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SELF-COMPASSION AND FEAR OF COMPASSION AS MEDIATORS IN THE RELATIONSHIPS OF CHILDHOOD INVALIDATION WITH EMOTION DYSREGULATION AND WITH BORDERLINE PERSONALITY DISORDER CHARACTERISTICS

Priyadarshani Florence Loess
University of Montana - Missoula

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By

PRIYADARSHANI FLORENCE LOESS, M.A.

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Jennifer Waltz, Ph.D., Chair
Psychology

Bryan Cochran, Ph.D.
Psychology

Duncan Campbell, Ph.D.
Psychology

Betsy Bach, Ph.D.
Communication Studies

Terry Reed, Ph.D.
Psychology Affiliate

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Self-compassion and Fear of Compassion as Mediators in the Relationships of Childhood Invalidation with Emotion Dysregulation and with Borderline Personality Characteristics

Chairperson: Jennifer Waltz

Abstract Content

According to Linehan's (1993) biosocial theory, the core feature of Borderline Personality Disorder (BPD) is emotion dysregulation, which arises from emotional vulnerability and an inability to effectively modulate emotional experiences. Linehan posits that the transaction of environmental invalidation with biological vulnerabilities leads to the development of BPD. Those with BPD often live painful, chaotic lives, experience extreme emotions and impulsivity, and engage in self-injurious behavior. While there are treatments with demonstrated effectiveness, they do not work for everyone, and there is a need to continue to advance interventions. Self-compassion is extending nonjudgmental kindness to one's self during stress, failure, or suffering, and recognizing that suffering is a shared human experience (Neff, 2003a). Some people, however, fear compassion (Gilbert, Mcewan, Matos, & Rivis, 2011). The purpose of this study was to examine the potential mediating roles of self-compassion and fear of compassion in relationships between childhood invalidation with emotion dysregulation and BPD characteristics. The sample included 257 undergraduate students from the University of Montana. Participants completed self-report measures on BPD, emotion dysregulation, invalidation, self-compassion, and fear of compassion. Results from a parallel mediation analysis supported the study hypotheses. Specifically, self-compassion and fear of compassion for self were significant mediators in the relationships between childhood invalidation with both emotion dysregulation and BPD characteristics. Fear of compassion from others was found to be a mediator in the relationship between childhood invalidation and BPD characteristics. This study adds to a growing body of literature that seeks to identify factors contributing to the development and maintenance of BPD symptoms.

Self-compassion and Fear of Compassion as Mediators in the Relationships of Childhood Invalidation with Emotion Dysregulation and with Borderline Personality Characteristics

Among the personality disorders, Borderline Personality Disorder (BPD) has been the focus of a substantial body of research designed to understand its causes, symptoms, and the therapeutic interventions that may alleviate the immense suffering that it brings. BPD has been the subject of this work in part due to the highly lethal behavior often associated with the disorder. Current theories about its development point to a "nature *and* nurture" explanation. One conceptualization of this nature-nurture explanation is Linehan's (1993) biosocial theory. Supporting this theory, people with BPD demonstrate differences in brain functioning and biological vulnerabilities, most notably emotional in nature. People with BPD also often experience childhood invalidation. Invalidation may be varied in form, though more broadly it refers to one's private experiences (e.g., thoughts and feelings), and/or overt expression of emotions, being met with punishing, extreme, or erratic responses that send the message that the person's behavior, thoughts, and feelings, are unacceptable. Forms of invalidation may include, but are not limited to, criticism, neglect, erratic punishment, humiliation, and sexual abuse. Fruzzetti and Shenk (2008) describe invalidating responses as those "that communicate high negative emotion (e.g., disgust, contempt, condescension, or other emotions associated with disrespect), high levels of negative judgment (e.g., the person's feelings, desires, actions, or thoughts are just "wrong"), or that the person's valid experiences are otherwise not legitimate" (p. 218).

According to Linehan's theory, biologically-based emotional vulnerabilities with which one is born or develop in early life, paired with a lack of opportunity to learn the

skills to manage emotions, lead to emotion dysregulation, the core feature of BPD (Linehan, 1993). These emotional vulnerabilities include high sensitivity to emotional stimuli, high reactivity during emotional experiences, and a slow return to emotional baseline after activating circumstances. Emotion dysregulation refers to deficits in awareness of, understanding, labeling, responding to, and modulating emotional responses (Iverson, Follette, Pistorello, & Fruzzetti, 2012).

A number of studies have addressed the impact of invalidation, methods to modulate emotions, and interventions to alleviate the severity of BPD symptoms. A novel area of research is to examine the role that self-compassion and fear of compassion have among these combined constructs. Self-compassion is the concept of extending nonjudgmental healing and kindness to one's self during times of stress, failure, or suffering. From a self-compassionate position, people recognize suffering as a commonly-shared human experience (Neff, 2003a). The concept of self-compassion is composed of three components: self-kindness, mindfulness, and common humanity (Neff, 2003a). Self-compassion has been linked to numerous salutary effects, such as reducing anxiety (Neff, Kirkpatrick, & Rude, 2007) and depression, and increasing life satisfaction (Neff, 2003a). It has also been found to be helpful in regulating emotions (Diedrich, Grant, Hofmann, Hiller, & Berking, 2014; Galhardo, Cunha, Pinto Gouveia, and Matos, 2013). Despite its beneficial effects, self-compassion has not been helpful for everyone, due in part to a phenomenon that is conceptualized as a *fear of compassion.* Fear of compassion is a fear of or active resistance to engaging in compassionate experiences and behaviors (Gilbert, McEwan, Matos, and Rivis, 2011). It may occur when compassion is extended to self, when receiving compassion from others, or when

giving compassion to others. Some explanations for this occurrence point to a conditioned response from early development (Gilbert, 2007).

The purpose of the current study is to examine whether the ability to respond to one's self with self-compassion reduces the impact of emotion dysregulation and symptoms of BPD in the context of childhood invalidation. Further, the purpose was to also examine whether having fear of compassion may serve to maintain emotion dysregulation and BPD symptoms in the context of childhood invalidation.

Borderline Personality Disorder

According the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM) (5th ed.; *DSM–5*; American Psychiatric Association, 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 those people who have it. Although BPD is often difficult to treat successfully, treatments with demonstrated efficacy and effectiveness have been developed. These treatments do not work for everyone, a need exists to continue to advance interventions for BPD.

BPD affects about 2% of the general population, and is seen in approximately 10% of outpatients and approximately 20% of inpatients of mental health settings (APA,

2013). To be diagnosed with BPD, one needs to meet five or more of nine criteria (APA, 2013). These 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, para. 1).

Because of the requirements that a person meet five or more of nine criteria, people may qualify for a BPD diagnosis in 256 different ways; thus, there is substantial heterogeneity in this population. In addition, any two people meeting criteria may share only one symptom in common. The symptom most commonly associated with BPD is mood lability (Linehan, 1993).

Early theories of the etiology of BPD were mainly psychodynamically informed. More recently, theorists have attempted to organize the diverse set of symptoms associated with BPD into categories that may provide insight into the disorder. For example, Gunderson (2011) grouped BPD symptoms into categories affecting the following types of functioning: affective, impulsive, interpersonal, and other. Affective instability due to a marked reactivity of mood (criterion six), chronic feelings of emptiness (criterion seven), and inappropriate, intense anger or difficulty controlling

anger (criterion eight) are included in the affective domain. Impulsivity (criterion four), and recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior (criterion five) are included in the impulsive domain. Examples of impulsivity may include impulsive spending, sex, substance abuse, reckless driving, and/or binge eating (APA, 2013). Frantic efforts to avoid real or imagined abandonment (criterion one), and a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation (criterion two) are included in the interpersonal domain. Identity disturbance (criterion three) and transient, stress-related paranoid ideation or severe dissociative symptoms (criterion nine) are included in the "other" domain (Gunderson, 2011).

Linehan (1993) presented a reorganization of the criteria for BPD by dividing them into five categories focused around the concept of "dysregulation." Dysregulation can be understood as instability, dysfunction, as well as a process without modulation, management, or control. Each category represents dysregulation in a particular domain: emotional, interpersonal, behavioral, cognitive, and self. The first category reflects emotional dysregulation and includes affective instability due to a marked reactivity of mood, and inappropriate, intense anger or difficulty controlling anger. 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 the DSM criteria of frantic efforts to avoid real or imagined abandonment, and a pattern of unstable and intense interpersonal relationships. 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 the DSM criteria of impulsivity, and recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior. Individuals engage in impulsive, self-injurious behaviors in attempts to harm themselves. Linehan's (1993) fourth category includes dysregulation in cognition and includes the DSM criteria of transient, stress-related paranoid ideation or severe dissociative symptoms. This can be seen as episodes of thought dysregulation in response to stressful events. The final category includes dysregulation in sense of self, including the DSM criteria of identity disturbance and transient, stress-related paranoid ideation or severe dissociative symptoms. The individual may feel emptiness or have little or no stable sense of self (Linehan, 1993).

Emotion Dysregulation

Much attention has been given to examining emotion dysregulation because of its involvement in influencing, predicting, and/or maintaining a variety of psychological disorders and problematic behaviors. According to D'Agostino, Covanti, Rossi Monti, and Starcevic (2017), there is no agreed upon definition for the conceptual core of emotion dysregulation when applied to all disorders within the literature. In their review article, they identified five dimensions of emotion dysregulation that were commonly identified among studies: decreased emotional awareness; inadequate emotional reactivity; intense experience of expression of emotions; emotional rigidity; and cognitive reappraisal difficulty. *Decreased emotional awareness* is the diminished "ability to identify and label emotional experience" (para. 4). For example, it may include expressing anger and shame but without the ability to identify the emotion. *Inadequate emotional reactivity* is the "tendency of the individual to react in an inappropriate manner

to intense and overwhelming emotions" (p. 5). For example, a person may employ desperate escape behaviors that are impulsive and destructive (e.g., self-harm or suicide) (Krystal, 1974; Linehan and Heard, 1992; Westen, 1991, as cited in Conklin, Bradley, & Westen, 2006). *Intense experience and expression of emotions* includes both positive and negative emotions. *Emotional rigidity* is the "domination of a particular emotion, with a diminished ability to experience any other emotion," (para. 7) as well as context-inappropriate emotional response (e.g., an emotional response that is unusual or unexpected, or violates cultural and social norms, or a lack of emotional response to situations that typically elicit emotional responses). *Cognitive reappraisal difficulty* is reevaluating emotions problematically and having difficulty attributing relevant meanings to them.

D'Agostino et al. (2017) identified the roles that these dimensions of emotion dysregulation serve in a variety of DSM-5 diagnoses. Some of the diagnoses for which emotion dysregulation serves a role include: autism spectrum disorder, attention-deficit/hyperactivity disorder, schizophrenia, bipolar disorder, depressive disorders, social anxiety disorder, generalized anxiety disorder, obsessive-compulsive disorder, posttraumatic stress disorder, anorexia nervosa, bulimia nervosa, sleep disorders, oppositional defiant disorder, schizotypal personality disorder, and borderline personality disorder (D'Agostino et al., 2017). Gratz & Tull (2010) have also found emotion dysregulation to be heightened among those with substance use disorders (SUD). D'Agostino et al. (2017) found that the dimensions of emotion dysregulation differentiate the aforementioned disorders in various proportions, but the disorders with the highest proportions included borderline personality disorder and eating disorders.

The manifestation of emotion dysregulation can also be understood in terms of Gratz and Roemer's (2004) conceptualization of difficulties in emotion regulation. This conceptualization includes 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. Deficits within these emotion regulation dimensions have been implicated in the maintenance of psychological disorders for children and adults.

McLaughlin, Hatzenbuehler, Mennin, and Nolen-Hoeksema (2011) investigated the longitudinal and reciprocal nature of the relationship between emotion dysregulation and psychopathology among adolescents. That is, they sought to understand how aspects of emotion dysregulation (emotional understanding, adaptive expression of negative emotions, and cognitive emotion management strategies like rumination) and psychopathology influenced one another over time. They found that deficits in these emotion regulation aspects predicted increases in symptoms of anxiety, aggression, and eating pathology. Furthermore, emotion regulation deficits were a risk factor for psychopathology, and not the other way around. That is, the development of psychopathology did not predict changes in emotion deficits (McLaughlin et al., 2011).

Using Gratz and Roemer’s (2004) conceptualization of emotion dysregulation, Buckholdt, Parra, and Jobe-Shields's (2014) study illustrated how difficulties with regulating emotions can influence problematic behaviors. Specifically, they examined the effects of parents’ emotion dysregulation on adolescents’ psychopathology, such as

internalizing and externalizing behaviors. In this study, internalizing behaviors included depression, anxiety, and withdrawal, among others. Externalizing behaviors included delinquent and aggressive behaviors. Adolescents who had parents with emotion dysregulation difficulties were more likely to have difficulty regulating their own emotions. Furthermore, parents with difficulties regulating emotions were more likely to invalidate their adolescents' emotions than those who were able to regulate their emotions. Additionally, adolescent emotion dysregulation mediated the relationship between parental emotional invalidation and adolescent internalizing and externalizing behaviors (Buckholdt, Parra, & Jobe-Shields, 2014).

Emotion dysregulation has also been shown to help maintain specific disorders. Racine and Wildes (2015) found that emotion dysregulation maintains anorexia nervosa (AN) symptom severity. Racine and Wildes (2015) assessed eating disorder severity and emotion regulation difficulties in those recently released from intensive eating disorder treatment. Data were collected longitudinally at three, six, and 12-month follow-ups. Those with initially high levels of emotion dysregulation were found to have an increase and later maintenance of AN symptom severity over time, compared to those with initially lower emotion dysregulation. This latter group had decreasing AN symptom severity throughout follow up.

The body of research on emotion dysregulation suggests that the inability to identify, understand, and effectively modulate emotional experiences has serious negative consequences. What is also noteworthy is the link between it and a significant number of psychological disorders, namely BPD.

Emotion Dysregulation within BPD. Emotion dysregulation, or the inability to efficiently regulate emotions, is considered to be a defining feature of BPD. This inability to regulate emotions leads to emotions spiraling out of control, showing frequent lability, becoming intense (e.g., extreme or amplified), and leading to the person having difficulty reasoning (Conklin, Bradley, & Westen, 2006). Linehan's (1993) biosocial theory proposes that what leads to emotion dysregulation is having emotional vulnerability along with the inability to regulate emotions. Emotional vulnerability includes a heightened emotional sensitivity, an inability to regulate intense emotional responses, and a slow return to emotional baseline (Crowell, Beauchaine, & Linehan, 2009). An individual with heightened sensitivity is quick to react, and reacts to cues or events that less vulnerable individuals do not. For example, a partner'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 (Linehan, 1993). An inability to regulate intense emotional responses is typically the norm because the person has extremes in feelings and expressions of emotions. Those with BPD tend to have much more intense emotional experiences compared to people without BPD. For example, what may cause only 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 reactivate emotional states. For example,

interpretations and social judgments may be biased by emotional states (Linehan, 1993), which may serve to perpetuate the intensity of negative emotions.

With respect to emotional vulnerabilities, Linehan (1993) describes four characteristics of emotional arousal that are challenging for individuals with BPD. The first is that they have difficulty regulating the integrated physiological, experiential, cognitive, and expressive components of their emotional experience. 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 they 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).

A growing body of research has examined the extent to which people with BPD exhibit emotion dysregulation. This research has included self-report, as well as physiological and behavioral measurements. To explore the basic question of whether emotion dysregulation is a core feature of BPD, Conklin et al. (2006) compared the nature of affect and affect regulation in those with BPD to those with dysthymic disorder (DD). Conklin et al. (2006) examined four different maladaptive emotion regulation strategies classified as internalized, externalized, avoidance, and disorganized. Internalizing strategies would direct negative emotions inwardly instead of to the

appropriate external source. Externalized strategies are used when people blame others for their own mistakes. Among other things, emotional avoidance included thinking about upsetting ideas without the accompanying emotions. A disorganized strategy is one where the individual engages in self-destructive behaviors (Conklin et al., 2006). The authors found that those with BPD, in contrast to those with DD, tended to use externalized and disorganized strategies. Furthermore, in general, those with BPD, compared to those with DD, 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 had similarly high levels of negative affect, and similarly low levels of positive affect. Thus, the results of this study support the idea that people with BPD have high emotional vulnerability as evidenced by high levels of negative affect (although not higher than those with DD). It also supported the idea that individuals with BPD are more emotionally dysregulated, and specifically that they use more other-blaming and self-destructive regulation strategies.

Researchers have also examined how emotion dysregulation affects the number of symptoms related to BPD (i.e. severity of BPD). Salsman and Linehan (2012) studied the effect of emotion dysregulation on symptoms of BPD using two models. In the first model, they examined *negative affect intensity* as a mediator in the relationship between emotion dysregulation and BPD symptoms. In the second model, they examined *negative affect reactivity* as a mediator in the relationship between emotion dysregulation and BPD symptoms. Intensity can be thought of as the strength of one's emotion, whereas reactivity can be thought of as the strength of one's emotional response to emotionally eliciting stimuli. Emotion dysregulation was measured according to Gratz and Roemer's

(2004) dimensions (as measured by the Difficulties in Emotion Regulation Scale-DERS). Results supported a model in which negative affect intensity mediated the relationship between the DERS emotion dysregulation dimensions *lack of emotional clarity* and *limited access to emotion regulation strategies*, and BPD symptoms, as measured by the Borderline Symptom List (BSL). The results also supported a model in which negative affect reactivity mediated the relationship between the DERS emotion dysregulation dimensions of *limited access to emotion regulation strategies* and *difficulty engaging in goal directed behavior*, and symptoms of BPD. These results suggest that emotion dysregulation, and in particular the dimension of limited access to emotion regulation strategies in the context of emotional reactivity and intensity, appears to have an effect on severity of BPD symptomology.

The end result of having emotional vulnerability and problems with regulating emotions is that the individual, as Linehan (1993) describes, is the "psychological equivalent of [a] third-degree burn patient" (p. 69). Any minor infraction by another person 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, which can be further dysregulating.

In addition to emotion dysregulation, two other forms of emotional functioning have been examined 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 other similar inner experiences. Instead, the person avoids them in a variety of ways. Distress tolerance, in contrast, can be defined as the "actual or perceived ability to

withstand negative emotional states" (Iverson et al., 2012, p. 416). Experiential avoidance and low distress tolerance are considered maladaptive coping behaviors, and could be understood as ways to avoid emotions, and/or failures of distress tolerance. One study examined the relative contribution of three domains of emotional functioning--emotion dysregulation, emotional avoidance, and distress tolerance--to symptom severity for individuals with BPD and subthreshold BPD. Iverson et al. (2012) examined these domains using self-report measures among outpatients, while controlling for symptoms of depression. They found that while each domain of emotional functioning independently predicted BPD symptom severity, experiential avoidance remained a unique contributor to symptom severity after controlling for depressive symptoms and emotion dysregulation. The results of this study suggest that while various forms of emotional functioning commonly found among those with BPD have implications for the severity of BPD, experiential avoidance may be particularly influential. Further, helping the person with BPD become willing to experience negative emotions may alleviate suffering.

Childhood Invalidation

According to Linehan's (1993) biosocial theory, invalidating environments and biological vulnerabilities are the two major transactional factors in the development of BPD. The manifestations of invalidation are varied, though one description of it is: "communication of private experiences is met by erratic, inappropriate, and extreme responses…it is often punished, and/or trivialized" (Linehan, 1993, p. 49). 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 tend to portray that problems can be easily solved. Such invalidation can cause people to believe the messages communicated by the invalidating environment, including that a) their reactions and emotions are "wrong" or inappropriate and, b) they possess the socially unacceptable characteristics the family has communicated.

For many children, invalidation typically comes from adults closest to them, such as parents, though it may come from others in their life. Invalidation occurs when the child's internal experiences, such as thoughts and feelings, are met with continual judgment, criticism, disgust, contempt, neglect, and/or they are attributed to unacceptable qualities, such as laziness, immaturity, ineptitude, or others. (Fruzzetti & Shenk, 2008; Sauer & Baer, 2010). Invalidating parent reactions can communicate that the child's emotions are not acceptable or tolerated, both of which can heighten the child's distress (Buckholdt, Parra, & Jobe-Shields, 2014). Invalidation does not allow the child to learn effective ways to regulate emotions, and instead teaches the child to inhibit emotions (Buckholdt et al., 2014). Invalidation may also occur in the form of using punishment erratically (Linehan, 1993). Furthermore, invalidation may occur in the form of severe parental criticism, embarrassment, and humiliation (i.e. psychological abuse) (Krause, Mendelson, & Lynch, 2003).

Other forms of invalidation may include child sexual abuse (CSA), which is a severe form of invalidation and a traumatization. Childhood abuse communicates that a child is not worthy of care and safety. Protection from abuse is often inadequate or absent, and those who have experienced abuse are not believed. CSA is prevalent among those with BPD (Zanarini, Yong, Frankenburg, & Hennen, 2002), though the experience

is not necessary for development of BPD. Zanarini et al., (2002) reported that 62% of their BPD patients had a history of CSA, and 86% reported other forms of physical, emotional, verbal abuse.

Testing of invalidation models

A large number of studies have been dedicated to understanding how invalidation, broadly defined, affects those exposed to it in childhood. For example, many studies have attempted to determine to which specific psychological disorders childhood invalidation is linked. Other studies have examined how different forms of invalidation may affect personality pathology, psychological distress, interpersonal problems, and problematic behaviors (e.g., aggression). Other studies have examined how the experience of childhood invalidation affects one's ability to regulate emotions. Many of the broad conclusions from these lines of research suggest that childhood invalidation sets a child up for numerous problematic behaviors and symptoms of psychological disorders in adulthood. Additionally, people who have experienced invalidation often learn to self-invalidate and/or invalidate others. The following studies provide evidence in support of the connection between childhood invalidation and emotional responding and/or BPD symptomatology. Krause, Mendelson, and Lynch (2003) examined the relationship between a history of recalled childhood invalidation, emotional inhibition, and psychological distress in adults. In this study, childhood invalidation included abuse, punishment, and minimization of distress. Emotional inhibition included avoidance, suppression of thoughts, and ambivalence over emotional expressions. Psychological distress included symptoms of depression and anxiety. Krause et al. (2003) found that emotional inhibition mediated the relationship between childhood emotional invalidation

and acute distress in adulthood, such that those with a history of invalidation were more likely to report emotional inhibition or avoidance as adults. Furthermore, this inhibition was associated with symptoms of depression and anxiety (Krause et al., 2003).

In another study, Hong and Lishner (2016) examined the predictive power of general and trauma-specific childhood invalidation on personality and subclinical psychopathology. General invalidation included Linehan's (1993) concepts of invalidation, such as perceived lack of warmth, perceived hostility and aggression, perceived indifference and neglect, and perceived undifferentiated rejection. Trauma-specific invalidation included child sexual assault. Borderline, narcissism, and psychopathy were the personality pathology characteristics studied, whereas self-reports of anxiety, depression, and posttraumatic stress disorder (PTSD) were included as subclinical psychopathology (Hong and Lishner, 2016). They found that childhood sexual abuse and general invalidation independently predicted symptoms of anxiety, depression, PTSD, and borderline personality pathology.

While the above studies explored the impact of childhood invalidation on functioning within adults, other studies have explored real-time effects of invalidation. For example, Herr, Jones, Cohn, and Weber (2015) investigated the effect of experimentally manipulated invalidation on emotion regulation. They tested the impact of receiving invalidation versus validation on subsequent aggressive behavior in individuals with varying degrees of difficulty regulating emotions. The participants responded to self-report measures of sadness before and after a sad mood induction. Their self-reports of sadness were either validated or invalidated by the experimenter. The participants then engaged in a behavioral measure of aggression (e.g., the Point Subtraction Aggression

Paradigm [PSAP]); they responded to the self-report of sadness after this as well. Herr et al. (2015) found that for those with higher levels of emotion regulation difficulties, invalidation led to more aggressive responses on the PSAP, compared to those with fewer difficulties. For those with fewer emotion regulation difficulties, aggressiveness was not significantly different based on whether they received invalidation or validation (Herr et al., 2015). Thus, it appears that validation of emotion may help prevent aggressive responses for those who have difficulty regulating their emotions. This is thought to be particularly helpful, as many individuals with BPD meet the DSM's criteria relating to experiencing and displaying anger.

A number of other studies have examined the relationship between invalidation and BPD symptoms. For example, Sturrock, Francis, and Carr (2009) tested Linehan's (1993) biosocial theory to explore relationships among childhood invalidation, distress tolerance, and BPD characteristics. In particular, they examined three different domains of strategies for tolerating distress. These included neutral strategies (e.g., anticipating affect and distracting), adaptive (e.g., accepting and managing affect), and maladaptive (e.g., avoiding affect). Avoidance of affect is considered a maladaptive form of coping because the person does not accept negative emotions, which is a necessary means to initiate problem solving. Sturrock et al. (2009) found that within their community sample, there was a relationship between a lack of perceived optimal parenting, especially from mothers, and symptoms of BPD, and this was mediated by avoidance of affect. Thus, a person who experienced maternal invalidation in childhood was more likely to engage in avoidance of affect and have more BPD traits.

Some research supports the role of invalidation in general, and invalidation related to the disclosure of childhood sexual abuse specifically, in the occurrence of BPD symptomatology. Hong, Ilardi, and Lishner (2011) examined severity of BPD symptoms in a sample of college students. They assessed for childhood sexual abuse, as well as perceived or anticipated invalidation of the disclosure of this experience(s) from others. Anticipated invalidation surrounding CSA refers to the participant's imagined level of support and blame received had they disclosed their CSA. Furthermore, Hong et al. (2011) assessed for general invalidation in the developmental home environment. They found that childhood sexual abuse alone is a poor predictor of BPD symptomatology; invalidation during early development and perceived and anticipated invalidation at the disclosure of childhood sexual abuse predicted BPD symptomatology.

Fruzzetti, Shenk, and Hoffman (2005) have proposed a theory that emphasizes the role that invalidation in current meaningful relationships has in the maintenance of BPD symptoms, referred to as the validation/invalidation family interactions transactional theory. Specifically, Fruzzetti et al. (2005) posit that emotionally vulnerable people are at increased risk for destructive transactions with others. For example, emotional arousal can lead to a decrease in cognitive capacity and less accurate emotional expression. This makes it difficult for others to accurately understand the person's emotional experience. This misunderstanding or misperception can feel invalidating. This can lead to a further increase in arousal, a further decrease in accurate expressions, and a continuation of the cycle. Sturrock and Mellor (2014) tested Fruzzetti's el al. (2005) validation/invalidation family interactions transactional theory, as well as Linehan's (1993) biosocial theory. They found that perceptions of past parental invalidation predicted symptoms of BPD,

and this was mediated by emotion dysregulation, poor distress tolerance, and perceptions of current relationship invalidation.

Selby, Braithwaite, Joiner, and Fincham (2008) investigated the mechanisms of dysfunction as they occur in interpersonal relationships among those with BPD. They examined childhood emotional invalidation, relationship dysfunction (e.g., level of closeness to partner, level of conflict, and relationship disturbances), and BPD symptoms. They found that symptoms of BPD predicted romantic relationship dysfunction, and this relationship was partially mediated by childhood emotional invalidation. Thus, the difficulties that an individual with BPD experiences in adult relationships may be in part explained by childhood experiences of invalidation.

Although the above studies support the notion that environmental invalidation is a key transactional component in the development and maintenance of BPD, support for this is not universal. For example, Gill and Warburton (2014) tested whether parental invalidation and emotional vulnerability independently predicted emotion dysregulation. Furthermore, they tested whether the interaction of these constructs predicted emotion dysregulation. In support of Linehan's (1993) theory, both parental invalidation and emotional vulnerability independently predicted emotion dysregulation, but contrary to theory, the interaction effect was not significant (Gill & Warburton, 2014). Reeves, James, Pizzarello, and Taylor (2010) used structural equation modeling to determine whether emotional vulnerability and invalidation led to emotion dysregulation. This study relied on self-report measures and found that emotion dysregulation had the strongest prediction for BPD symptoms, as is expected with Linehan's (1993) theory. Emotional invalidation, in contrast, did not predict BPD symptoms. Furthermore, Reeves et al.

(2010) found that emotion dysregulation partially mediated the relationship between emotional vulnerability and symptoms of BPD. This study suggests that emotional domains related to vulnerability and dysregulation predict BPD severity, as does invalidation. The interactional/transactional nature of emotional domains and invalidation should be explored further.

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, self-compassion has three components: 1) self-kindness, 2) common humanity, and 3) mindfulness. 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-judgment. Painful thoughts are acknowledged and held in awareness, and are neither suppressed nor exaggerated (Neff, 2011).

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 instead that 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 individuals to identify the ways in which their 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. Some people may go to great lengths to avoid the negative affect that results from self-judgment of their 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

self. As self-compassion is related to emotional approach coping (Neff, 2003a), adopting this type of coping may allow individuals to understand the function of their behavior in relationships. Such a skill set could have a two-fold salutary effect on individuals with BPD, particularly in interpersonal relationships. They can reduce irrational emotional responses, but when they occur, they can better control the impact they may have on another person. This can repair, rather than rupture, meaningful relationships.

The benefits of practicing self-compassion have been explored in numerous studies. In general, self-compassion has been found to reduce anxiety (Neff, Kirkpatrick, & Rude, 2007) and depression, and increase life satisfaction (Neff, 2003a). When self-compassion has been used as an emotion regulation strategy, it has demonstrated benefits in the context of several issues. For example, self-compassion improved depressed mood in college students with Major Depressive Disorder after a negative mood induction (Diedrich, Grant, Hofmann, Hiller, & Berking, 2014). Vettese, Dyer, Li, and Wekerle (2011) examined relationships among self-compassion, childhood maltreatment, and emotion dysregulation in transitional age youth (ages 16-24) seeking treatment for substance use. The types of childhood abuse included minimization/denial, emotional and physical neglect, and physical, emotional, and sexual abuse. Self-compassion mediated the relationship between childhood maltreatment and emotion dysregulation (Vettesse et al., 2011). Self-compassion has also been shown to be helpful in transforming negative emotions. For example, Galhardo, Cunha, Pinto Gouveia, and Matos (2013) found that self-compassion mediated the relationship between feelings of shame and infertility in a group of women. Furthermore, Kelly, Carter, and Borairi, (2014) observed that group therapy that implicitly encouraged self-compassion led to less shame for those

undergoing treatment for eating disorders. These studies illustrate the link between self-compassion and emotion regulation.

Other research has explored the role that self-compassion, or the lack of it, may serve in maintaining psychopathology. For example, Westphal, Leahy, Pala, and Wupperman (2016) investigated the relationships between adverse parenting (i.e., indifference and abuse), self-compassion, and psychopathology. They examined self-compassion and perceived emotional invalidation as mediators in the relationship between adverse parenting and risk for BPD, Posttraumatic Stress Disorder (PTSD), and Major Depressive Disorder (MDD) in a sample of psychiatric outpatients. They found that self-compassion and emotional invalidation mediated the relationship between parental indifference (and not abuse) and risk for BPD, PTSD, and MDD. Additionally, Xavier, Pinto Gouveia, and Cunha (2016) examined the moderating effect of self-compassion on depressive symptoms and daily hassles on non-suicidal self-injury (NSSI) among adolescents. Self-compassion moderated the relationship between depressive symptoms and NSSI, but not with daily hassles. Furthermore, Xavier et al. (2016) tested the subscales of self-compassion as a moderator in these relationships. Five of the six subscales moderated the relationship between depressive symptoms and NSSI, but none did for daily hassles. The subscales that were statistically significant were self-kindness, mindfulness, self-judgment, isolation, and over-identification, but common humanity was not. These two studies in particular demonstrate the effects of self-compassion within the well-known relationship between adverse childhood experiences and psychopathology.

Given its salutary effects, self-compassion has been suggested as a helpful concept to incorporate into psychotherapy. For example, interventions designed to

increase self-compassion have been suggested as potentially useful for individuals with BPD (Warren, 2015), and in particular those who experience self-loathing (Krawitz, 2012). Feliu-Soler et al. (2016) developed a randomized controlled trial to examine the effects of a short-term training program of self-compassion and loving kindness for those with BPD. Participants were randomly assigned to a loving kindness and compassion meditation (LKM/CM) or mindfulness continuation training (control group). After three weeks, those in the LKM/CM experienced improvements in BPD symptoms, self-criticism, mindfulness, acceptance, and self-kindness when compared to the control group (Feliu-Soler et al., 2016).

Fear of Compassion

A *fear of compassion* has been observed in some people who struggle with receiving kindness, warmth, and affiliation (Gilbert, McEwan, Catarino, Baiao, & Palmeira, 2014). As the term implies, Gilbert et al. (2011) described a fear of compassion as a fear of or active resistance to engaging in compassionate experiences and behaviors. Gilbert et al. (2011) noted that this fear may occur when compassion is extended to self, when receiving it from others, or when providing it to others. Gilbert, McEwan, Catarino, Baiao, and Palmeira (2014) explain that positive emotions (e.g., joy, love, kindness, safety) may be feared rather than experienced as pleasurable. Fears of positive emotions may have been established from early experiences wherein a child was punished for having positive emotions (Gilbert, 2007; Shaver & Mikulincer, 2002). Others may experience feelings of guilt from having positive emotions in the context of unhappy environments or families (Gilbert et al., 2014). Gilbert et al. (2002) have hypothesized that fears of compassion may have developed in similar ways as fear of positive

emotions. Some may believe that they are undeserving of compassion, that compassion is a sign of weakness, or that compassion can elicit memories of when the person received both kindness and abuse from a significant figure (Gilbert et al., 2014).

Fear of compassion has not been examined explicitly in BPD, though it has been examined with other psychological disorders and problematic behaviors. Gilbert, McEwan, Matos, and Rivis (2011) have developed self-report measures that assess fear of receiving compassion and kindness from oneself, from others, and for a fear of expressing compassion to others. They examined these constructs in a sample of college students and therapists. They found that for both groups, fear of compassion for self was linked with a fear of compassion from others. They suggest that this involves a general difficulty with affiliative emotions. Furthermore, they found that fear of compassion for self and from others were linked to self-coldness, self-criticism, and depression. Gilbert, McEwan, Gibbons, Chotai, Duarte, and Matos (2012) explored the link between fear of compassion with emotional processing, empathy, and mindfulness, as well as the link between happiness with emotional processing, empathy, and mindfulness, in University students. They found that fears of compassion for self, from others, and fear of happiness, were positively associated with depression, anxiety, stress, alexithymia, and self-criticism, and negatively associated with mindfulness and empathy (Gilbert et al., 2012).

Kelly, Vimalakanthan, and Carter (2014) examined the roles of self-esteem, self-compassion, and fear of compassion in the context of disordered eating. Kelly et al. (2014) examined these constructs among women college students and women in treatment for disordered eating. They found that those in the treatment program had lower levels of self-compassion, and higher levels of fear of compassion than the student group.

When analyzing each group individually, they found that when self-esteem was controlled, high fear of compassion predicted disordered eating in the treatment program group, whereas low self-compassion predicted disordered eating in the student group. These results suggest that addressing fears of compassion may be useful for those with eating disorders, whereas cultivating self-compassion may be helpful in prevention of eating disorders.

Gilbert et al. (2014) studied the relationships between fears of happiness and compassion, depression, alexithymia, and attachment security styles in a sample of depressed adults. These adult attachment measure subscales included *Depend* (ability to depend on others), *Anxiety* (the extent to which one worries about being abandoned by one's partner, and the desire to merge with one's partner), and *Close* (one's ability to get close with the partner). The measurement of fear of compassion included the fear of compassion for self and receiving it from others. A depressed group, composed of people with varying levels of depression, compared to a group of students without depression, had higher levels of fear of happiness and compassion from others. Within the depressed group, a series of regression analyses showed that fear of compassion for self and from others did not predict symptoms of depression, anxiety, and stress. It did, however, predict the three types of attachment (Gilbert et al., 2014). For example, both fear of compassion for self and from others was negatively associated with attachment styles *Close* and *Depend*, and positively associated with *Anxious* style. Finally, Gilbert et al. (2014) found that fear of happiness and fear of compassion for self did mediate the relationship between alexithymia and depression. This suggests that feeling insecure in

attachment may influence the development of fears of compassion, and this fear of compassion may help explain negative emotions later in life.

Miron, Seligowski, Boykin, and Orcutt (2016) examined self-compassion and fear of compassion as an indirect cause in the relationship between childhood abuse and symptoms of depression and PTSD. Within this sample of undergraduate students, Miron et al. (2016) found that those with a history of combined childhood sexual and physical abuse had greater symptoms of depression and PTSD than those with no history. Furthermore, Miron et al. (2016) found that fear of self-compassion, but not self-compassion, mediated this relationship between abuse and psychopathology symptoms, such that those with greater levels of fear of compassion experienced greater symptomatology. Xavier, Cuhnoa, and Pinto-Gouveia (2015) examined the impact that childhood experiences, affect, and attitudes toward compassion had on adolescent's engagement in self-harm. In particular, the early experiences examined were experiencing threat and feelings of submissiveness. Negative affect and fears of compassion for self, for others, and from others were also examined. Xavier et al., (2015) found that negative affect, followed by early experiences, followed by fears of compassion best predicted self-harm behaviors. Though fear of compassion may have served a functional purpose (e.g., because showing and receiving compassion led to punishment), these studies suggest long-term dysfunction, if allowed to persist.

The current literature suggests that high levels of fear of compassion are implicated in the maintenance of a variety of problematic behavior and emotional difficulties, such as anxiety, depression, alexithymia, self-criticism, disordered eating, and PTSD. Its development may arise from certain styles of attachment, or when

expressions of or experiencing compassion and other positive emotions is met with punishment or invalidation in early development.

Childhood invalidation is prevalent among individuals who meet criteria for BPD, thus it is conceivable that those with BPD may also develop fear of compassion. For example, many people with BPD experience self-criticism/self-loathing/self-hatred, which could be related to fear of compassion. Furthermore, the finding that fear of compassion mediates the relationship between childhood abuse and symptoms of depression and PTSD may extend to those with BPD, as many people with BPD have experienced childhood abuse, PTSD, and depression. Fear of compassion predicted adult attachment styles in a group of depressed individuals. This included the *anxiety* attachment style; in the context of BPD, childhood invalidation and fear of compassion may cultivate similar attachment styles. Rivera (2013) found an inverse relationship between self-compassion and BPD characteristics. Results of this study also indicated that self-compassion mediated the relationship between BPD characteristics and mindfulness in a sample of college students. Thus, there is some evidence to suggest that individuals who are more likely to respond to themselves with self-compassion are less likely to experience symptoms of BPD. Additionally, people with BPD are difficult to treat in therapy, and this could be related to fear of compassion since therapy often involves receiving compassion from a therapist. More research is needed to explore these ideas.

Current Study. The purpose of the study is to expand our understanding of self-compassion and fears of compassion, and their potential roles in perceived childhood invalidation, emotion dysregulation, and BPD symptoms. Previous literature supports the

idea that emotion dyregulation is a core feature of BPD, and that it arises from emotional vulnerability paired with an inability to efficiently modulate emotional experiences. While the evidence remains mixed, several studies support Linehan's (1993) biosocial theory that the transaction between invalidation and emotional vulnerabilities leads to the development of BPD. Self-compassion may assist in regulating emotions by allowing individuals to better understand their emotional experience and implement effective regulation strategies. One study (see Loess, Waltz, & Siegel, in preparation) supports the notion that self-compassion serves as a moderator in the relationship between emotion dysregulation and BPD characteristics, such that this relationship is attenuated for those with higher levels of self-compassion. A fear of compassion, which is not simply the absence of self-compassion, but the active fear or resistance to engaging in compassionate behavior with self or with receiving it from others, is explored as a partial explanation for the relationships among the constructs in this study. The current study extends previous research by examining the roles that self-compassion and fear of compassion may serve in constructs related to childhood invalidation, emotion dysregulation, and symptoms of BPD. Specifically, the purposes of this study are to address the following questions:

1) Does self-compassion mediate the relationship between childhood invalidation and emotion dysregulation?

2) Does self-compassion mediate the relationship between childhood invalidation and BPD characteristics?

3) Does fear of compassion for self mediate the relationship between childhood invalidation and emotion dysregulation?

4) Does fear of compassion for self mediate the relationship between childhood invalidation and BPD characteristics?

5) Does fear of compassion from others mediate the relationship between childhood invalidation and emotion dysregulation?

6) Does fear of compassion from others mediate the relationship between childhood invalidation and BPD characteristics?

It is hypothesized that self-compassion, fear of compassion for self, and fear of compassion from others will serve as mediator variables in these relationships. Specifically, the following hypotheses correspond to the research questions presented above:

H_1: Self-compassion will mediate the relationship between childhood invalidation and emotion dysregulation.

H_2: Self-compassion will mediate the relationship between childhood invalidation and BPD characteristics.

H_3: Fear of compassion for self will mediate the relationship between childhood invalidation and emotion dysregulation.

H_4: Fear of compassion for self will mediate the relationship between childhood invalidation and BPD characteristics.

H_5: Fear of compassion from others will mediate the relationship between childhood invalidation and emotion dysregulation.

H_6: Fear of compassion from others will mediate the relationship between childhood invalidation and BPD characteristics.

The answers to these questions were examined using two multiple parallel mediator models. In the first model, self-compassion, fear of compassion for self, and fear of compassion from others, were all tested as mediators in the relationship between childhood invalidation and emotion dysregulation. In the second model, self-compassion, fear of compassion for self, and fear of compassion from others, were all tested as mediator variables in the relationship between childhood invalidation and BPD characteristics. Furthermore, for exploratory purposes the six subscales of the self-compassion scale – self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identified - were independently tested as mediators in all relationships between invalidation and emotion dysregulation and invalidation and BPD characteristics.

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 was used to determine sample size. Previous research (Loess, Waltz, & Siegel, in preparation) found a large effect size ($R^2 = 0.43$) for self-compassion as a moderator in the relationship between emotion dysregulation and BPD characteristics in a college sample. For the current study, a power analysis, using G*Power software was run with projected small, medium, and large effect sizes. When a small effect size was utilized for calculation of power ($F^2 = 0.02$), the suggested N was 934. With a medium effect size input ($F^2 = 0.15$), the suggested N was 107. With a large effect size input ($F^2 = 0.35$), the suggested N was 48.

For the purposes of this study, an N of 125 was proposed to coincide with the effect size found in the study mentioned above. The final sample obtained included a total number of 257 participants; because one of the important variables in the study, BPD characteristics, tends to have a relatively low base rate in this population, ultimately the decision was made to collect a larger sample size to include more individuals with higher scores on this variable.

Materials

Participants filled out a brief demographic questionnaire asking for their age, gender, race/ethnicity, sexual orientation, relationship status (single, married, in a committed relationship, divorced, other), and class standing (Freshman, Sophomore, Junior, Senior, other).

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, and from non-patients. The BSL is a 23-item self-report measure. Participants respond to item 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". Cronbach's alpha for the total score is α = 0.97. The test-retest reliability after one week is r = 0.82. The alpha obtained for the current study was 0.96.

Emotion regulation was measured using the Difficulties in Emotion Regulation Scale (DERS) (Gratz & Roemer, 2004). 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". The DERS has good internal consistency with Cronbach's alpha at 0.93. Over a period of four to eight weeks, the DERS has good test-retest reliability with $\rho = 0.88$. The alpha obtained for the current study was 0.94

Self-compassion was measured using the Self-Compassion Scale (SCS) (Neff, 2003a). The SCS measures psychological well-being in the form of 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 overall internal consistency is 0.92. The SCS has good test-retest reliability (0.91). The alpha obtained for the current study was 0.92. Internal consistencies for each of the six subscales were calculated as well. The following alphas were obtained: self-kindness = 0.80; self-judgment = 0.79; common humanity = 0.79; isolation = 0.77; mindfulness = 0.74; over-identified = 0.76.

Invalidating childhood experiences were measured using the Parental-Acceptance-Rejection Questionnaire Short Form (PARQ Adult) (Rohner & Ali, 2016). The PARQ Adult is a self-report test that measures adults' retrospective memories of the extent to which they experienced parental acceptance or rejection in childhood. Participants respond to questions on a four-point, Likert scale (1=almost never true to 4=almost always true) separately for their mother and father figures. The psychometric properties have been reported to be good, with a reliability alpha of 0.95**.** The alpha

obtained for this study for the mother-figure was 0.96, and the alpha obtained for father-figure was 0.96. The heteronormative nature and dual-parent assumptions of this measure should be noted. That is, it is limited by its assumption that respondents will have grown up with a mother and father figure. This measure was chosen, however, because the four subscales of invalidation are relevant to Linehan's (1993) conceptualization of invalidating environments: perceived lack of warmth and affection; perceived hostility and aggression; perceived indifference and neglect; and perceived undifferentiated rejection.

Fear of compassion from others was measured using scale two of the Fear of Compassion Scale: Responding to the Expression of Compassion from Others (Paul Gilbert et al., 2011). Participants respond to 13 items in a similar likert scale to Scale 3. An example from this measure includes, "Feelings of kindness from others are somehow frightening." Cronbach's alpha was reported to be good, at 0.87 (Gilbert et al., 2011). The alpha obtained for the current study was 0.91.

Fear of compassion for self was measured using scale three of the Fear of Compassion Scale: Expressing Kindness and Compassion for Yourself (Gilbert et al., 2011). This scale includes 15 items assessing the extent to which one agrees with statements about expressing kindness and compassion towards the self. Responses reflect a likert scale from 0=Don't agree at all, to 4=Completely agree. An example includes, "When I try and feel kind and warm to myself I just feel kind of empty." Cronbach's alpha was reported at 0.92 (Gilbert et al., 2011). This sub-scale had good internal consistency with Cronbach's alpha at 0.85. The alpha obtained for the current study was 0.93.

Procedure

Undergraduate students signed up through the University of Montana SONA system for online completion of the study during the Fall, 2017 and Spring, 2018 semesters. The purpose of the study was described as the following: "…to learn about self-attitudes, childhood experiences, and emotional experiences and expression." Participants who signed up for the online study through SONA were directed to Qualtrics web-based survey software, and were first given the opportunity to review and sign the informed consent (see Appendix A). When consent was given, participants were presented with a demographics questionnaire first, followed by the PARQ, SCS, FCS-from others, FCS-self, DERS, and BSL measures, in this order (see appendices A-H). Upon completion, participants were debriefed electronically, and were provided referral information for local services and national hotlines (see Appendix I).

Analysis

Statistical analyses were carried out using IBM® SPSS® Statistics, version 25. The PROCESS Macro for SPSS (Hayes, 2013) using Model 4 was used to carry out mediation analyses. Correlations were conducted to test the hypothesized relationships between all variables. All analyses employed 2-tailed hypotheses.

Mediation analyses were conducted to test the hypotheses that self-compassion, fear of compassion for self, and fear of compassion from others mediate the relationship between childhood invalidation and emotion dysregulation, as well as childhood invalidation and BPD characteristics. Self-compassion (SCS), fear of compassion from others (FCS-others), and fear of compassion for self (FCS-self) were simultaneously

entered as parallel mediators in the relationships between invalidation and emotion dysregulation and with invalidation and BPD characteristics.

Four separate models were tested. In the first model, parental invalidation from parent-figures (PARQ-mother/father) was entered as a predictor variable. Next, the three mediator variables (SCS, FCS-self, FCS-other) were entered. Finally, the criterion variable, emotion dysregulation (DERS) was entered. For the second model, these same variables were analyzed similarly but the criterion variable, emotion dysregulation (DERS), was replaced with the second criterion variable of interest, BPD characteristics (BSL). Bootstrapping was generated to represent the sampling distribution of the indirect effect. For each model, 10,000 bootstrap confidence intervals were generated (Hayes, 2013). For exploratory purposes, the six subscales of the self-compassion scale were entered as parallel mediators in the relationships between invalidation with emotion dysregulation (model 3) and invalidation with BPD characteristics (model 4).

Results

The questionnaire used to measure childhood invalidation – the Parental Acceptance Rejection Questionnaire (PARQ) – yielded two separate responses for a participant's perception of their mother-figure and father-figure. For the purposes of this study, the responses for each parent-figure were averaged to yield one score that represents invalidation experienced by primary caregivers in childhood. Further, participants that grew up within single-parent households completed information about another prominent figure in their lives, regardless of whether they were in the same household.

Descriptive statistics. Seventy-two percent of the sample identified as "female," 28% identified as "male," one person identified as "other," and one person did not provide a response. The mean age was 21.7 (*SD*= 6.2). Eighty-seven percent of participants identified as "heterosexual/straight" and six percent identified as "bisexual." Eighty percent of the sample identified as "Non-Hispanic White," and seven percent identified as "Mixed Race or Other." Fifty percent of the sample indicated that they were Freshmen, and 30% indicated that they were Sophomores. Full demographic results can be found in Table 1.

[Insert table 1 here]

Transformations. Data for the variables that measured childhood invalidation and BPD characteristics were positively skewed (e.g., PARQ-mother/father skewness = 1.013; and BSL skewness = 1.431), and were therefore transformed. PARQ-mother/father was logarithmically transformed, while the BSL was square root transformed. These transformations reduced the skewness to approximate a more normal distribution (e.g., PARQ-mother/father = 0.531 skewness; and BSL = 0.397 skewness). These transformed variables were used in regression analyses. Descriptive statistics for all variables can be found in Table 2.

[Insert table 2 here]

Correlations. All variables were correlated with one another using 2-tailed tests for bivariate correlations. All correlations resulted in statistically significant relationships at the $p < 0.01$ level, and in the expected directions. For example, mother/father-figure invalidation (PARQ-mother/father) was positively associated with fear of compassion from others (FCS-others), fear of compassion for self (FCS-self), emotion dysregulation

(DERS), and BPD characteristics (BSL). Mother/father-figure invalidation was negatively associated with self-compassion (SCS). Correlations between all variables are presented in Table 3.

[Insert table 3 here]

Testing mediation using path analysis.

Model 1. In model 1, self-compassion, fear of compassion from others, and fear of compassion for self were tested as mediators in the relationship between childhood invalidation and emotion dysregulation. Results from a parallel mediation indicated that self-compassion and fear of compassion for self were indirectly related to emotion dysregulation through their relationships with the childhood invalidation. That is, they served as mediators. The model did not support fear of compassion from others serving as a mediator in this relationship.

First, invalidation from parent-figures significantly predicted mediators - self-compassion ($R^2 = 0.125$, $\beta = -1.73$, $p < 0.001$), fear of compassion from others ($R^2 = 0.173$, $\beta = 40.44$, $p < 0.001$), and fear of compassion for self ($R^2 = 0.117$, $\beta = 26.88$, $p < 0.001$). Second, the total effect, which includes the predictor and mediator variables predicting the criterion variable was significant ($p < 0.001$). Third, the direct effect, which is the effect of the predictor variable on the criterion variable, while controlling for mediator variables was no longer significant ($p = 0.439$). Fourth, to test the indirect effect (the effect through the mediator), a 95% confidence interval was generated using 10,000 bootstrap samples. The confidence interval for self-compassion (0.125 to 2.59) and fear of compassion for self (0.048 to 0.151) were significantly different than zero, therefore indirectly influencing the relationship. Fear of compassion from others (-0.016 to 0.091)

was not significantly different than zero, and therefore did not indirectly influence the relationship. Please note that the completely standardized confidence intervals were interpreted. See Figure 1 for the effects associated with these pathways.

[Insert figure 1 here]

Model 2. In model 2, self-compassion, fear of compassion from others, and fear of compassion for self were tested as mediators in the relationship between childhood invalidation and BPD characteristics. Results indicated that self-compassion, fear of compassion for others, and fear of compassion for self were indirectly related to emotion dysregulation and BPD characteristics through their relationship with the childhood invalidation. That is, they served as mediators.

First, as is the same from the previous model, invalidation from parent-figures significantly predicted mediators - self-compassion ($R^2 = 0.125$, $\beta = -1.73$, $p < 0.001$), fear of compassion from others ($R^2 = 0.173$, $\beta = 40.44$, $p < 0.001$), and fear of compassion for self ($R^2 = 0.117$, $\beta = 26.88$, $p < 0.001$). Second, the total effect was significant ($p < 0.001$). Third, the direct effect was no longer significant ($p = 0.0864$). Fourth, the 95% confidence interval that was generated using 10,000 bootstrap samples provided evidence that self-compassion was significantly different than zero (0.052 to 0.161), as was fear of compassion for self (0.037 to 0.113), as well as fear of compassion from others (0.056 to 0.179), and therefore indirectly influenced the relationship. Again, these reflect the completely standardized indirect effect. See Figure 2 for the effects associated with these pathways.

[Insert figure 2 here]

Model 3 – Exploratory analysis. In model 3, subscales of the self-compassion scale – self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identified - were tested as parallel mediators in the relationship between childhood invalidation and emotion dysregulation. Results indicated that subscales - isolation and over-identified - were indirectly related to emotion dysregulation through their relationship with the childhood invalidation, and thus served as mediators.

The completely standardized 95% confidence interval that was generated using 10,000 bootstrap samples provided evidence to support that mediation occurred. For example, the confidence interval for isolation was significantly different than zero (0.035 to 0.147). The confidence interval for over-identified was also significantly different than zero (0.054 to 0.167). See Figure 3 for the effects associated with these pathways.

[Insert figure 3 here]

Model 4 – Exploratory analysis. In model 4, subscales of the self-compassion scale – self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identified - were tested as parallel mediators in the relationship between childhood invalidation and BPD characteristics. Results indicated that subscales - self-judgment and isolation - were indirectly related to BPD characteristics through their relationship with childhood invalidation, and thus served as mediators.

The completely standardized 95% confidence interval that was generated using 10,000 bootstrap samples provided evidence to support that mediation occurred. For example, the confidence interval for self-judgment was significantly different than zero (0.004 to 0.125). The confidence interval for over-identified was also significantly

different than zero (0.010 to 0.114). See Figure 4 for the effects associated with these pathways.

[Insert figure 4 here]

Discussion

The purpose of this study was to better understand the roles of self-compassion and fear of compassion in the relationships between childhood invalidation and emotion dysregulation with BPD characteristics. Difficulties in regulating emotions are a component of many psychological disorders. In the case of BPD, emotion dysregulation is considered a core component (Linehan, 1993). Those with BPD are also considered a difficult-to-treat population because they often engage in ineffective, maladaptive, and problematic methods of regulating their intense emotions.

A prominent theory of emotion dysregulation within BPD is that it arises from the transaction between emotional vulnerabilities and invalidation over time (Linehan, 1993). These emotional vulnerabilities manifest as high sensitivity to emotional stimuli, high reactivity during emotional experiences, and a slow return to emotional baseline. Invalidation occurs when one's private experiences and/or overt expression of emotions are punished, dismissed, or otherwise treated as unacceptable (Linehan, 1993). Recently, there has been growth in the area of understanding the psychological benefits of practicing self-compassion; however, self-compassion and fear of compassion have not been explicitly examined in those with intense emotion dysregulation or BPD characteristics who have experienced childhood invalidation. The current study addresses this gap in the research.

In sum, the results of this study support the notion that self-compassion and fear of compassion play roles in the link between childhood invalidation with emotion dysregulation and with BPD characteristics. More specifically, self-compassion and fear of compassion for self were found to have an indirect influence on the relationship between childhood invalidation and emotion dysregulation. Further, self-compassion, fear of compassion from others, and fear of compassion for self were found to indirectly influence the relationship between childhood invalidation and BPD characteristics. Keeping in mind that causality cannot be assumed, these compassion-related variables may be understood as "third variables," or mediator variables, in these relationships. Fear of compassion from others did not serve as a mediator in the relationship between childhood invalidation and emotion dysregulation. The results also indicated that childhood invalidation predicts one's level of self-compassion and fears of compassion. Further, one's level of self-compassion and fears of compassion can be understood as mechanisms for how childhood invalidation, emotion dysregulation, and BPD characteristics relate to one another. These findings will be discussed in greater detail as follows.

Self-compassion. Linehan's (1993) biosocial theory indicates that the transaction of emotional vulnerabilities and invalidation over time explain the development of BPD symptoms, but there appear to be certain mechanisms by which this occurs. Having low levels or an absence of self-compassion appears to be one mechanism. If a person's family communicated pervasively that they were unworthy, pathological, bad, for example, that person may start to adopt these views and blame and criticize themself in response to hardships, rather than responding with self-compassion. They learn to self-

invalidate similarly to the ways in which they experienced invalidation. Often, this self-invalidation does not leave much room for the person to also be self-compassionate.

Those who came from invalidating backgrounds likely never had self-compassion modeled for them (Neff & McGehee, 2010). This may have been because their developmental environment lacked the skills to be self-compassionate, or because it was not adequately modeled by their own families earlier in life. Alternatively, a person may have been punished for responding with any self-kindness, as invalidating families may view self-compassion as a weakness, unacceptable, or useless (Neff, 2012). For example, if a child was teased by peers at school and expressed sadness about this to an invalidating parent, the parent may have communicated that they should "quit feeling sorry for [them]self," as opposed to a response that supports self-compassion, e.g., "It's hard to get teased. It makes sense that you feel sad. Lots of kids get teased and they feel bad when that happens." The former response communicates that one should not take one's painful feelings seriously or have compassion for one's self in such situations. Further, if the person learned self-compassion, they may have never attempted it because they learned that their inner thoughts and feelings or overt behaviors were wrong, and/or that they would be unworthy of it. Or, they may have adopted similar views of their invalidating environment, such as regarding self-compassion as a weakness, unacceptable, or useless.

Some people who experienced invalidating environments may still be able to develop a capacity for self-compassion. In this situation, it may be the case that other significant people in their lives, such as grandparents, teachers, friends, or other positive role models provided compassion and/or modeled self-compassion. Perhaps it was not

until late childhood or early adulthood, when the invalidating environment was not the only and/or main influence that the person was able to adopt and maintain a self-compassionate stance. This is in line with ideas of attachment behavior; caring behaviors of the parent soothes the infant. (Gilbert, 2010). Some people may be more resilient or have a stronger sense of self, and be able to respond to themselves with compassion even if this behavior was punished by the environment. They may have engaged in self-compassion as protection from the invalidating treatment from their environment. They also may have used more covert, as opposed to overt, forms of self-compassion in order to avoid punishment for this behavior.

Responding with self-compassion during hardship appears to reduce the likelihood that a person will become frequently dysregulated or develop BPD symptoms. Many people with BPD avoid their emotional experiences or they employ ineffective, maladaptive strategies to regulate their emotions (Linehan, 1993). For example, sometimes a symptom, such as self-harm, happens in the context of intense self-loathing. This self-loathing could arise in the context of making a mistake or failure. Self-punishment is among the reasons that people with BPD self-harm (Gratz, 2003). Being able to respond to one's self with self-compassion instead of self-loathing in the face of mistakes may decrease the likelihood of engaging in self-harm for purposes of self-punishment.

Sometimes people with BPD self-harm so that they may experience relief from their intense distress and negative emotions (Gratz, 2003; Klonsky, 2007). Practicing self-compassion may be an effective and adaptive way to relieve distress and negative emotions because it may help the person enter into a more positive state. Further, some

people self-harm so that they can feel something, as opposed to feeling numb or dissociated (Klonsky, 2007). The mindfulness component of self-compassion may serve to keep one from feeling numb or dissociated, as it requires a willingness to observe unwanted thoughts and experience a range of emotions.

Fear of Compassion for Self. Having fear of compassion for self mediated the relationship between childhood invalidation with emotion dysregulation as well as with BPD characteristics. This extends beyond the idea that simply lacking self-compassion or having low levels of self-compassion may be an indirect influence on emotion dysregulation and BPD characteristics. Having an active fear or resistance to self-compassion may also be an indirect influence.

As mentioned above, those who have had invalidating environments may have been punished for any self-compassionate behavior. Though, rather than the punishment serving to simply eliminate the behavior, it may have also created a fear of being self-compassionate. For example, this may be seen in the example above where the child is teased by peers: An invalidating parent may further convey that "quit crying, you're just going to get teased worse" or "I'll give you something to cry about." These responses indicate to the child that acknowledging painful emotions in a self-compassionate way may lead to worse punishment or bad outcomes, creating fear in addition to punishing the self-compassionate response. Some environments may have punished this behavior with the intent to instill fear. For example, this may be the case for environments that used fear as a form of psychological abuse. Environments that use corporal punishment or the threat of it as forms of punishment, often invoke fear and anxiety in children (Gershoff, 2002).

For people whose typical stance is having feelings of self-hatred and shame, extending self-compassion may seem threatening, as it conflicts with this sense of self. According to Erikson (1980), identity development is a life-long process, though we often have experiences that challenge our sense of identity. We respond by seeking information that confirms our identity, or we change our sense of identity (Erikson, 1980). Incorporating a new and drastically different response may be emotionally dysregulating for some. Trying to reconcile such disparate ideas, for example, of being worthy of self-hatred or worthy of self-compassion, may also contribute to identity disturbance, or instability in sense of self. Kernberg (1975) described identity diffusion in those with BPD as the inability to integrate positive and negative representations of self. Further, this may be particularly salient for those who employ black-and-white or either-or thinking styles. That is, they may feel that it is impossible to be both self-hating and self-compassionate. Whether this is phenomenologically possible is a theoretical question, however, this rigid form of thinking may prevent one from incorporating self-compassion, or to be fearful of it, because they do not have the cognitive skill set to think dialectically.

In terms of clinical implications, those who have an active fear or resistance to self-compassion may struggle with treatments designed to increase the practice of self-compassion (Gilbert and Proctor, 2006). In order to practice and incorporate self-compassion into one's life, one may need to first address and allay the fear that practicing it elicits. Some clients may be turned off by, or become dysregulated by a therapist's suggestion to be self-compassionate. As an example, a therapist may say the following to their client who constantly compares themself to others and is overly critical when it

comes to their performance in a race they lost; “I can see how badly you feel about this because you have really been practicing hard. I think now would be a good opportunity for you to practice self-compassion because although you didn’t win the race, your time has really improved since your last race. To practice, you might tell yourself something like, given that you just started running this year, you’ve come a long way, and your hard work reflects that. You can see both your strengths and areas to improve.” A client who is fearful about being self-compassionate may respond with, “If I really was doing well I wouldn’t have lost the race, and I don’t think your suggestion is helpful. Why would I be happy with losing? Clearly I wasn’t practicing hard enough. I must be too lazy and slow and being nice to myself is only going to make me think that this is acceptable, and it’s not.” This client has harsh self-criticism, perfectionism and extreme thinking, but also fears that being self-compassionate will not help them to “succeed” in the way they believe it will.

For some people, the function of fearing or disregarding self-compassion is to avoid unwanted or painful experiences, or to avoid embodying unwanted or disliked qualities. For example, some people believe that practicing self-compassion means that they are being self-indulgent, and they tend to believe that being self-critical is the only way for them to become motivated (Neff, 2012). Others may be self-critical in order to engage in action. For example, a commonly seen behavior within Western cultures is stigmatizing larger bodies to promote a culture of diet and exercise. This, though, appears to have the opposite effect, in that it does not promote engaging in diet and exercise (Vartanian, Pinkus, & Smyth, 2016). Other people think that if they respond with self-compassion they will become lazy, and that they will not be productive or get things

done. This may be particularly salient for people who are dysregulated and/or impulsive. People who have difficulty controlling their own behavior may think that if they respond with self-compassion, they will become even less likely to be able to function. For example, if a person gets criticized at work, they may believe that if they extend self-kindness they will get more sad and upset, as well as fear that they will not get their work done. If they criticize and admonish themselves, they may believe that this will help them to stay on task and keep working.

Other people find self-compassion to be a weakness because they fear they will not hold themselves accountable for their infractions (Gilbert & Proctor, 2006). Some find self-compassion to be dangerous because it makes them feel vulnerable. For example, Gilbert and Proctor (2006) found that one member who participated in their group therapy study that was designed to increase self-compassion said that it felt as though compassion for self would "let one's guard down" (p. 371). Other people in this study found that practicing self-compassion led to feeling anxious. Gilbert and Proctor (2006) theorized that this conditioned response of anxiety occurred because at one time they allowed others to care for them, and this was followed by abuse or rejection.

Some people who experience early invalidating environments may not develop a fear of self-compassion. Similar factors that allowed one to develop self-compassion, as mentioned above, may have also prevented the development of this fear of compassion for self. For example, they may have had good relationships with significant others outside of their invalidating environment that provided compassion and/or modeled self-compassion. They may have been resilient in such a way that they overcame their fear of self-compassion, or never developed the fear to begin with. Further, the invalidating

environment may have punished self-compassionate behavior, but this punishment did not instill a fear of compassion. For example, perhaps the invalidating environment conveyed the practice of self-compassion to be silly or useless, but did not inflict fear or severe punishment when/if the person engaged in it.

Being open to self-compassion, rather than fearing it, may decrease the likelihood of developing emotion dysregulation and BPD characteristics. As mentioned, self-hatred, self-criticism, shame, and seeing oneself as inherently bad or evil are common experiences among those with BPD. These feelings also typically contribute to emotion dysregulation, which often leads to problematic, harmful, and/or self-injurious behavior (Xavier, Pinto Gouveia, & Cunha, 2016). Alleviating or removing the fear of compassion for self may open up the possibility that one can be self-compassionate without it leading to negative consequences. In particular, removal of the fear may increase the likelihood that the person may engage in self-compassion, and gain the psychological benefits of the practice. Attenuating or removing fear of compassion for self may also help with self-regulation by changing levels of stress hormones and neurotransmitters (e.g., cortisol and norepinephrine) that are associated with fear (Steimer, 2002; Stockhorst & Antov, 2016). Future research may examine how a reduction in this fear would affect one's ability to incorporate self-compassion to help regulate their emotions. For example, being relieved of this fear may change one's automatic fear response to a more thoughtful and less impulsive way of responding. Further, alleviating a fear of compassion may allow the person the opportunity to learn that they do not need to rely on harmful approaches (e.g., self-criticism, shame, etc.) in order to be motivated and be productive. As mentioned above, some people think that being self-compassionate is self-indulgent or will make

them lazy or unaccountable (Gilbert & Proctor, 2006; Neff, 2012). They may be more effective in their emotion dysregulation, interactions with others, and goal-directed pursuits if the fear of compassion for self is no longer a factor or hindrance.

Fear of Compassion from Others. Fear of compassion from others mediated the relationship between childhood invalidation and BPD characteristics, but not the relationship between childhood invalidation and emotion dysregulation. In general, people benefit from and need to feel compassion from others. Care and affection are primal needs that are necessary for the development of attachment (Bowlby, 1969). Receiving compassion from others, however, may be challenging for those who have experienced severe invalidation and abuse in childhood. Receiving compassion from others may be feared because this novel concept in their life is not understood. It is hypothesized that it may be disruptive and dysregulating to their sense of self and/or their beliefs about how they are perceived by others (Erikson, 1980). For example, many people with BPD believe that they are "evil" or "unlovable" (APA, 2013), and receiving compassion from others may be confusing and conflicting with this idea of self. As a consequence, receiving compassion from others may not have its well-intended effects.

Those with BPD are often characterized by their interpersonal difficulties (APA, 2013), and this makes sense in the context of experiencing invalidation and/or abuse. That is, their invalidation and/or insecure attachments in childhood may have influenced their choice of significant others or friends in adulthood such that they end up in further destructive relationships (Clarkin, Yeomans, & Kernberg, 2007; Fonagy & Bateman, 2008). Whether they engage with validating or invalidating others, they may seek out ways to have their needs met that are problematic and ineffective in nature, and often this

is the case for those with BPD. For example, many people with BPD who are not skillful with respect to emotion regulation, distress tolerance, and interpersonal effectiveness threaten to harm themselves or become impulsive after a hurtful interaction with a friend, family member, partner, and/or therapist. This way of interacting is often one explanation for their generally unstable and tumultuous relationships. Some people seek validation, care, and compassion from others to help them regulate their emotions. Given a history of invalidation, receiving compassion from others may be both desperately desired and intensely feared. Further, because people with BPD often lack the ability to regulate themselves, and assistance with regulation from others can be very powerful, they end up engaging in extreme behavior, the function of which may be to get that help with regulation.

Some people with BPD are also characterized by their anger and/or aggression towards others (APA, 2013). Treating professionals who work with this population may be on the receiving end of this emotion and behavior. Counterintuitively, this response may be in the context of treating professionals extending compassion, and that may be because the person actually fears it. It would be important to know if the person misunderstands and misinterprets the compassion that they receive and then feels invalidated by it, or it if it inadvertently increases negative emotional arousal. Some people who have backgrounds of invalidation may have received compassion at times, only to feel manipulated by it, and/or later be punished, feel abused, and/or see receiving compassion as an unpredictable response (Gilbert & Proctor, 2006).

It may be the case that fear of compassion from others did not mediate the relationship between childhood invalidation and emotion dysregulation, while it did when

predicting BPD characteristics, for a reason that is relational in nature. The measure that was used to assess BPD characteristics (Bohus et al., 2009) in the present study included several items that were relational (e.g., "I didn't trust other people," "I was lonely," "I suffered from shame," and "criticism had a devastating effect on me"). The measure used for assessing emotion dysregulation does not ask for difficulties in regulating emotions in the context of relationships with others. There may be a subset of people who have difficulty regulating their emotions, and who do not endorse having characteristics of BPD, whose fear of compassion from others is not as extreme as those who endorse BPD characteristics. In other words, it may be that for those who also endorse having BPD characteristics, receiving compassion elicits a stronger fear than for those who suffer from emotion dysregulation alone. Taken together, what these results suggest is that perhaps cultivating a means of accepting compassion from others can help alleviate the painful and maladaptive characteristics that so many people with BPD symptoms have.

It may be that BPD characteristics represent a more severe form of emotion dysregulation. The same people whose emotion dysregulation leads to BPD characteristics may be also likely to fear compassion from others. Fearing compassion from others seems particularly problematic, perhaps even more so than not having compassion for self. The fear of compassion from others could be representative of a general distrust of others. This may be because people in their lives who may have been compassionate at times may have also been abusive and punitive at other times Gilbert et al., 2014). As a result, compassion from others cannot be counted on, expected, or trusted. Fearing compassion from others may lead to a greater sense of isolation. Not only does the person potentially feel bad about themselves, but they cannot even trust and

receive care from others. This could be one of the factors that drives a person from simply being dysregulated to actually developing characteristics of BPD.

The results of the current study are consistent with the idea that childhood invalidation is often associated with emotion dysregulation and BPD characteristics. Further, one's ability to respond with self-compassion, their fears about self-compassion, and/or their fears about receiving compassion from others can partially explain this pathway.

Exploratory findings. Of the six subscales that compose the self-compassion scale – two scales, *isolation and over-identified* – were found to be mediators in the relationship between childhood invalidation and emotion dysregulation. The *isolated* subscale measures the extent to which one separates their experience from the larger human experience. Specifically, one sees one's suffering as due to one's own unique inadequacy and deficiencies, rather than as part of a universal human experience. Mistakes or flaws are seen in a pathologizing, as opposed to a normative manner. The *over-identified* subscale measures the extent to which a person over-identifies with their painful thoughts and feelings, rather than maintaining some balance and viewing them within a larger perspective. For example, when not over-identified, one is able to step back and notice thoughts or feelings, rather than being controlled by them. The self-compassion subscales - *self-judgment and isolation* – served as mediators in the relationship between childhood invalidation and BPD characteristics. The *self-judgment* subscale measures the extent to which a person is harsh and critical in the aftermath of failure, as well as the extent to which one ignores pain and suffering.

Isolation. The commonality between both tested pathways described above is that the *isolation* subscale served as a mediator. In an isolating approach, one sees mistakes, failures, and distress as unique to them, rather than experiences all humans share. The feeling that one is "inherently flawed" may be intensified if they also believe that they are alone in their difficult experience. When one makes mistakes or fails, they feel disconnected from others because they believe that no one else makes mistakes or fails (Neff, 2003a). Neff (2012) hypothesizes that within an isolating approach, people develop "tunnel-vision" such that they see their flaws as uniquely theirs, and the reality that everyone else also makes mistakes is not considered or is missed. People with this perspective assume that everyone else seems to be "perfect" and are without inadequacies.

Responding to difficulties from an "isolating" perspective may increase feelings of shame. Shame is a central emotion in BPD (Rüsch et al., 2007), and this makes sense given the experience of receiving pervasive invalidation. People with BPD tend to experience shame in higher levels in response to negative evaluations, for example, compared to those without BPD (Gratz, Rosenthal, Tull, Lejuez, & Gunderson, 2010). Shame often leads to behaviors such as avoidance, hiding, and escape (Rüsch et al., 2007). These particular behaviors may compound one's feelings of isolation. Having a shared experience with others may reduce shame. Participants in a Compassionate Mind Training indicated that sharing their feelings of isolation and fear that they felt throughout their lives and during abuse with other participants was important to them. Participants also found validation of their grief to be important (Gilbert & Proctor, 2006).

A reliably strong predictor of suicide is social isolation (Van Orden et al., 2010; Joiner, Van Orden, Witte, Selby, & Ribeiro, 2009). According to the interpersonal-psychological theory of suicidal behavior (Joiner, 2005), the combination of being a perceived burden on others and feeling socially alienated/not belonging predict suicide. When one has a low sense of belonging, they do not feel valued by others, and do not feel part of a group. People who engage in an isolated perspective in the context of self-compassion may have trouble finding commonalities with others, seeing themselves as uniquely flawed. Further, their feelings of shame may be so high that they avoid seeking out others. Feelings of isolation seem especially important to target within treatment, as those with BPD have high rates of completed suicide, and high suicidal ideation, desires, and attempts (APA, 2013).

Feelings of isolation may capture elements of both self-judgment (I am bad) and a lack of common humanity (my badness separates me from other people). It is hypothesized that invalidating environments may lead one to feeling isolated. Specific communications, such as saying "there is something wrong with *you*" and experiences, such as consistently being singled out and/or punished, could lead to the development of isolated feelings. In extreme forms of invalidation, such as sexual abuse, many survivors are told by their abuser that they are bad and at fault for their abuse. Some people blame themselves for their abuse as a way to gain control or try to make sense of something incomprehensible. That is, they believe that they must be bad or have done something wrong to deserve the abuse they received. Some people have no support or safe place to talk about their abuse, because they are either blamed by others or do not feel that there is anyone they can tell. From this, they often feel that they are uniquely damaged, at fault,

alone, and some do not learn until later in life that many people experience sexual abuse and it is not their fault.

Another type of invalidation that may lead to an isolating perspective is emotional abuse that involves frequent, direct, intense criticism; communications such as "you are horrible, no one is as bad as you." For some people, there may have been an imbalance in the way that they were treated compared to their siblings. For example, they may have been punished more severely such that they came to feel as though they were uniquely bad. Some families may explicitly "pick on" one member of the family. Some people may feel singled out within their family because their emotional experience is disparate from the rest of the family and the family cannot understand them. All of these experiences could lead to the development of an "isolated" perspective regarding self-compassion, and ultimately an increase in dysregulation and BPD symptoms.

Over-identified. Results of the current study suggest that, in the context of a history of invalidation, the tendency to over-identify with one's emotions is associated with greater emotion dysregulation. Over-identifying with thoughts and emotions may make it particularly difficult to regulate emotions. For example, research has demonstrated that simply labeling one's emotions tends to reduce the intensity of the emotions (see Brooks et al., 2017). When a person is over-identified with an emotion, they are likely to be less able to step back and label the emotion. For example, they may not be able to describe "My anger just got much more intense." In addition to the direct effects of stepping back and labeling emotions, this is often a first step in the process of regulation. For example, being aware that one is experiencing anxiety and labeling it as such can lead to more

targeted emotion regulation behaviors. After recognizing that one is experiencing anxiety, they may engage in breathing or other relaxation techniques.

Early invalidation may lead to a person feeling over-identified with their emotions. When early environments provide validation, the child feels comforted, learns that they can rely on the environment to help them cope with their distress, and learn how to understand, express, and regulate their emotions (Buckholdt et al., 2014). Validation can have a calming effect, which puts the person in a better position to step back and label and understand their emotional experience.

Self-judgment. Self-judgment may have served as a mediator because it is related to the common feelings of shame and self-hatred that many people with BPD have. Many people who have experienced invalidating environments in childhood learn to self-invalidate later in life. For some, self-invalidation may manifest in the form of self-judgment. Those who view themselves so harshly also believe that they are inherently bad. Some who believe that they are bad also believe that they deserve to be punished, and will engage in deliberate self-harm as a form of punishment. The feelings of being bad may dominate such that they believe that they are unworthy of self-compassion. Similarly, extending self-compassion may not be easy or considered an option for those who believe that they are "unlovable." It is likely that the forms of self-judgment that the person has resemble the type of invalidating judgment they received in childhood. For example, if one's motives were judged to be manipulative, aggressive, lazy, etc., they may see their failures in a similar light, and do not respond with forgiveness and kindness. Further, some develop harsh and extreme views of self in the aftermath of trauma, which many, though not all people, with BPD experience.

Practicing non-judgment is central in Dialectical Behavior Therapy (DBT), a treatment with demonstrated efficacy and effectiveness for emotion dysregulation and behaviors associated with BPD. Specifically, participants within this treatment engage in one of DBT's main modes of therapy, which is Skills Training. Within Skills Training, participants learn the practice of Mindfulness; the Mindfulness skill *nonjudgmentally* is a fundamental skill (Lynch, Trost, Salsman, & Linehan, 2007).

Implications. The results of this study suggest that addressing self-compassion, fear of compassion from others, and fear of compassion for self may be helpful in reducing emotion dysregulation and characteristics of BPD. There are therapeutic interventions that target the practice of self-compassion, and the fear of compassion. For instance, Neff and Germer (2013) have developed an 8-week Mindful Self-Compassion (MSC) training. For their pilot study of MSC, participants were adults recruited from the community. MSC has been shown to increase self-compassion, mindfulness and well-being, as well as reduce stress, depression, and anxiety. This training has expanded to many other formats, such as an in-person course, workshop, and online training, among others. Each week of the program focuses on a different topic, such as an introduction to self-compassion and mindfulness, application of self-compassion in life, and how to develop an inner compassionate voice, among others. Gilbert and Proctor (2006) have developed Compassionate Mind Training, which is a group therapeutic approach for people with high shame and self-criticism. This approach consists of exploring the nature of self-criticism, introducing the idea of self-compassion, exploring the fears of developing compassion, and exploring the nature of self-attacking. In one study that explored this within a group therapy format, participants had reduced depression, anxiety, self-

criticism, shame, inferiority, and submissive behavior at the end of 12 sessions (Gilbert and Proctor, 2006).

Having a fear of compassion from others may serve as a barrier in treatment (Gilbert and Proctor, 2006). It is possible that the typical warm and compassionate stance that therapists generally adopt in relating to their clients elicits fear for some, so much so that therapy may be avoided or other treatment interventions become less effective. Therefore, therapists may want to approach the therapeutic relationship somewhat differently with clients who seem to exhibit a lot of fear of compassion. This may involve the therapist being very aware of the fear of compassion, engaging non-judgmentally but with perhaps with less overt cues that might set off the fear, and increasing expressions of compassion over the course of treatment. With some clients this may mean employing a more matter-of-fact approach, which would not include as many overtly compassionate statements such as, "I am so sorry that happened to you, that sounds terrible!"

Treatments that specifically target and reduce fears may be helpful to incorporate into treatment with people who have emotion dysregulation/BPD, and who have fears of compassion from others. For example, exposure-based therapies are highly effective in treating phobias and trauma. Using an exposure-based approach with compassion may help to reduce this barrier and increase overall treatment effectiveness. In line with the principles of exposure-based therapies, the therapist and client might determine the function that fear of compassion has in the client's ability to progress in therapy. Further, as an in-vivo form of exposure, the therapist may offer compassion to the client in a graduated manner during sessions. Alternatively, the client may identify opportunities to receive compassion from others with varying intensity outside of the therapy.

One of the main treatments for emotion dysregulation and BPD symptoms is DBT. This complex treatment has elements within it that are similar to the constructs examined within this study. For example, mindfulness skills are 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, 2015). This practice is aimed at increasing love and compassion towards the self, as well as others. 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 practice, and it may be useful to include in DBT treatment as well, potentially as an adjunct to the mindfulness module. As mentioned above, the mindfulness skill, nonjudgmental stance, addresses self-judgments in an effort to reduce them. There is a skill within the emotion regulation module called "check the facts" that is often applied to self-judgments. Further, there are validation skills within the interpersonal effectiveness module that have an emphasis on learning to recognize self-invalidation and replace it with self-validation (Linehan, 2015).

A central practice within DBT is to provide validation to clients whenever possible. There are six ways or "levels" of expressing validation. A "level 5" validation communicates to the person that their emotional or behavioral response is normative and a response that any person would have (Linehan, 1993). This type of responding may be thought of as similar to having a perspective of *common humanity*, by communicating to the person that their response is shared by others. This type of perspective would be the opposite of the *isolating* perspective. This level of validation is meant to counteract effects of the invalidating environment, as well as reinforce normative responding. Given

that *isolation* mediated the relationship between childhood invalidation with both emotion dysregulation and BPD characteristics makes sense within a DBT perspective, and supports the importance of level 5 validation, which is a central DBT intervention.

Level 6 validation, "radical genuineness," is meant to communicate that the therapist is relating with authenticity, person-to-person, and without a "therapeutic mask" (Linehan, 2015). People with BPD are often seen as "different," or "scary" and are avoided or rejected because of it. This rejection may serve to reinforce one's isolating view. Radical genuineness is meant to counter that experience, to create a genuine human connection where the communication is "you are worthy of care and I am with you as a real person."

DBT therapists may also target feelings of isolation by emphasizing that DBT is "a community of therapists treating a community of clients" throughout therapy. This may help clients to feel a part of something larger, and see that others struggle similarly in life. The self-disclosure component of DBT is also designed, in part, to normalize the idea that everyone struggles with emotions and that even therapists need skills to help address their own emotions (Linehan, 1993).

Limitations. Several limitations of this study are important to note. The study employed a college student sample; thus, people who have never gone to college are not represented. In addition, the sample was fairly homogenous in terms of demographics (e.g., primarily women, non-Hispanic European-American, heterosexual, and in their early 20's). Results may not generalize to more diverse populations; however, understanding emotion dysregulation and BPD symptoms in a college sample is particularly important, given the high levels of impulsivity and self-harm reported in this

population (Glenn and Klonsky, 2010). The study did not include a clinical sample, and the results may not generalize to a clinical population. Finally, though a mediational analysis allows us to determine indirect effects, we cannot infer that the manner in which these variables influenced one another was of a causal nature.

Future Research. Future studies should examine these mediating variables within a clinical sample. Treatment development studies may be needed to identify ways to target fears of compassion in people with high levels of emotion dysregulation and BPD symptoms. It may be helpful to compare the effectiveness of treatments that incorporate self-compassion and address fear of compassion for those with BPD to those without BPD. Or, it may be helpful to measure the levels of these compassion-related constructs before and after treatment intervention for those who struggle with emotion dysregulation. Future research should also examine these relationships in a more diverse sample to improve generalizability.

Conclusion

Self-compassion and fear of compassion from self and others are important factors in understanding the relationship between childhood invalidation with both emotion dysregulation and BPD characteristics. The results of this study demonstrated that these compassion constructs served as mediators in these relationships. When examining these relationships with just the subscales of the self-compassion scale, isolation, in particular, was found to mediate these relationships. This suggests that an isolating perspective may be particularly important in understanding and addressing dysregulation and symptom severity. The findings from this study complement current research suggesting that self-compassion is a useful practice for promoting well-being,

and that fears of compassion interfere with well-being. The practice of self-compassion is generally a helpful approach, and may be particularly helpful for those with emotion dysregulation and BPD characteristics who have experienced childhood invalidation. For those with a fear of being self-compassionate or receiving compassion from others, this practice may only be helpful after these fears have been addressed and alleviated. This study contributes to the larger body of research on self-compassion and fears of compassion by examining their novel roles in the relationship between childhood invalidation with emotion dysregulation and with BPD characteristics in a college sample.

Tables and Figures.

Table 1

Demographics

	N	%
Gender		
Female	185	72
Male	70	28
Other	1	0.4
Not Disclosed	1	0.4
Relationship Status		
Single	135	53
Dating	34	13
Dating one person exclusively	85	33
Living with a partner	25	10
In a civil union/partnership	1	0.4
Married	14	5
Divorced	5	2
Sexual Orientation		
Heterosexual	224	87
Gay	6	2
Bisexual	15	6
Pansexual/Omnisexual	2	0.8
Asexual	6	2.4
Demisexual	1	0.4
Queer	1	0.4
Questioning	1	0.4
“I don’t care”	1	0.4
Ethnicity		
American Indian/Alaska Native	6	2
Asian or Asian American	16	6
Black or African American	1	0.4
Hispanic or Latino	12	5
Non-Hispanic White	205	80
Mixed race/Other	17	7
Class standing		
Freshman	129	50
Sophomore	77	30
Junior	31	12
Senior	13	5
Other	7	3
Received counseling		
Yes	143	56
No	114	44

Table 2

Descriptive statistics for variables

Measure	Mean	SD	Median	Range	Skewness
PARQ-Average	37.91	12.37	33.50	60.00	1.01
SCS	3.21	0.39	2.99	3.10	0.307
FCS-Others	33.32	12.79	31.00	60.00	0.606
FCS-Self	24.52	10.34	22.00	53.00	0.887
DERS	88.48	22.63	87.00	118.00	0.487
BSL	16.46	16.69	33.00	81.00	1.431

**Note.* These are non-transformed variables. The range reflects the sample.

Table 3

Correlations Between all Variables

Measure	1.	2.	3.	4.	5.	6.
1. PARQ-Avg	-					
2. SCS	-.353**	-				
3. FCS-Others	.416**	-.495**	-			
4. FCS-Self	.342**	-.474**	.652**	-		
5. DERS	.356**	-.725**	.550**	.604**	-	
6. BSL	.364**	-.551**	.538**	.591**	.651**	-

Note. **$p < .01$, all correlations are 2-tailed, PARQ-Avg was logarithm transformed, while the BSL was square root transformed.

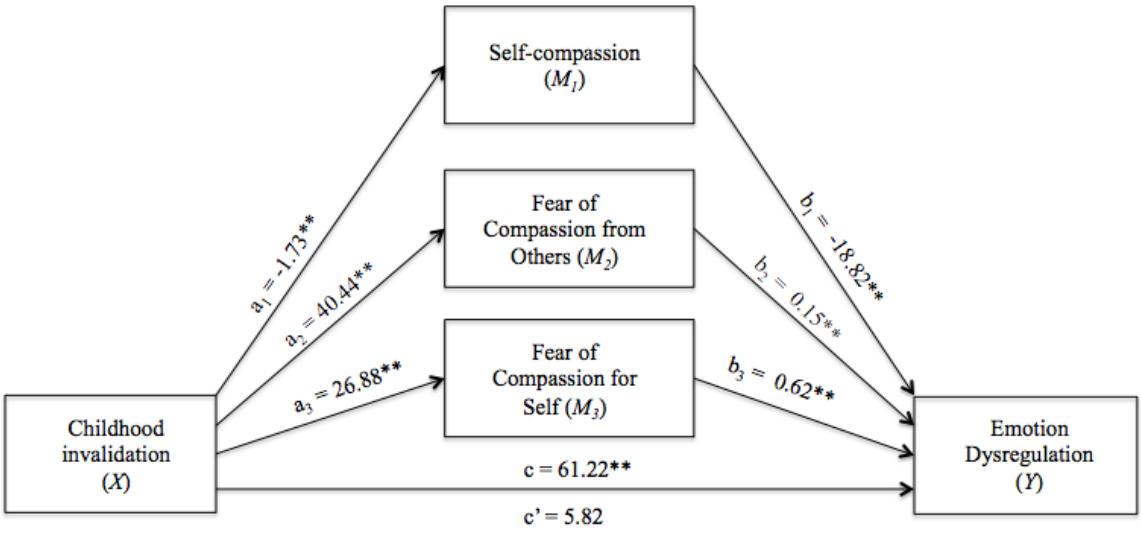

Figure 1. The mediating effect of self-compassion, fear of compassion from others, and fear of compassion for self, in the relationship between childhood invalidation and emotion dysregulation. Notes: *p < .05, ** p < .01.

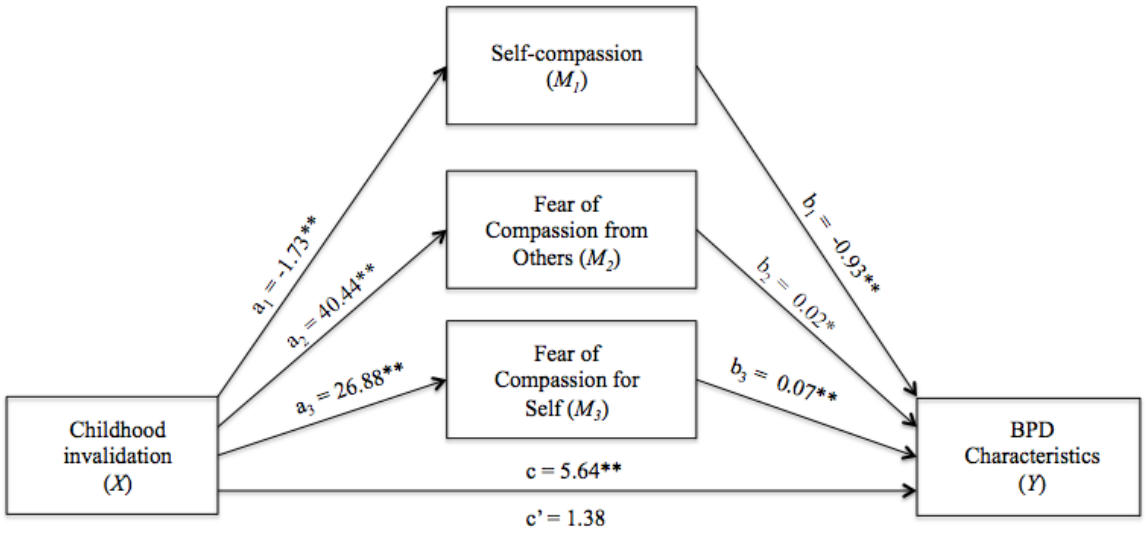

Figure 2. The mediating effect of self-compassion, fear of compassion from others, and fear of compassion for self, in the relationship between childhood invalidation and BPD characteristics. Notes: *p < .05, ** p < .01

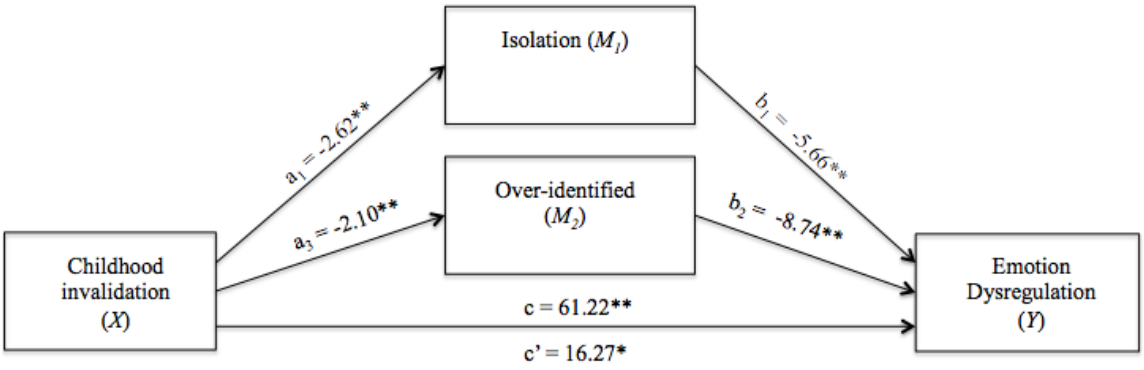

Figure 3. The mediating effect of Self-Compassion Scale subscales – Isolation and Over-identified - in the relationship between childhood invalidation and emotion dysregulation. Notes: *p < .05, ** p < .01.

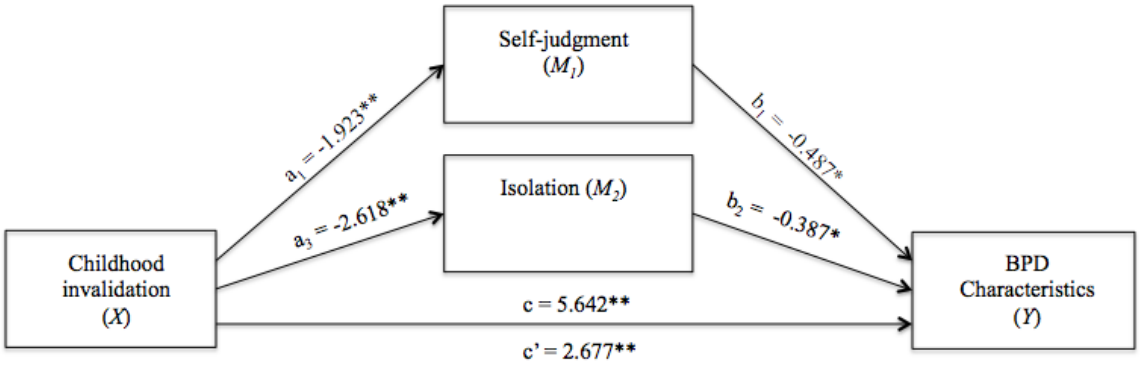

Figure 4. The mediating effect of Self-Compassion Scale subscales – Self-judgment and Isolation - in the relationship between childhood invalidation and BPD characteristics. Notes: *$p < .05$, ** $p < .01$.

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Appendix A

SUBJECT INFORMATION AND INFORMED CONSENT

Study Title: Study of the practice of self-compassion

Investigator(s):

Principal investigator: Priya Loess (priyadarshani.loess@umontana.edu) 243-4521

Faculty Supervisor: Jennifer Waltz, Ph.D. (jennifer.waltz@umontana.edu) 243-5750

Purpose:

The purpose of this research study is to learn about self-attitudes, childhood experiences, and emotional experiences and expression.

Procedures:

If you agree to take part in this research study, you will be given a set of questionnaires to complete. They will inquire about 1) basic demographic information, 2) general information about emotions, 3) information about self-attitudes and expression, 4) and difficulties you may have experienced. The entire study will take approximately 40 minutes.

Payment for Participation:

You will receive two points for your Psychology 100 (or other Psyx course) research participation requirement.

Risks/Discomforts:

There is minimal anticipated discomfort for those contributing to this study, so risk to participants is minimal; however, answering some questions may cause you to think things that could lead to feeling sad or upset.

Benefits:

There is no promise that you will receive any benefit from taking part in this study. You may learn something useful about yourself. Your participation may contribute to our scientific understanding of the topic under study.

Confidentiality:

The questionnaires you complete will be kept confidential and will not be released without your consent except as required by law. Your identity will remain anonymous. Thus, your name cannot and will not be used if the results of this study are written in a scientific journal or presented at a scientific meeting. The data will be stored in a secure computer data file. Your responses will be kept anonymous.

Voluntary Participation/Withdrawal:

Your decision to take part in this research study is entirely voluntary. You may refuse to take part in or you may withdraw from the study at any time without penalty or loss of benefits to which you are normally entitled. You may leave the study for any reason.

Questions:

If you have any questions about the research contact: Priya Loess, 243-4521, or at priyadarshani.loess@umontana.edu. If you have any questions regarding your rights as a research subject, you may contact the UM Institutional Review Board (IRB) at (406) 243-6672.

Statement of Your Consent:

I have read the above description of this research study. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will also be answered by a member of the research team. I voluntarily agree to take part in this study. Please print or save a copy of this page for your records.

I have read the above information and agree to participate in this research project.

____ *Enter survey*

Appendix B

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? _____

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 (Straight)
- Gay
- Bisexual
- Lesbian
- Pansexual/Omnisexual
- Asexual
- Other (please list) _____

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 C

Adult PARQ: Mother

The following pages contain a number of statements describing the way mothers (mother caregivers) sometimes act toward their children. Read each statement carefully and think how well it describes the way your mother treated you when you were about 7-12 years old. Work quickly. Give your first impression and move on to the next item. Do not dwell on any item. Four boxes are drawn after each sentence. If the statement is basically true about the way your mother treated you, ask yourself "Was it almost always true?" or "Was it only sometimes true?" If you think your mother almost always treated you that way, put an X in the box ALMOST ALWAYS TRUE; if the statement was sometimes true about the way your mother treated you then mark SOMETIMES TRUE. If you feel the statement is basically untrue about the way your mother treated you then ask yourself, "Was it rarely true?" or "Was it almost never true?" If it is rarely true about the way your mother treated you put an X in the box RARELY TRUE; if you feel the statement is almost never true then mark ALMOST NEVER TRUE.

Remember, there is no right or wrong answer to any statement, so be as honest as you can. Respond to each statement the way you feel your mother really was rather than the way you might have liked her to be.

Are you answering this questionnaire for your:

1) Mother ☐

2) Mother Caregiver ☐

Step-mother ☐

Grandmother ☐

Aunt ☐

Sister ☐

Other ☐

MY MOTHER	ALMOST ALWAYS TRUE OF MY MOTHER	SOMETIMES TRUE OF MY MOTHER	RARELY TRUE OF MY MOTHER	ALMOST NEVER TRUE OF MY MOTHER
1. Said nice things about me.				
2. Paid no attention to me.				
3. Made it easy for me to tell her things that were important to me.				
4. Hit me, even when I did not deserve it.				
5. Saw me as a big nuisance.				
6. Punished me severely when she was angry.				
7. Was too busy to answer my questions.				
8. Seemed to dislike me.				
9. Was really interested in what I did.				
10. Said many unkind things to me.				
11. Paid no attention when I asked for help.				
12. Made me feel wanted and needed.				
13. Paid a lot of attention to me.				
14. Went out of her way to hurt my feelings.				
15. Forgot				

important things I thought she should remember.				
16. Made me feel unloved if I misbehaved.				
17. Made me feel what I did was important.				
18. Frightened or threatened me when I did something wrong.				
19. Cared about what I thought, and liked me to talk about it.				
20. Felt other children were better than I was no matter what I did.				
21. Let me know I was not wanted.				
22. Let me know she loved me.				
23. Paid no attention to me as long as I did nothing to bother her.				
24. Treated me gently and with kindness.				

Adult PARQ: Father

The following pages contain a number of statements describing the way fathers (father caregivers) sometimes act toward their children. Read each statement carefully and think how well it describes the way your father treated you when you were about 7-12 years old. Work quickly. Give your first impression and move on to the next item. Do not dwell on any item. Four boxes are drawn after each sentence. If the statement is basically true about the way your father treated you, ask yourself "Was it almost always true?" or "Was it only sometimes true?" If you think your father almost always treated you that way, put an X in the box ALMOST ALWAYS TRUE; if the statement was sometimes true about the way your father treated you then mark SOMETIMES TRUE. If you feel the statement is basically untrue about the way your father treated you then ask yourself, "Was it rarely true?" or "Was it almost never true?" If it is rarely true about the way your father treated you put an X in the box RARELY TRUE; if you feel the statement is almost never true then mark ALMOST NEVER TRUE.

Remember, there is no right or wrong answer to any statement, so be as honest as you can. Respond to each statement the way you feel your father really was rather than the way you might have liked her to be.

Are you answering this questionnaire for your:

1) Father ☐

2) Father Caregiver ☐

Step-father ☐

Grandfather ☐

Uncle ☐

Brother ☐

Other ☐

MY FATHER	ALMOST ALWAYS TRUE OF MY FATHER	SOMETIMES TRUE OF MY FATHER	RARELY TRUE OF MY FATHER	ALMOST NEVER TRUE OF MY FATHER
1. Said nice things about me.				

2. Paid no attention to me.				
3. Made it easy for me to tell him things that were important to me.				
4. Hit me, even when I did not deserve it.				
5. Saw me as a big nuisance.				
6. Punished me severely when he was angry.				
7. Was too busy to answer my questions.				
8. Seemed to dislike me.				
9. Was really interested in what I did.				
10. Said many unkind things to me.				
11. Paid no attention when I asked for help.				
12. Made me feel wanted and needed.				
13. Paid a lot of attention to me.				
14. Went out of his way to hurt my feelings.				
15. Forgot important things I thought he should remember.				
16. Made me feel unloved if I misbehaved.				
17. Made me feel what I did was important.				
18. Frightened or threatened me when I did something wrong.				
19. Cared about what I thought, and liked me to talk about it.				
20. Felt other children were better than I was no matter what I did.				
21. Let me know I was not wanted.				
22. Let me know he loved me.				

23. Paid no attention to me as long as I did nothing to bother him.				
24. Treated me gently and with kindness.				

Appendix D

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 E

Different people have different views of compassion and kindness. While some people believe that it is important to show compassion and kindness in all situations and contexts, others believe we should be more cautious and can worry about showing it too much to ourselves and to others. We are interested in your thoughts and beliefs in regard to kindness and compassion in three areas of your life:

1. Responding to compassion from others

2. Expressing kindness and compassion towards yourself

Below are a series of statements that we would like you to think carefully about and then circle the number that best describes how each statement fits you.

SCALE

Please use this scale to rate the extent that you agree with each statement

Don't agree at all 0 1 2 3 4 Completely agree

Somewhat agree

Scale 2: Responding to the expression of compassion from others

1. Wanting others to be kind to oneself is a weakness	0 1 2 3 4 5
2. I fear that when I need people to be kind and understanding they won't be	0 1 2 3 4 5
3. I'm fearful of becoming dependent on the care from others because they might not always be available or willing to give it	0 1 2 3 4 5
4. I often wonder whether displays of warmth and kindness from others are genuine	0 1 2 3 4 5
5. Feelings of kindness from others are somehow frightening	0 1 2 3 4 5
6. When people are kind and compassionate towards me I feel anxious or embarrassed	0 1 2 3 4 5
7. If people are friendly and kind I worry they will find out something bad about me that will change their mind	0 1 2 3 4 5
8. I worry that people are only kind and compassionate if they want something from me	0 1 2 3 4 5
9. When people are kind and compassionate towards me I feel empty and sad	0 1 2 3 4 5
10. 10. If people are kind I feel they are getting too close	0 1 2 3 4 5
11. Even though other people are kind to me, I have rarely felt warmth from my relationships with others	0 1 2 3 4 5
12. I try to keep my distance from others even if I know they are kind	0 1 2 3 4 5

13. If I think someone is being kind and caring towards me, I ‘put up a barrier’	0 1 2 3 4 5

Appendix F

Scale 3: Expressing kindness and compassion towards yourself

1. I feel that I don't deserve to be kind and forgiving to myself	0 1 2 3 4 5
2. If I really think about being kind and gentle with myself it makes me sad	0 1 2 3 4 5
3. Getting on in life is about being tough rather than compassionate	0 1 2 3 4 5
4. I would rather not know what being 'kind and compassionate to myself' feels like	0 1 2 3 4 5
5. When I try and feel kind and warm to myself I just feel kind of empty	0 1 2 3 4 5
6. I fear that if I start to feel compassion and warmth for myself, I will feel overcome with a sense of loss/grief	0 1 2 3 4 5
7. I fear that if I become kinder and less self-critical to myself then my standards will drop	0 1 2 3 4 5
8. I fear that if I am more self compassionate I will become a weak person	0 1 2 3 4 5
9. I have never felt compassion for myself, so I would not know where to begin to develop these feelings	0 1 2 3 4 5
10. I worry that if I start to develop compassion for myself I will become dependent on it	0 1 2 3 4 5
11. I fear that if I become too compassionate to myself I will lose my self-criticism and my flaws will show	0 1 2 3 4 5
12. I fear that if I develop compassion for myself, I will become someone I do not want to be	0 1 2 3 4 5
13. I fear that if I become too compassionate to myself others will reject me	0 1 2 3 4 5
14. I find it easier to be critical towards myself rather than compassionate	0 1 2 3 4 5
15. I fear that if I am too compassionate towards myself, bad things will happen	0 1 2 3 4 5

Appendix G

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 H

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

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-compassion.

If as a result of participation in this survey you are experiencing distress, or are experiencing distress in general, we encourage you to consider seeking help. Following are some potential resources:

Counseling Services at the Curry Health Center
406-243-4711

Western Montana Mental Health Line
406-532-9710

St. Patrick Hospital Emergency Services
406-543-7271

YWCA Missoula
406-542-1944

National Suicide Prevention Lifeline
1-800-273-8255

SAMHSA National Helpline
1-800-662-4357
TTY: 1-800-487-4889

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 (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