This allows one to identify the ways in which his/her own actions may be maintaining or exacerbating a stressful situation (Neff, 2003a). Neff (2003a) also posits that self-compassion may be useful in other emotion regulation strategies. A state of mindfulness during self-compassion allows one

to approach painful, negative feelings with kindness, rather than avoiding them. This more positive outlook has the potential to promote change in more effective ways (Neff, 2003a).

Applying this to individuals with emotion regulation deficits, self-compassion may affect the regulation of emotion. An individual may go to great lengths to avoid the negative affect that results from self-judgment of his or her real or imagined shortcomings. Rather than self-judging and engaging in ineffective strategies (e.g. self-harm), an individual may be able to implement more effective strategies by extending kindness to him or herself. Additionally, self-compassion is related to emotional approach coping (Neff, 2003a). Adopting this type of coping may allow one to understand the function of his or her behavior in relationships. Such a skill set could have a two-fold salutary effect on the individual with BPD, particularly in interpersonal relationships. He or she can keep irrational emotional responses at bay, but if and when they occur, he or she can better control the impact they may have on another person. This can repair, rather than rupture, meaningful relationships.

Current Study. The purpose of the current study was to examine the moderating role of self-compassion in the relationship of emotion dysregulation on borderline personality disorder characteristics. To the best of our knowledge, self-compassion has not been studied in those with BPD. Although the current study did not use a clinical population, it examined the relationship between emotion dysregulation and self-compassion in those with high BPD symptoms. It was hypothesized that Borderline Personality Disorder (BPD) characteristics (as measured by the Borderline Symptom List-BSL) would be positively associated with emotion dysregulation (as measured by the Difficulties in Emotion Regulation Scale-DERS) and affect intensity (as measured by the Affect Intensity Measure-AIM). It was also hypothesized that self-compassion (as measured by the Self Compassion Scale-SCS) would be negatively associated with BPD

characteristics (BSL), emotion dysregulation (DERS), and affect intensity (AIM). In addition, the study examined two models attempting to explain the role of self-compassion in the occurrence of BPD symptoms. In the first proposed model, it was hypothesized that self-compassion (SCS) would moderate the relationship between emotion dysregulation (DERS) and BPD characteristics (BSL). That is, individuals with higher levels of self-compassion would have fewer characteristics associated with BPD, and those with lower levels of self-compassion would have a greater number of BPD characteristics, in the context of emotion dysregulation. In the second model, it was hypothesized that self-compassion (SCS) would moderate the relationship between affect intensity (AIM) and BPD characteristics (BSL). Those with higher levels of self-compassion would have fewer characteristics associated with BPD, and those with lower levels of self-compassion would have a greater number of BPD characteristics, in the context of affect intensity. Neff (2003a) proposes that self-compassion may share some of the same benefits of self-esteem (e.g. positive stance toward self), but without the negative impact of self-evaluation and drawing comparisons between self and others. Thus, self-esteem, as measured by the Rosenberg Self-Esteem Scale (RSES), was compared as a moderator in both models, in replacement of self-compassion, so the role of each of these variables (self-compassion, self-esteem) could be explored. It was hypothesized that the relationship between emotion dysregulation (DERS) and BPD characteristics (BSL) would remain consistent across levels of self-compassion (SCS).

Methods

Participants

Participants were recruited from the subject pool of undergraduate students enrolled in psychology classes at the University of Montana (UM). Those under the age of 18 were excluded. A power analysis, using G*Power software, with a small effect size (0.02) at the 0.05

alpha level and with power set at 0.80, suggested that the number of participants needed would be 311. The final proposed number of participants was 300. The sample included a total of 296 participants. Data for five participants were excluded due to a clerical error affecting one of the measures. An additional participant's data were excluded due to the researcher's awareness of language barriers that led to misunderstanding of questions asked. The researcher followed up with endorsed critical items from this participant; the participant acknowledged that he had a hard time understanding the questions and changed his answers on the spot. The remaining questions were judged to be misrepresentative of the participant's attitudes and were excluded. The final sample included 290 participants. The mean age was 21.6 (*SD*= 5.5, 23%=19 years of age). There were 212 females (73.1%). For statistical analysis purposes, one of the participants was coded as male although he indicated both "male" and "transgender" on the demographics questionnaire. A little over half of the participants endorsed receiving counseling (50.4%). The remaining 46.6% of participants endorsed receiving counseling at various amounts of years ranging from 0.02 years to 26 years (*M*=1.06, *SD*=2.77). Full demographic results can be found in table 4.

Materials

Participants completed a brief demographic questionnaire asking for their age, gender, relationship status, sexual orientation, race, and class standing. The questionnaire also included the following questions regarding mental health care: "Have you ever received counseling?" and "If yes, for how long?" (see Appendix A).

Borderline personality disorder characteristics were measured using the short form of the Borderline Symptom List (BSL-23) (Bohus et al., 2009). The BSL was designed to discriminate BPD patients from other patient groups. The BSL is a 23-item self-report measure asking for

symptom presence. Participants respond to symptom presence over the last week. Items are evaluated using a 5-point Likert scale, ranging from "not at all", "a little", "rather", "much", to "very strong". Bohus et al. (2009) reported Cronbach's alpha for the total score as $\alpha = 0.97$, and the test-retest reliability after one week was $r = 0.82$ (see Appendix B). The alpha obtained for the current study was 0.93.

Emotion regulation ability was measured using the Difficulties in Emotion Regulation Scale (DERS) (Gratz & Roemer, 2003). The DERS is a 36-item self-report measure that measures difficulties on six different dimensions of emotion regulation: 1) lack of awareness, 2) lack of clarity, 3) nonacceptance, 4) limited access to effective regulation strategies, 5) impulse control while experiencing negative emotions, and 6) goal-directedness while experiencing negative emotions. Participants rate how often the items apply to them, from "almost never", "sometimes", "about half the time", "most of the time", and "almost always". Gratz & Roemer (2003) reported good internal consistency for the DERS with Cronbach's alpha at 0.93. Over a period of four to eight weeks, the DERS has good test-retest reliability with $\rho = 0.88$ (Gratz & Roemer, 2003) (see Appendix C). The alpha obtained for this study was 0.94.

Affect intensity was measured using the Affect Intensity Measure (AIM) (Larsen & Diener, 1987). This 40-item self-report measures the intensity with which a person experiences emotions. The items reflect ordinary emotional experiences in life. Participants respond to items on a six point Likert scale: "never", "almost never", "occasionally", "usually", "almost always", and "always". The AIM has good test-retest reliability with $r = 0.81$ after one month (Larsen & Diener, 1987), and has good internal consistency with cronbach's alpha equal to 0.87 (Bryant, Yarnold, & Grimm, 1996) The total AIM score was scored according to Bryant, Yarnold, and Grimm's (1996) three-factor model. Bryant et al. (1996) determined via confirmatory factor

analysis that a three-factor model including positive affectivity, negative intensity, and negative reactivity (taken together is referred to as AIR) was a better measurement model for the AIM (see Appendix D). The alpha obtained for this study was 0.88.

Self-compassion was measured using the Self-Compassion Scale (SCS) (Neff, 2003b). This instrument measures the extent to which the respondent experiences compassion directed inwardly. Participants respond to items in terms of how they typically act during difficult times. This 26-item self-report measure assesses six different intercorrelated factors: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification. The subscale scores were combined to create a total score that indicates an overall level of self-compassion. Neff (2003b) reported the scale's overall internal consistency as 0.92. and good test-retest reliability (0.91) (see Appendix E). The alpha obtained for this study was 0.93.

Self-esteem was measured using the Rosenberg Self-Esteem Scale (RSES) (Rosenberg, 1989). This widely used measure has been shown to have good reliability, with a Cronbach's alpha of 0.91 (see Appendix F). The alpha obtained for this study was 0.90

Participants responded to open-ended, qualitative questions concerning attitudes about practicing self-compassion. Neff's (2003a) definition of self-compassion was provided at the top of the measure: self-compassion can be defined as "being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness." It also "involves offering nonjudgmental understanding to one's pain, inadequacies and failures, so that one's experience is seen as part of the larger human experience." This was followed by the following questions: "In your experience, how do you think self-compassion is a useful approach to handling stressful situations? and "Do you engage

in self-compassion as described above, and, if so, how? Please provide some examples of what you think and/or do." (see Appendix G). The first 50 qualitative responses for each question were inductively coded independently by the researcher and a research assistant. Major themes were identified. The researcher and research assistant reconciled any discrepant themes via consensus coding. The remaining 240 qualitative responses for questions 1 and 2 were then independently categorized into the original themes, or the themes were revised, or new themes were created so that the responses were adequately represented by the researcher and research assistant.

Procedure

Undergraduate students signed up through the University of Montana SONA system for designated dates and times throughout the Spring, Summer, and Fall 2014 semesters. A maximum of 30 to 40 students at a time were allowed to sign up for each session. Participants were seated in various available classrooms on UM's campus. Participants sat with an empty seat between them to ensure privacy of participants' responses.

The study was described to the participants in SONA as a study concerning self-attitudes and emotional expression. When participants entered the classroom they were read instructions by the researcher (see appendix H). Participants provided informed consent before being given the measures. After completion of the questionnaires, the researcher and assistant checked critical items on the BSL (e.g. those addressing suicidality/non-suicidal self-injury (NSSI)). If a critical item(s) was endorsed the researcher spoke with the participant privately and separately outside of the classroom. A suicide risk assessment was completed with these participants. No participant required immediate intervention. All participants were thanked for their participation

and given a debriefing form to read (see appendix I). Two points of research credits were awarded for each participant through SONA.

All of the measures were organized in paper packets, and participants were asked to complete questionnaires in the order presented. The order of four of the seven measures followed that of the Latin square design. These four include the DERS, AIM, SCS, and the RSES. The other three measures, the demographic questionnaire, the BSL, and the qualitative questions, were fixed in order. The demographic questionnaire was always presented first, while the BSL, which assesses BPD symptoms, was always the second to last measure in the packet; the ordering of the BSL was to prevent the potential for responses to questions of a potentially distressing nature (e.g. assessing for suicidality and self-harm on the BSL) to affect subsequent responses. Qualitative questions concerning participants' views on and practice of self-compassion were included at the end of the questionnaire packet. Of the 290 participants, 95 received order 1, 70 received order 2, 64 received order 3, and 61 received order 4. Considering the unequal frequencies among the orders, a one-way analysis of variance (ANOVA) was conducted to test the effect of order on BSL scores. The effect of order on BSL scores was not significant at the $p < .05$ level for the four conditions $F(3, 286) = 1.53$, $p > .05$.

Analysis

Correlations were conducted to test the hypothesized relationships between BPD characteristics (BSL) with emotion dysregulation (DERS) and affect intensity (AIM), as well as self-compassion (SCS) with BPD characteristics (BSL), emotion dysregulation (DERS), and affect intensity (AIM). All of these correlations were tested as 1-tailed. Because the RSES was included for exploratory purposes, correlations were tested between this and all other variables as 2-tailed with no hypothesized direction.

Simultaneous multiple regression was conducted to test two hypothesized models. In the first model self-compassion (SCS) was tested as a moderator of the relationship between the predictor, emotion dysregulation (DERS), on the criterion, BPD characteristics (BSL). In the second model, self-compassion (SCS) was tested as a moderator of the relationship between the predictor, affect intensity (AIM), and the criterion, BPD characteristics (BSL). Similarly, self-esteem (RSES) was independently tested as a moderator of the relationship between emotion regulation (DERS) and BPD characteristics (BSL), and of the relationship between affect intensity (AIM) and BPD characteristics (BSL). All variables were mean-centered.

Results

Statistical analyses were carried out using IBM® SPSS® Statistics, version 22. Descriptive statistics for all variables can be found in table 1. Note that the RSES does not provide a "neutral" response, and thus forces respondents to choose how much they agree or disagree with the statements. A total RSES score was calculated for each participant if at least 80% of the responses were interpretable. One participant was excluded on analyses with the RSES because she circled both "agree" and "disagree" for more than 20% (2 questions) of the questions.

[Insert table 1 here]

Correlations. It was hypothesized that the BSL would be positively correlated with the DERS and AIM, and that the SCS would be negatively correlated with the BSL, DERS, and AIM. There were no hypothesized predictions for RSES with any of the variables, as this was included for exploratory purposes. Correlations supported the stated hypotheses (see table 2). The RSES was significantly positively correlated with the SCS, and significantly negatively correlated with the BSL, DERS, and AIM.

[Insert table 2 here]

Regression. The hypothesis that self-compassion (SCS) would serve as a moderator in the relationship between emotion dysregulation (DERS) and BPD characteristics (BSL) was supported. Self-compassion (SCS) explained 42.5% of the variance in this model, $F(3, 286) = 70.45$, $p < .01$, interaction term: $\beta = -.138$, $t(286) = -2.00$, $p < .01$. SCS did not serve as a moderator in the relationship between affect intensity (AIM) and BPD characteristics (BSL), interaction term: $\beta = -.064$, $t(286) = -1.21$, $p > .05$. Self-esteem (RSES) also served as a moderator in the relationship between emotion dysregulation (DERS) and BPD characteristics (BSL), and this explained 41.4% of the variance, $F(3, 285) = 67.33$, $p < .01$, interaction term: $\beta = -.112$, $t(285) = -2.3500$, $p < .05$. There was a trend toward self-esteem (RSES) acting as a moderator of the relationship between affect intensity (AIM) and BPD characteristics (BSL) $F(3, 285) = 44.41$, $p < .01$, interaction term: $\beta = -.096$, $t(285) = -1.96$, $p = .052$. To graph the moderating role of self-compassion, the relationships between predictor and criterion variables were tested across two levels of self-compassion (low and high). A median split was conducted on the scores from the SCS to form two groups of individuals with low and high levels of self-compassion. A median split was also conducted on the RSES scores to produce two groups of individuals with low and high self-esteem. Scatterplots depicting the regression lines for the relationship between DERS and BSL for low and high groups of both self-compassion and self-esteem can be found in figures 1 and 2.

[Insert figure 1 here]

[Insert figure 2 here]

Simple slopes. Simple slopes analyses were tested in all regression analyses that were significant. Simple slopes analyses revealed that the relationship between emotion dysregulation

(DERS) and BPD characteristics (BSL) varied across levels of self-compassion (SCS). The values chosen for this analysis of simple slopes approximated the following values for SCS: +/- one standard deviation from the mean, +/- two standard deviations from the mean, and at the mean. This amounted to the following specific values chosen: -0.30 to 0.70 (mean), 16.70 to 18.70 (+1 SD), -16.36 to -19.30 (-1 SD), 31.70 to 35.70 (+2 SD), and -26.30 to -31.30 (-2 SD). These same approximations were used in the simple slopes analysis for self-esteem (RSES), and this amounted to the following specific values: -1 to 1 (mean), 5 to 6 (+1 SD), -5 to -6 (-1 SD), values of 9 (+2 SD), and values of -9 (-2 SD). The *t*-statistics and their corresponding p-values are provided in table 3. Two different scatterplots depicting the relationship between DERS and BSL across varying levels of SCS and RSES can be found in figures 3 and 4.

[Insert table 3 here]

[Insert figure 3 here]

[Insert figure 4 here]

Scores on the BSL were positively skewed. Eleven scores were above two standard deviations from the mean. There was one extreme score; this was determined to be a legitimate score and was kept in the analysis. The principal investigator spoke individually with the participant with the extreme score due to endorsement of critical items. Based on this interaction it was determined that this individual was circling items purposely, and responded accurately. Without the inclusion of the extreme score, however, results from regression analyses with SC as a moderator were marginally significant ($p = 0.055$).

Qualitative. Several major themes were inductively coded for qualitative question 1, "In your experience, how do you think self-compassion is a useful approach to handling stressful situations?" and question 2, "Do you engage in self-compassion as described above, and, if so,

how? Please provide some examples of what you think and/or do." The initial inter-rater reliability for the first 50 responses to question 1 was 48%. The initial inter-rater reliability for the first 50 responses to question 2 was 64%. These differences in coding were reconciled via consensus coding. The remaining 240 qualitative responses for questions 1 and 2 were then independently categorized into the original themes, or the themes were revised, or new themes were created so that the responses were adequately represented by the researcher and research assistant. The inter-rater reliability for the latter 240 responses to question 1 was 63%, and the inter-rater reliability for the latter 240 responses to question 2 was 69%. Again, discrepant codes were reconciled via consensus coding. The qualitative results are provided in tables 5 and 6.

Participants' responses were placed in multiple codes if that was appropriate; the entirety of one's response was not limited to being represented by only one code. For example, the following response was placed in the codes of "common humanity," "perspective," and "self-kindness:" "In my experience I think being open to your own suffering is important in dealing with stressful situations. Knowing that you're not perfect and are going to make mistakes, but rather than beat yourself up over it, learn to forgive yourself and know it probably won't be the last time it happens."

Thirteen major themes arose for question number 1 (see table 5). The majority of individuals found that practicing self-compassion was useful in stressful situations because it allowed them to gain a broader, more inclusive and helpful perspective of themselves, the situation, as well as placing the stressful situation in context of the past, present, future. An example of one participant's response that encapsulates this code is "It helps put things into perspective, aware of your feelings and what you have been through and aware of other's feelings as well."

A number (13%) of participants appeared to misunderstand the construct of self-compassion. They seemed to confuse it for thinking positively and reflecting on positive aspects of self or the situation. This included "looking at the bright side". An example of this is the following response: "I think that self-compassion is useful in a stressful situation because it brings a positive outlook on even a horrible incident. That even though times are tough you can see past the hardship."

Neff's (2003a) components of self-compassion (self-kindness, common humanity, mindfulness) were reflected in the definition provided to participants, although these components were not given by name. Thus, the second largest percentage of codes reflected self-compassion as useful because it allows one to be kind, forgiving, accepting of oneself, as well as recognizing that being critical or avoidant is not useful in a stressful situation. This code was labeled "self-kindness." This similar pattern was seen in responses as reflecting Neff's (2003a) other two components: common humanity (16%) and mindfulness (12%). Seventeen percent of participants conveyed that self-compassion was useful because it in some form benefitted their emotional well-being. This included acknowledging and the allowance of emotions, as well as regulating them. Other major themes that arose were providing growth (learning from adversity and moving forward with improved sense of self); problem-solving (allowing one to think clearly and find solutions to work through stressful situations); being a protective factor (providing safety from/prevents further harm), among others. Brief descriptions can be seen for the remaining qualitative codes in table 5.

Twenty major themes arose for question number 2 (see table 6). The majority (40%) of responses for question 2 were coded as "self-kindness." That is, participants indicated that their form of self-compassion included not being harsh, and accepting and being forgiving of mistakes

made. For example, one participant responded with, “Yes, I try to be nonjudgmental of the feelings I experience. I am trying to pay attention to my negative thought patterns and emotions without assigning value judgments to them. I try to remember that understanding and recognizing feelings is more useful than trying to control them at the outset.” Other major forms of practicing self-compassion included taking a break (taking a breather); acknowledging and sitting with emotions; perspective-taking (understanding the self and situation in the context of the larger picture); positive-thinking; engaging the senses (e.g. engaging in something pleasing to the sense such as reading, watching a movie, exercising, taking a bubble bath, eating a nice meal, etc.); social support (being with friends/family, or talking about stressful situations with friends/family); and problem-solving, among others. An example of a response that was coded with “engaging the senses” and “social support” is the following, “Self-compassion to me would be hanging out with my daughter, going for a bike ride in the mountains, feeling the wind and taking in the great outdoors.” For a full list of response codes for question number 2 see table 6.

Discussion

Having difficulty regulating emotions, as well as having higher affect intensity was directly related to BPD characteristics. Having low levels of self-compassion was inversely related to BPD characteristics, emotion dysregulation, and affect intensity. Higher levels of self-esteem were related to lower BPD characteristics, emotion dysregulation, and affect intensity, and directly related to self-compassion. Practicing higher, versus lower, levels of self-compassion may serve as a protective factor by reducing the probability that a tendency toward emotion dysregulation will lead to BPD symptoms. Self-esteem similarly served as a protective factor in this relationship. As is depicted in the regression lines in figure 1, there is a weaker relationship between emotion dysregulation and BPD characteristics for those with high levels of

self-compassion, relative to those with low levels of self-compassion. The results obtained from the moderation analyses are partially consistent with Linehan's (1993) biosocial theory. In particular, self-compassion moderating the relationship between emotion dysregulation and BPD characteristics is consistent, however, the finding that self-compassion does not moderate the relationship between affect intensity and BPD characteristics is not consistent with this theory.

Research has shown that practicing self-compassion is related to several facets of psychological well-being. Self-compassion has been shown to buffer against having negative self-feelings (Leary, Tate, Adams, Allen, and Hancock, 2007). Those who practice self-compassion report greater feelings of social connectedness and life satisfaction (Neff, 2003a); less anxiety (Neff, Kirkpatrick, & Rude, 2007); less depression (Neff, 2003a); less rumination (Neff, 2003a); less procrastination (Williams, Stark, and Foster, 2008); less body dissatisfaction (Albertson, Stark, and Foster, 2008); and more feelings of optimism and self-efficacy (Smeets, Neff, Alberts, & Peters, 2014), among many others. The present study lends support to the idea that self-compassion is, to our knowledge, a first to add to this list of data that suggest that self-compassion also decreases the likelihood of the development of characteristics that are common to BPD, even in the context of emotion dysregulation.

There are a number of possible reasons why self-compassion served as a moderator. Being self-compassionate may be somewhat in contrast to responding to oneself with self-invalidation, a process that often occurs among those with BPD (Linehan, 1993). One consequence of invalidating environments is that the person learns to self-invalidate. An invalidating environment "punishes, ignores, dismisses, or trivializes" emotional experiences of others (Lindenboim, Chapman, & Linehan, 2007, p. 228). Rather than teaching one how to trust one's own experience as valid, the invalidating environment teaches the individual to invalidate

his or her own experience, and instead rely on external feedback. Self-invalidation may occur in the form of inhibiting one's emotional experience and expression, a mistrust of one's own perception of reality, and oversimplifying problem-solving (Lindenboim et al., 2007). Having self-compassion necessarily requires the individual to mindfully pay attention to one's experience, and offer understanding, comfort, and soothing in response to mistakes made. If one can practice self-compassion it may reduce the likelihood that he or she also self-invalidates. The moderating role of self-compassion may reflect that the person, rather than adopting an invalidating environment, either was not exposed to such an environment, or somehow managed to maintain a compassionate stance toward the self rather than falling into a pattern of self-invalidation. Future research could examine whether those who are benefitting from self-compassion as a moderator also grew up in more invalidating environments.

Self-compassion may also have served as a moderator due in part to other contrasting features of self-compassion and BPD characteristics. For example, having self-compassion means being mindful of one's own experience and emotions, not avoiding them or exaggerating them. Iverson et al. (2012) found that individuals with BPD often engage in experiential avoidance as a form of emotional functioning. Additionally, extending self-kindness may help to alleviate a common core belief among those with BPD that he or she is evil or bad (APA, 2013).

Some features of BPD that are the most troublesome result from difficulties in interpersonal relationships. Gunderson (2011) describes individuals with BPD as unable to find living worthwhile unless a strong connection to another caring individual is present. It is important to note that even people who do not have BPD rely heavily on social support and derive a sense of meaning from relationships. This reality sometimes becomes pathologized when observed in individuals with BPD. Sometimes individuals with BPD develop strong

positive feelings about another person, that later leads to disappointment or anger. From a Dialectical Behavior Therapy (DBT) perspective, we understand this pattern to flow from the emotional vulnerability and emotion dysregulation that is understood to be central to DBT. Small slights or upsetting behaviors on the part of the other person may produce strong emotional responses in the emotionally vulnerable individual, who then does not have the skills to manage that response. The behavioral dysregulation resulting from emotional dysregulation can lead to angry outbursts, blaming, accusations or withdrawal. Such dramatic shifts in perceptions of oneself can also occur. Intense responses to real or perceived mistakes or short-comings can lead to intense self-invalidation, blaming, and hatred. Extending self-kindness may serve to attenuate this fluctuation in feelings about the self. Self-compassion is thought to promote compassion toward others (Neff, 2003a), and thus may create a more secure relationship. Although Neff's (2003a) definition of "common humanity" includes finding connection to others through a shared experience of mistakes and failure, drawing on an even larger sense of connection may serve to help alleviate sense of aloneness, self-blame and self-pathologizing. Being able to reassure oneself that one is part of a larger group and not uniquely pathological may reduce reassurance-seeking in relationships that can become destructive. Furthermore, having an understanding of common humanity may be particularly relevant because a reliably strong predictor of suicide, a feature associated with BPD, is social isolation (Van Orden et al., 2010; Joiner, Van Orden, Witte, Selby, & Ribeiro, 2009). Relying upon a shared connection to humanity during crisis could serve as a protective factor against suicidal ideation and/or gestures and behaviors.

Self-compassion may have served as a moderator because of its direct function of regulating emotions. When one acknowledges, understands, and expresses emotion, he or she is

said to be using emotional approach coping, and this is considered beneficial to managing stressful situations (Stanton, Danoff-Burg, Cameron, and Ellis, 1994). Neff (2003a) conceptualizes self-compassion as a useful emotional approach coping strategy because one's emotional experience is treated mindfully with kindness, and within the larger context of humanity. In doing so, this enables the individual to transform negative emotions by developing a cognitive and emotional understanding of the situation and promoting effective change (Neff, 2003a). In the current study, self-compassion was neither analyzed nor speculated as a mediating variable between emotion dysregulation and BPD characteristics. It is, however, thought that it may be serving as a self-regulating mechanism in cognitive, affective, and behavioral domains.

Affect Intensity. Neither self-compassion nor self-esteem served as a moderator in the relationship between affect intensity and BPD characteristics, although self-esteem was marginally significant. Although there was a significant correlation between AIM and BSL, as would be predicted by DBT theory, this relationship does not appear to vary depending on one's level of self-compassion. The DERS measures one's ability to regulate emotions based on six different dimensions, and the AIM measures the intensity of which one experiences his or her emotions. It may be that having high affect intensity alone is not dysregulating to a point at which having self-compassion serves as a self-regulatory process or as a moderator. For example, Salsman and Linehan (2012) found that negative affect intensity (as measured by the AIM) mediated the relationship between having a lack of emotional clarity (a subscale on the DERS) and BPD characteristics (as measured by the BSL). Additionally, they found that negative affect reactivity mediated both having limited access to emotion regulation strategies, and difficulty engaging in goal directed behavior with BPD characteristics. These results taken together with the results from the current study suggest it may be the case that some form of

dysregulation predicts BPD characteristics more strongly than only having high intensity and reactivity of emotions. DBT theory proposes that high emotional vulnerability, of which emotional intensity is just one component, puts one at risk for an inability to regulate, especially in the context of an invalidating environment. It may be that intensity alone does not necessarily lead to dysregulation, unless pervasive dysregulation is present. Future research should attempt to disentangle the relationships of these variables.

Self-esteem. That self-esteem also served as a protective factor in the relationship between emotion dysregulation and BPD characteristics is not necessarily predicted by theory, but is also not overly surprising. Having positive perceptions of the self may reduce the tendency to become emotionally dysregulated in the context of challenging life experiences, and thus to symptoms of BPD. Having high levels of self-esteem is related to higher positive affect and life satisfaction, and lower depression and anxiety (Crocker & Park, 2004). The types of self-esteem questions used in this study include items that tap into a global regard of self, such as is seen in the item "On the whole, I am satisfied with myself" (Rosenberg, 1989).

One distinction that Neff (2003a) draws between self-compassion and self-esteem is that self-esteem is based on social comparisons and ideal standards. Self-compassion does not rely on evaluations or self-judgments. At times self-esteem is based on our perceptions of how others view us. For many with BPD, identity development and self-regard is strongly affected by the feedback that is given or imagined by others (APA, 2013; Linehan, 1993). Neff (2003a) describes the possible drawbacks to promoting self-esteem, such as developing an unrealistic view of self, self-centeredness, and narcissism. In addition, inherent in the notion of self-esteem (e.g. I am a "good" or "competent" or "adequate" person) is the possibility that one could alternatively be evaluated as the opposite – bad, incompetent or inadequate. Self-compassion

avoids these potential pitfalls, by universally viewing the self as worthy of kindness and care, despite one's overall "worth" as evaluated by either the self or others.

Qualitative results. The results of the qualitative analyses suggest that self-compassion serves as a self-regulating mechanism that alleviates stress. For those who ostensibly understood the concept of self-compassion, they described it as useful because it helps regulate emotions, improves emotional well-being, allows one to adopt a healthy perspective, and because they recognize self-criticalness and avoidance as not as useful, among other reasons; this may preclude one from engaging in some characteristics typically seen in BPD when one is stressed.

The results also suggest that the construct of self-compassion is difficult for some to understand. This was noted when participants described self-compassion as being useful because it allows one to see the positive side of self or the situation, as well as when they described positive thinking as their form of self-compassion practice. Positive thinking includes only focusing on or emphasizing positive aspects of self or the situation, whereas self-compassion includes having a balanced approach to how one is feeling, offering kindness, and understanding the experience as universal. Participants may not have understood this idea for a number of reasons. It may be a relatively new concept, as Neff (2003a) suggests for those living in Western cultures, and thus difficult to understand without further explanation or opportunities to practice. One participant noted that this concept was one never thought about before. Others could see the utility in practicing, but did not practice. It also may be that participants did not fully read and/or understand the definition of self-compassion provided to them. Future research should examine what definition of self-compassion is most easily comprehended by a western audience.

Limitations. The participants in this sample were fairly homogenous (e.g. non-Hispanic White, heterosexual, and in their early 20s), thus the results may not generalize to more diverse

populations. The sample included mostly female students, however, BPD is predominantly diagnosed among this gender (APA, 2013). The correlational nature of this study precludes understanding potential causation between variables measured. Emotion dysregulation is conceptualized as both a core component (Linehan, 1993) and DSM-5 diagnostic criterion (termed affective instability) (APA, 2013) of BPD. Therefore, an understanding that emotion dysregulation is a precursor to the development of other BPD symptoms is reasonable. Similarly, in this study self-compassion cannot be said to be causing a reduction or increase in BPD symptoms but that the relationship between emotion dysregulation and BPD characteristics varies depending on the level of self-compassion one has. Although common sense might suggest that having higher levels self-compassion causes the relationship between emotion dysregulation and BPD characteristics to weaken, claims of this direct cause cannot be provided by statistical moderation alone. Additionally, the cross-sectional nature of this study precludes understanding the causal impact of self-compassion on the relationship between emotion dysregulation and BPD characteristics. Longitudinal studies, especially experimental in nature, that measure the change in these variables after implementing self-compassion practice for a period of time, for example, would better expound on causation among these variables studied. The sample obtained was that of convenience and does not adequately represent the clinical population of most interest - those with BPD. It also represents a sample of individuals who self-selected into this study based on fulfilling research requirements, the title and information of the study, or for a range of other reasons not determined. This study does allow for understanding the role of self-compassion in college students with varying levels of emotion dysregulation and BPD characteristics. This is of particular importance given the impulsivity and self-harm seen in college students (Glenn and Klonsky, 2010).

Implications. The practice of self-compassion may be included in treatment at counseling centers on college campuses for those exhibiting emotion dysregulation and/or BPD symptoms. Counseling centers on University campuses may offer time-limited treatment; it may not be feasible for college students exhibiting BPD symptoms to receive comprehensive DBT treatment in these treatment settings. In one study, however, Pistorello, Fruzzetti, MacLane, Gallop, and Iverson (2012) found the incorporation of DBT in college counseling centers effective at reducing suicidality, among other things. Treatment lasted for seven to twelve months, and was provided by expert clinicians of DBT. In lieu of comprehensive DBT for counseling centers without the available resources, incorporation of the teaching of self-compassion in conjunction with other treatment may provide salutary effects for those struggling with regulating emotions, self-harm, and self-hate, among other things.

Mindfulness is a core component of DBT skills training, and there are numerous practices taught. One of these practices, which has been recently added, is loving-kindness practice (Linehan, 2014). This practice is aimed at increasing love and compassion towards the self, and all others, including those both loved and hated. The results of the current study support the addition of this practice into DBT. The practice of self-compassion as it is described by Neff (2003a) is somewhat different than loving-kindness practices, and it may be useful to include in DBT treatment as well, potentially as an adjunct to the Mindfulness module.

Future research. Future research is needed to test self-compassion as a moderating variable in those with a BPD diagnosis. Germer and Neff (2013) have developed an 8-week Mindful Self-Compassion (MSC) training. MSC has been shown to increase self-compassion, mindfulness and well-being, as well as reduce stress, depression, and anxiety (Neff & Germer, 2002). Future studies should include a quasi-experimental study testing the effects of MSC in those with and

without a BPD diagnosis, as well as an experimental design measuring the pre and post levels of self-compassion in those exhibiting BPD symptoms. Although high levels of both self-compassion and self-esteem served as a protective factor in the relationship between emotion dysregulation and BPD characteristics, future studies should delineate the differences between these two constructs in this relationship. Furthermore, one hypothesis in understanding the results of this study is that self-compassion may be taking the place of forms of self-invalidation. Further research should study this relationship, and in particular examine the likelihood that those with high levels of self-compassion came from validating environments.

Conclusion

The findings from this study complement current research suggesting that self-compassion is a useful practice for promoting well-being. It is a particularly helpful practice when one faces the inevitable reality of temporary failure and mistakes. Although it may be difficult to practice at times for a variety of reasons, it is a skill that can be cultivated and maintained as an internal mechanism within the individual. Self-compassion is a helpful approach when one is struggling with regulating emotions and has a predisposition to the development of BPD symptoms. This study contributes to the larger body of research on self-compassion by examining its novel role in the relationship between emotion dysregulation and BPD characteristics in a college sample.

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Tables and Figures.

Table 1
Descriptive statistics for variables

Measure	Mean	SD	Median	CI-lower	CI-upper	Skewness
DERS	81.30	22.18	78.50	78.74	83.87	.641
AIM	105.02	16.44	105.00	103.12	106.92	-.049
SCS	79.30	17.23	79.00	77.31	81.30	-.024
BSL	15.39	14.24	12.00	13.75	17.04	1.64
RSES	20.73	5.42	21.00	20.10	21.35	-.386

Table 2

Correlations Between all Variables

Measure	1.	2.	3.	4.	5.
1. DERS	-				
2. AIM	.191**	-			
3. SCS	-.730**	-.226**	-		
4. BSL	.606**	.164**	-.579**	-	
5. RSES	-.676**	-.137*	.714**	-.549**	-

Note. **$p < .01$, *$p < .05$, all correlations are 1-tailed except those involving RSES.

Table 3
Simple slopes

	SCS	RSES
		t
At mean	0.55 (9)	1.14 (31)
+ 1 SD	-0.51 (13)	2.60* (19)
- 1 SD	-0.21 (19)	2.43* (14)
+ 2 SD	0.93 (5)	.627 (10)
- 2 SD	-1.99 (7)	5.66* (4)

Note. Numbers in parentheses represent degrees of freedom.

Table 4
Demographics

	N	%
Gender		
Female	212	73.1
Male	78	26.9
Relationship Status		
Single	133	45.9
Dating	25	8.6
Dating one person exclusively	90	31.0
Living with a partner	31	10.7
In a civil union/partnership	1	0.3
Married	23	7.9
Divorced	6	2.1
Sexual Orientation		
Heterosexual	257	88.6
Gay	0	0
Bisexual	23	7.9
Lesbian	3	1.0
Other	7	2.4
Ethnicity		
American Indian/Alaska Native	10	3.4
Hawaiian/Pacific Islander	3	1.0
Asian or Asian American	12	4.1
Black or African American	2	0.7
Hispanic or Latino	8	2.8
Non-Hispanic White	238	82.1
Mixed race/Other	17	5.9
Class standing		
Freshman	129	44.5
Sophomore	72	24.8
Junior	38	13.1
Senior	41	14.1
Other	10	3.4
Received counseling		
Yes	143	49.3
No	145	50.0

Table 5
Qualitative Codes for question 1

Category	Description	% in category
Improves perspective	Enables one to have greater awareness of self, and behavioral consequences in given situational context	40
Self-kindness	Allows one to be kind, forgiving, accepting of oneself, as well as recognizing that being critical or avoidant is not useful	39
Growth	Learning from adversity and moving forward with improved sense of self	18
Benefits emotional well-being	Acknowledgment, allowance, and regulation of emotions	17
Common humanity	Understanding that everyone makes mistakes	16
Problem solving	Allows one to think clearly and find solutions to work through challenge/stress	15
Positive perspective	Allows one to focus on the brighter side of situation and aspects of self	13
Mindfulness	Maintaining awareness of present situation with equanimity	12
Protective factor	Provides safety from/prevents further harm	5
Use not apparent	Did not practice or were unsure of practice	3
Misunderstood as compassion	Responded with describing having compassion for others	3
Faith-based	Described self-compassion in reference to God	<1
Not codable	Response was undeterminable	<1

Table 6
Qualitative Codes for question 2

Category	Description	% in category
Self-kindness	Practices self-kindness, acceptance, forgiveness, etc.	20
Taking a break	Takes a mental break and relaxes, takes deep breathes, etc.	18
Getting in touch with emotions	Takes time to acknowledge and understand his/her emotional experience	17
Unsure of practice	Does not practice, difficult to practice, does not practice enough, or unable to provide an example	17
Perspective-taking	Considers self in the context of "larger picture"	16
Positive thinking	Thinks about positive aspects of self	16
Engaging the senses	Reading, writing, exercising, being in nature, engaging in activities that are pleasing (e.g. eating a nice meal, listening to music, etc.)	15
Social support	Talk about stressful situation with friends/family	15
Self-improvement	Learning from mistakes, focusing on goals, and moving past stressful situation	10
Problem solve	Actively pursuing strategies/solutions to stressful situation/problem	10
Common humanity	Remind self that others make mistakes	6
Meditative practice	Any form of meditation, yoga	4
Avoidance	Refrains from thinking about stressful situation	4
Misunderstood as compassion	Extends compassion to others (not understanding concept of self-compassion)	4
Faith-based practice	Pray, remind self of spiritual/religious teachings	3
Not codable	Response undeterminable	3
Change behavior	Do the opposite of problematic behavior causing stress	1
Therapy	Engage in and attend therapeutic services	2

Have compassion for others	Extend compassion to others because it fulfills feelings of self-compassion	<1
Downward social comparison	Thinking one is superior to others	<1

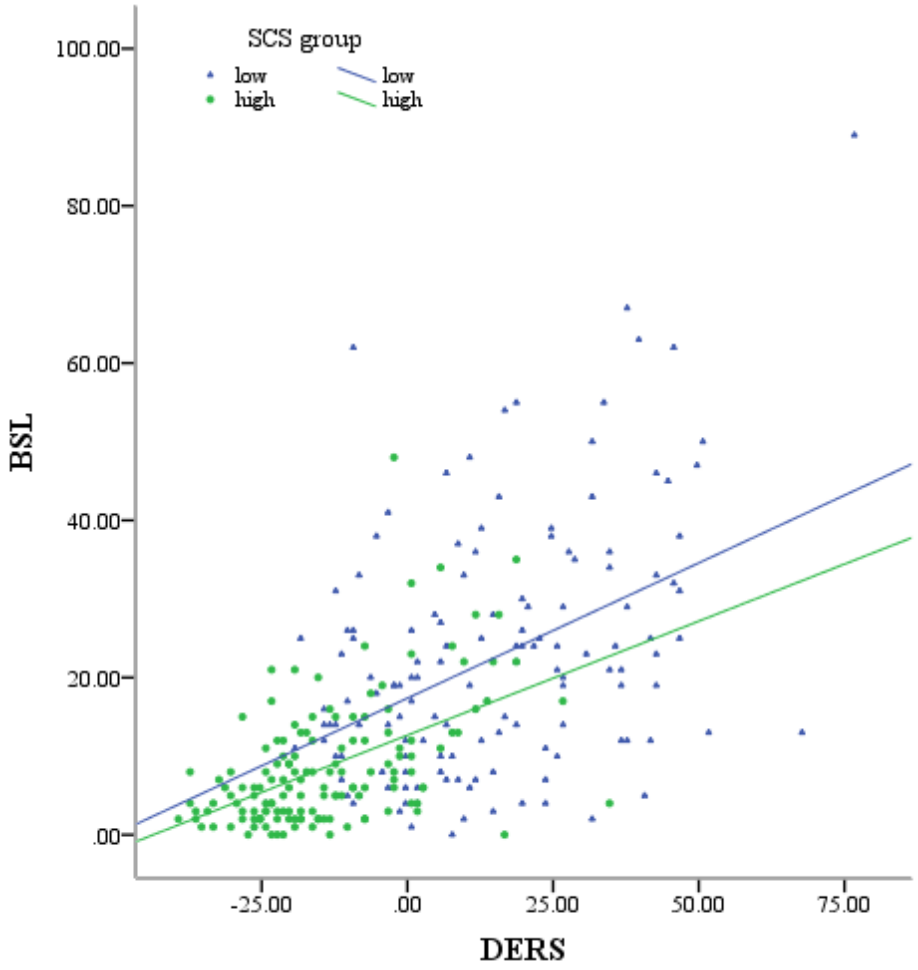

Figure 1. Regression for DERS on BSL at low and high levels of SCS.

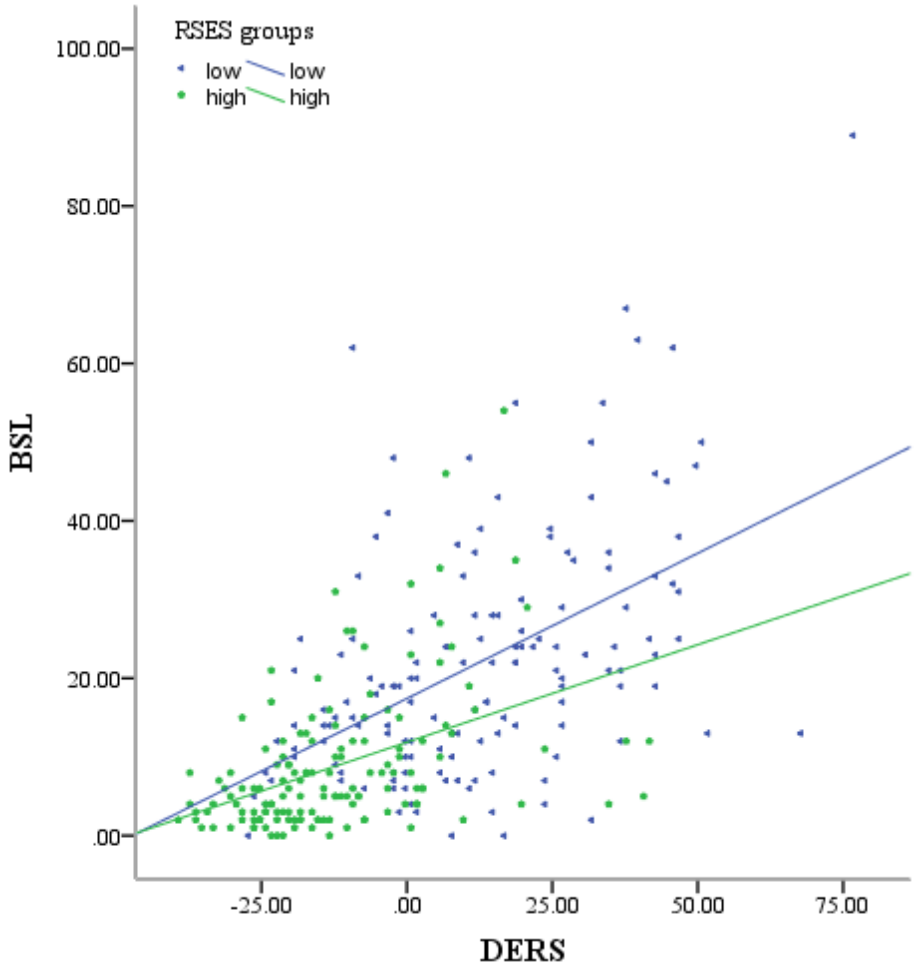

Figure 2. Regression for DERS on BSL at low and high levels of RSES.

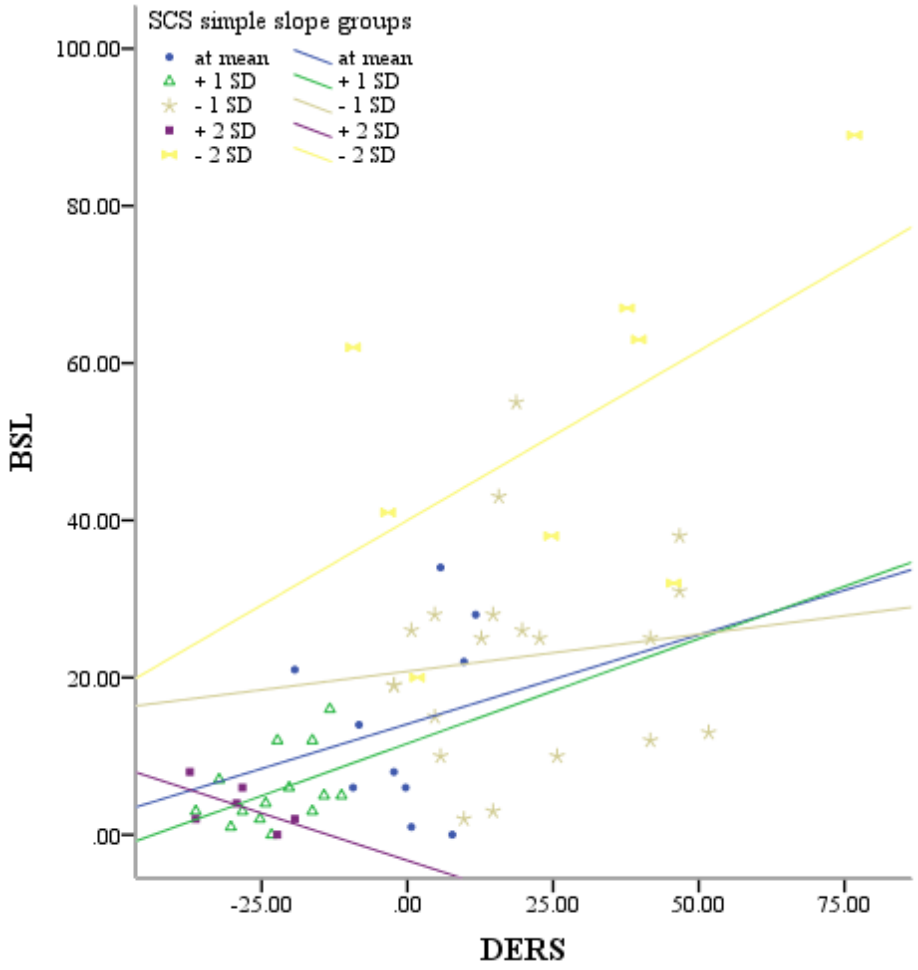

Figure 3. Simple slopes for DERS on BSL at the mean, +/- 1 and +/- 2 SD from the mean of SCS.

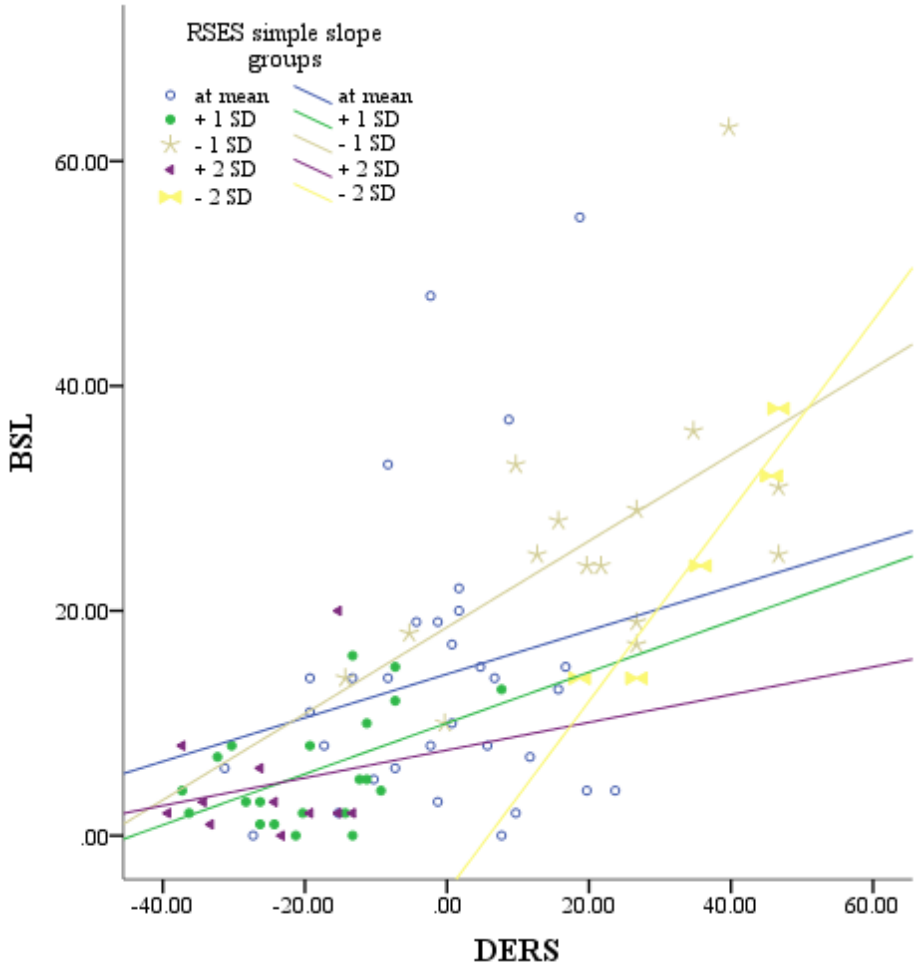

Figure 4. Simple slopes for DERS on BSL at the mean, +/- 1 and +/- 2 SD from the mean of RSES.

Appendix A

Demographic Information

Instructions: Please answer the following questions by filling in the blank or circling the option that describes you best.

1) What is your age? _____

2) What is your gender?
Female
Male
Transgender

3) What is your relationship status? (Circle all that apply)
Single/Never Been Married
Dating
Dating one person exclusively
Living with a partner
Civil union/partnership
Married
Divorced
Widowed

4) What is your sexual orientation?
Heterosexual
Gay
Bisexual
Lesbian
Other

5) How do you describe yourself? (Please circle the one option that best describes you)

American Indian or Alaska Native
Hawaiian or Other Pacific Islander

Asian or Asian American
Black or African American

Hispanic or Latino
Non-Hispanic White

Mixed race/Other (describe) _____

6) What is your class standing?
Freshman
Sophomore
Junior
Senior
Other (Describe) _____

7) Have you ever received counseling? _____ If yes, for how long? _____

Appendix B

Please follow these instructions when answering the questionnaire: In the following table you will find a set of difficulties and problems which possibly describe you. Please work through the questionnaire and decide how much you suffered from each problem in the course of the last week. In case you have no feelings at all at the present moment, please answer according to how you *think you might have felt.* Please answer honestly. **All questions refer to the last week. If you felt different ways at different times in the week, give a rating for how things were for you on average.**

Please be sure to answer each question.

	not at all	a little	rather	much	very strong
1. It was hard for me to concentrate	0	1	2	3	4
2. I felt helpless	0	1	2	3	4
3. I was absent-minded and unable to remember what I was actually doing	0	1	2	3	4
4. I felt disgust	0	1	2	3	4
5. I thought of hurting myself	0	1	2	3	4
6. I didn't trust other people	0	1	2	3	4
7. I didn't believe in my right to live	0	1	2	3	4
8. I was lonely	0	1	2	3	4
9. I experienced stressful inner tension	0	1	2	3	4
10. I had images that I was very much afraid of	0	1	2	3	4
11. I hated myself	0	1	2	3	4
12. I wanted to punish myself	0	1	2	3	4
13. I suffered from shame	0	1	2	3	4
14. My mood rapidly cycled in terms of anxiety, anger, and depression	0	1	2	3	4
15. I suffered from voices and noises from inside or outside my head	0	1	2	3	4
16. Criticism had a devastating effect on me	0	1	2	3	4
17. I felt vulnerable	0	1	2	3	4
18. The idea of death had a certain fascination for me	0	1	2	3	4
19. Everything seemed senseless to me	0	1	2	3	4
20. I was afraid of losing control	0	1	2	3	4
21. I felt disgusted by myself	0	1	2	3	4
22. I felt as if I was far away from myself	0	1	2	3	4
23. I felt worthless	0	1	2	3	4

Now we would like to know in addition the quality of your **overall** personal state in the course of the **last week**. 0% means **absolutely down,** 100% means **excellent.** Please check the per- centage which comes closest.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
(very bad) <----------> (excellent)										

During the last week…		Not at all	once	2-3 times	4-6 times	Daily or more often
24.	I hurt myself by cutting, burning, strangling, headbanging etc.	0	1	2	3	4
25.	I told other people that I was going to kill myself	0	1	2	3	4
26.	I tried to commit suicide	0	1	2	3	4
27.	I had episodes of binge eating	0	1	2	3	4
28.	I induced vomiting	0	1	2	3	4
29.	I displayed high-risk behavior by knowingly driving too fast, running around on the roofs of high buildings, balancing on bridges, etc.	0	1	2	3	4
30.	I got drunk	0	1	2	3	4
31.	I took drugs	0	1	2	3	4
32.	I took medications that had not been prescribed or if had been prescribed, I took more than the prescribed dose	0	1	2	3	4
33.	I had outbreaks of uncontrolled anger or physically attacked others	0	1	2	3	4
34.	I had uncontrollable sexual encounters of which I was later ashamed or which made me angry	0	1	2	3	4

Appendix C

D.E.R.S.

Please indicate how often the following statements apply to you by writing the appropriate number from the scale below on the line beside each item.

Response categories:

1 Almost never (0-10%)

2 Sometimes (11-35%)

3 About half the time (36-65%)

4 Most of the time (66 – 90%)

5 Almost always (91-100%)

1. ____ I am clear about my feelings.

2. ____ I pay attention to how I feel.

3. ____ I experience my emotions as overwhelming and out of control.

4. ____ I have no idea how I am feeling.

5. ____ I have difficulty making sense out of my feelings.

6. ____ I am attentive to my feelings.

7. ____ I know exactly how I am feeling.

8. ____ I care about what I am feeling.

9. ____ I am confused about how I feel.

10. ____ When I'm upset, I acknowledge my emotions.

11. ____ When I'm upset, I become angry with myself for feeling that way.

12. ____ When I'm upset, I become embarrassed for feeling that way.

13. ____ When I'm upset, I have difficulty getting work done.

14. ____ When I'm upset, I become out of control.

15. ____ When I'm upset, I believe that I will remain that way for a long time.

16. ____ When I'm upset, I believe that I'll end up feeling very depressed.

17. ____ When I'm upset, I believe that my feelings are valid and important.

18. ____ When I'm upset, I have difficulty focusing on other things.

19. ____ When I'm upset, I feel out of control.

20. ____ When I'm upset, I can still get things done.

21. ____ When I'm upset, I feel ashamed with myself for feeling that way.

22. ____ When I'm upset, I know that I can find a way to eventually feel better.

23. ____ When I'm upset, I feel like I am weak.

24. ____ When I'm upset, I feel like I can remain in control of my behaviors.

25. ____ When I'm upset, I feel guilty for feeling that way.

26. ____ When I'm upset, I have difficulty concentrating.

27. ____ When I'm upset, I have difficulty controlling my behaviors.

28. ____ When I'm upset, I believe there is nothing I can do to make myself feel better.

29. ____ When I'm upset, I become irritated with myself for feeling that way.

30. ____ When I'm upset, I start to feel very bad about myself.

31. ____ When I'm upset, I believe that wallowing in it is all I can do.

32. ____ When I'm upset, I lose control over my behaviors.

33. ____ When I'm upset, I have difficulty thinking about anything else.

34. ____ When I'm upset, I take time to figure out what I'm really feeling.

35. ____ When I'm upset, it takes me a long time to feel better.

36. ____ When I'm upset, my emotions feel overwhelming.

Appendix D

A.I.M.

DIRECTIONS: The following questions refer to emotional reactions to typical life-events. Please indicate how YOU react to these events by placing a number from the following scale in the blank space preceding each item. Please base your answers on how YOU react, not on how you think others react or how you think a person should react.

NEVER	ALMOST NEVER	OCCASIONALLY	USUALLY	ALMOST ALWAYS	ALWAYS
1	2	3	4	5	6

1. _____ When I accomplish something difficult I feel delighted or elated.

2. _____ When I feel happy it is a strong type of exuberance.

3. _____ I enjoy being with other people very much.

4. _____ I feel pretty bad when I tell a lie.

5. _____When I solve a small personal problem, I feel euphoric.

6. _____ My emotions tend to be more intense than those of most people.

7. _____ My happy moods are so strong that I feel like I'm in heaven.

8. _____ I get overly enthusiastic.

9. _____ If I complete a task I thought was impossible, I am ecstatic.

10. _____ My heart races at the anticipation of some exciting event.

11. _____ Sad movies deeply touch me.

12. _____ When I'm happy it's a feeling of being untroubled and content rather than being zestful and aroused.

13. _____ When I talk in front of a group for the first time my voice gets shaky and my heart races.

14. _____ When something good happens, I'm usually much more jubilant than others.

15. _____ My friends might say I'm emotional.

16. _____ The memories I like the most are of those times when I felt content and peaceful rather than zestful and enthusiastic.

17. _____ The sight of someone who is hurt badly affects me strongly.

18. _____ When I'm feeling well it's easy for me to go from being in a good mood to being really joyful.

19. _____ "Calm and cool" could easily describe me.

20. _____ When I'm happy I feel like I'm bursting with joy.

21. _____ Seeing a picture of some violent car accident in a newspaper makes me feel sick to my stomach.

22. _____ When I'm happy I feel very energetic.

23. _____ When I receive a reward I become overjoyed.

24. _____ When I succeed at something, my reaction is calm and contentment.

25. _____ When I do something wrong I have strong feelings of shame and guilt.

26. _____ I can remain calm even on the most trying days.

27. _____ When things are going good I feel “on top of the world”.

28. _____ When I get angry it's easy for me to still be rational and not overreact.

29. _____ When I know I have done something very well, I feel relaxed and content rather than excited and elated.

30. _____ When I do feel anxiety it is normally very strong.

31. _____ My negative moods are mild in intensity.

32. _____ When I am excited over something I want to share my feelings with everyone.

33. _____ When I feel happiness, it is a quiet type of contentment.

34. _____ My friends would probably say I'm a tense or “high-strung” person.

35. _____ When I'm happy I bubble over with energy.

36. _____ When I feel guilty, this emotion is quite strong.

37. _____ I would characterize my happy moods as closer to contentment than joy.

38. _____ When someone compliments me, I get so happy I could “burst”.

39. _____ When I am nervous I get shaky all over.

40. _____ When I am happy the feeling is more like contentment and inner calm than one of exhilaration and excitement

Appendix E

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never				**Almost always**
1	**2**	**3**	**4**	**5**

_____ 1. I'm disapproving and judgmental about my own flaws and inadequacies.

_____ 2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.

_____ 3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.

_____ 4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.

_____ 5. I try to be loving towards myself when I'm feeling emotional pain.

_____ 6. When I fail at something important to me I become consumed by feelings of inadequacy.

_____ 7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.

_____ 8. When times are really difficult, I tend to be tough on myself.

_____ 9. When something upsets me I try to keep my emotions in balance.

_____ 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

_____ 11. I'm intolerant and impatient towards those aspects of my personality I don't like.

_____ 12. When I'm going through a very hard time, I give myself the caring and tenderness I need.

_____ 13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

_____ 14. When something painful happens I try to take a balanced view of the situation.

_____ 15. I try to see my failings as part of the human condition.

_____ 16. When I see aspects of myself that I don’t like, I get down on myself.

_____ 17. When I fail at something important to me I try to keep things in perspective.

_____ 18. When I’m really struggling, I tend to feel like other people must be having an easier time of it.

_____ 19. I’m kind to myself when I’m experiencing suffering.

_____ 20. When something upsets me I get carried away with my feelings.

_____ 21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.

_____ 22. When I'm feeling down I try to approach my feelings with curiosity and openness.

_____ 23. I’m tolerant of my own flaws and inadequacies.

_____ 24. When something painful happens I tend to blow the incident out of proportion.

_____ 25. When I fail at something that's important to me, I tend to feel alone in my failure.

_____ 26. I try to be understanding and patient towards those aspects of my personality I don't like.

Appendix F

S.E.S.

BELOW IS A LIST OF STATEMENTS DEALING WITH YOUR GENERAL FEELINGS ABOUT YOURSELF. IF YOU **STRONGLY AGREE**, CIRCLE **SA**. IF YOU **AGREE** WITH THE STATEMENT, CIRCLE **A**. IF YOU **DISAGREE**, CIRCLE **D**. IF YOU **STRONGLY DISAGREE**, CIRCLE **SD**.

		1. STRONGLY AGREE	2 AGREE	3. DISAGREE	4. STRONGLY DISAGREE
1.	I feel that I'm a person of worth, at least on an equal plane with others.	SA	A	D	SD
2.	I feel that I have a number of good qualities.	SA	A	D	SD
3.	All in all, I am inclined to feel that I am a failure.	SA	A	D	SD
4.	I am able to do things as well as most other people.	SA	A	D	SD
5.	I feel I do not have	SA	A	D	SD

	much to be proud of.				
6.	**I take a positive attitude toward myself.**	**SA**	**A**	**D**	**SD**
7.	**On the whole, I am satisfied with myself.**	**SA**	**A**	**D**	**SD**
8.	**I wish I could have more respect for myself.**	**SA**	**A**	**D**	**SD**
9.	**I certainly feel useless at times.**	**SA**	**A**	**D**	**SD**
10.	**At times I think I am no good at all.**	**SA**	**A**	**D**	**SD**

Appendix G

Self-compassion can be defined as "being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness." It also "involves offering nonjudgmental understanding to one's pain, inadequacies and failures, so that one's experience is seen as part of the larger human experience."

In your experience, how do you think self-compassion is a useful approach to handling stressful situations?

Do you engage in self-compassion as described above, and, if so, how? Please provide some examples of what you think and/or do.

Appendix H

Hello and thank you for your participation. First I will be handing out a consent form.

Instructions to be read by experimenter after passing out Informed Consent Form:

Please read the form I have just given you. It gives information about the study and your participation. If you have any questions, feel free to raise your hand. If you decide you want to participate in the study, please sign the form.

Instructions to be read following collection of the Informed Consent forms:

This study will involve completing some questionnaires concerning self-attitudes and emotional expression. Please do not put your name on any forms, and please complete them in order. Raise your hand when you are done and I will collect your forms. We will check them for completion and safety purposes, and let you know when you are free to leave.

Appendix I

Debriefing Form

Information About This Study and Resources

Thank you very much for your time and effort in completing this research study.
The study you just participated in was designed to aid our understanding of self-attitudes and emotional expression during times of distress.

If you are experiencing any distress from your participation in this study, please feel free to speak with the researcher.

If you are experiencing distress in your life, we would like to encourage you to consider seeking help. Following are some potential resources:

Curry Health Center Counseling Services
406-243-4711

Clinical Psychology Center (CPC)
406-243-2367

Missoula Mental Health Services & Crisis Hotline
406 -532-9700

If you have any questions, comments, or concerns about the study, please call the investigator, Priya Loess at (406) 243-4521, or the faculty supervisor, Dr. Jennifer Waltz at (406) 243-5750. You may also email us at priyadarshani.loess@umontana.edu or jennifer.waltz@montana.edu or (Please note that we cannot guarantee the confidentiality of any information sent by university email.)

Investigators	
Priya Loess	(406) 243-4521
Jennifer Waltz	(406) 243-5750