ORIGINS OF SELF-COMPASSION: THE IMPACT OF THE EARLY CAREGIVING ENVIRONMENT

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A Dissertation
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ABSTRACT

The purpose of the present study was to examine the impact of early attachment on self-compassion in early adulthood utilizing a causal model to assess the mediating effects of emotional regulation and shame (Figure 1). Participants were 133 undergraduate students (143 females and 90 males) between 18 and 28 years old ($M = 22.7$ yrs.) from a Southern California university. Structural equation modeling (SEM) using EQS (version 6.1) was used to analyze the data. Results showed an indirect effect of early attachment on self-compassion through emotional regulation and shame; a direct, moderate effect of early attachment on emotional regulation and shame; a moderate, direct effect of shame on self-compassion; and a direct, large effect of emotional regulation on self-compassion. The results of this study suggest that the quality of the early caregiving environment influences young adults’ emotional regulation and shame proneness, which in turn impacts their capacity for self-compassion (which effects psychological, physical, and interpersonal well-being). Findings are discussed in terms of implications for clinical and school settings. Further, the findings underscore the long-term and widespread impact of the early caregiving environment on subsequent development.
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DEDICATION

I dedicate this doctoral dissertation to my sister, Gabriela. About a decade ago, Gabriela encouraged me to go back to school. Although at that time I thought that it was too late for me to re-start my academic journey, she convinced me of the contrary. Her perspective that time passes with or without me going to school, so might as well have a degree in few years, made me enroll in my first classes. Ten years later, I have a master’s degree in Clinical Psychology, a post master’s credential in School Psychology, and a doctorate in Educational Leadership.

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CHAPTER ONE:  
INTRODUCTION 

Self-compassion is a relatively new psychological construct which refers to witnessing one’s own suffering in challenging times and attending to that suffering with kindness and a non-judgmental stance while recognizing that suffering is part of the common human experience (Neff, 2003a). While research studies over the past decade have identified a number of beneficial psychological and even physiological outcomes of self-compassion, little research attention has focused on its origins. The purpose of the current study is, in general, to examine the impact of the early caregiving environment on self-compassion in young adults.

Self-compassion is similar to the concept of compassion which refers to the ability to notice and be touched by another’s suffering, having the desire to alleviate that suffering, and recognizing that humans are fragile and imperfect, therefore prone to failing and making mistakes (Goetz, Keltner, & Simon-Thomas, 2010). The self-compassion construct has three facets that interact and combine with each other to form a self-compassionate state of mind. These include *mindfulness* (versus *over-identification*), *self-kindness* (versus *self-judgment*), and *common humanity* (versus *isolation*). *Mindfulness* refers to the capacity to keep one’s attention in the present moment, with awareness of body and mind in relationship with the environment, and be open to one’s suffering in difficult times without judgment, denial, or suppression of whatever feelings,
thoughts, or sensations arise (Bishop et al., 2004; Brown & Ryan, 2003; Kabat-Zinn, 1990). By contrast, when encountering difficult situations, individuals typically tend to dismiss difficult feelings and painful sensations which can lead to ineffective coping strategies (Holahan & Moos, 1987). The opposite of mindfulness is over-identification which is the tendency to become identified with negative emotions, thoughts, and sensations that arise in difficult situations (Neff, 2003b). When rumination over thoughts, emotions, and sensations occur, individuals tend to experience symptoms of depression and anxiety (Nolen-Hoeksema, 2000). Next, self-kindness entails being loving, gentle, and accepting towards oneself when facing personal limitations (Neff & Knox, 2017). It also involves internal dialogues that are encouraging and comforting instead of self-critical, and it requires active self-soothing in times of distress when facing inadequacies and difficult situations (Neff & Knox, 2017). This is in contrast to self-judgment that involves self-criticism when assessing personal experiences which often leads to feelings of shame, an intensely painful emotion that comes with feeling unworthy or defective and leads to increased feelings of isolation (Brown, 1999; Brown, 2006; Tangney & Dearing, 2002). Finally, common humanity refers to recognizing that suffering is a part of the human experience (Neff & Germer, 2017; Neff & Knox, 2017). It involves acknowledging that failure and perceived imperfections are common human experiences and that all human beings struggle with feelings such as shame or imperfection, which in turn leads to feeling less isolated as well as recognizing the vulnerability of being human.
Neff, 2003b; Neff & Germer, 2017). Common humanity involves understanding that what makes us feel separate is what we actually have in common, which is the opposite of feeling isolated.

The concept of compassion towards self (and others) emerged from Buddhist philosophy where it is prevalent throughout Buddhist writings (Chödrön, 2001). Compassion towards others, though, is more popular throughout western societies (Goetz, Keltner, & Simon-Thomas, 2010). Neff’s (2003a, 2003b) steps towards operationalizing and introducing the construct of self-compassion in the field of educational psychology has gradually led to a large body of research over the last fifteen years and has increased the popularity of this construct. Since then, the self-compassion construct has been used in numerous studies that focus on topics such as psychological and physiological functioning and well-being (Neff & Germer, 2017) as described below.
CHAPTER TWO:
LITERATURE REVIEW

Impact of Self-Compassion on Human Development/Behavior

The research literature on self-compassion has been rapidly expanding with findings suggesting that self-compassion is associated with many positive outcomes including psychological well-being, decreased psychopathology, resilience/self-efficacy, increased motivation, improved self-worth, better physical health and increased physiological functioning, and positive interpersonal relationships (Neff & Germer, 2017).

Self-compassion and Psychological Well-Being

Numerous studies reveal a strong relationship between self-compassion and psychological well-being from adolescence to late adulthood (Zessin, Dickhauser, & Garbade, 2015).

Research studies on adolescents show that self-compassion increases satisfaction with life and positive affect, while decreasing symptoms of depression, perceived stress, negative affect, and the tendency to ruminate when experiencing difficult situations; furthermore, these improvements are maintained over time (Bluth & Blanton, 2014; Galla, 2016). When the three “components” of self-compassion have been examined in relationship to individuals’ moods, results show that mindful adolescents tend to experience less stress and increased positive mood compared to those who over-identify with their struggles (Bluth & Blanton, 2014). Also, when adolescents feel a sense of connection with
others (versus feeling isolated), they feel more satisfied with their life and experience significantly less stress and negative mood (Bluth & Blanton, 2014).

During young adulthood, with the many changes in the social environment, life style, and increased levels of responsibility impacting social and psychological well-being (Conley, Kirsch, Dickson, & Bryant, 2014; Gall, Evans, & Bellerose, 2000; Terry, Leary, & Mehta, 2013), high levels of self-compassion show a number of positive outcomes including increased psychological flexibility and the tendency to live consistent with own values and accepting of one’s internal experiences without judgment (Marshall & Brockman, 2016). In addition, self-compassionate young adults are more satisfied with their lives (Gunnell, Mosewich, McEven, Eklund, & Crocker, 2017; Hope, Koestner, & Milyavskaya, 2014, Neff, 2003a), have higher levels of self-esteem, and experience less depression, anxiety, and stress compared to those with lower levels of self-compassion (Marshall & Brockman, 2016). Finally, higher levels of self-compassion have also been found to positively correlated with positive affect, vitality, sense of competence, and the desire to interact with others (Gunnell, Mosewich, McEven, Eklund, & Crocker, 2017).

In later adulthood, studies show that higher levels of self-compassion can become a buffer of the negative effects of health decline (Homan, 2016) as well as a psychological asset in achieving overall psychological well-being (Phillips & Ferguson, 2012).
In sum, higher levels of self-compassion are related to increased positive affect, vitality, life satisfaction, flexibility, and the tendency to live in line with one’s values and sense of competency; all of which promote psychological well-being in adolescence and adulthood. Furthermore, the impact of self-compassion on well-being appears to be maintained over time (Galla, 2016; Hope, Koestner, & Milyavskaya, 2014).

**Self-Compassion and Motivation**

Research studies have also found that self-compassion can increase one’s motivation as it increases one’s sense of learning competency, proactive behaviors, and self-efficacy while decreasing stress which tends to exacerbate the tendency to procrastinate.

First, self-compassion increases one’s sense of learning competency which directly impacts intrinsic motivation (Neff, Hsieh, & Dejitterat, 2005). Those with higher levels of self-compassion are more motivated by curiosity and the desire to learn and understand the material without fear of making mistakes; they also understand that mistakes are part of the learning process (Neff, Hsieh, & Dejitterat, 2005). Self-compassionate people tend to embrace goals that are meaningful to them and are less affected by the goals that focus on pleasing others or demonstrating competence by performing better than others to avoid feelings of not being good enough (Hope, Koestner, & Milyavskaya, 2014). Findings from daily reports on progress towards goals suggests that the affect of those with higher levels of self-compassion is not influenced by the progress
towards their goal, but by the meaningfulness of the goal; the affect of those with lower levels of self-compassion, though, is influenced by their progress on goals (Shimizu & Shigemasu, 2015).

Second, self-compassion increases proactive behaviors, i.e., activities that increase personal achievement and create productive change in the environment through civic and extracurricular activities (Bateman & Crant, 1993). When the individual “components” of self-compassion are examined in relationship to proactive behaviors, results show that mindful individuals who are kind towards themselves are more likely to engage in proactive behaviors than those who feel isolated and fused with negative thoughts or emotions (Akin, 2014).

Third, studies show that self-compassion increases feelings of self-efficacy, i.e., believing in one’s abilities and persevering in the face of challenging learning activities (Schunk, 1990). Studies suggest that self-compassionate people are more likely than those with low levels of self-compassion to persevere when faced with challenges instead of avoiding difficult tasks (Iskender, 2009; Manavipour & Saeedian, 2016).

Fourth, studies show that self-compassion is also related to the tendency to procrastinate: individuals with high levels of self-compassion are less likely to procrastinate and are better able to manage their worries about competence (Williams, Stark, & Foster, 2008). Conversely, individuals with low levels of self-compassion are more likely to procrastinate and tend to experience higher levels of stress related to procrastination (Sirois, 2014).
Finally, individuals with higher levels of self-compassion are more likely to be motivated to examine their weaknesses and believe that those weaknesses can be improved (Breines & Chan, 2012).

In sum, research studies suggest that self-compassion promotes motivation and emotional resiliency as it increases one’s learning competencies, proactive behaviors, self-efficacy in challenging situations, and motivation towards self-improvement.

Self-Compassion and Psychopathology

Research studies also show a negative relationship between self-compassion and various psychopathologies including depression, anxiety, eating disorders, and trauma-related disorders.

First, numerous studies have examined the association between self-compassion and depression in clinical and non-clinical samples. Findings show that higher levels of self-compassion are linked to lower levels of depression (Barry, Loflin & Doucette, 2015; Diedrich, Hofmann, Cuijpers, & Berking, 2016; Ehret, Joormann, & Berking, 2015; Johnson & O’Brien, 2013; Neff, & McGehee, 2010; Zeller, Nitzan-Assayag, & Bernstein, 2014). Individuals who have not experienced depression report higher levels of self-compassion than those who are in depression remission or who are currently depressed (Ehret, Joormann, & Berking, 2015). Moreover, individuals who never experienced depression and those who are in depression remission have higher levels of self-compassion than those who are currently depressed (Ehret, Joormann, & Berking, 2015).
Self-compassion is significantly and negatively correlated with feelings of depression and this relationship appears to be moderated by feelings of shame (Johnson & O’Brien, 2013). Johnson and O’Brien (2013), for example, used a randomized experimental design to examine the role of self-compassion on depression and shame and found that practicing self-compassion significantly reduced symptoms of shame and depression, indicating that self-compassion has a soothing effect on feelings of distress triggered by shame. Similar findings indicating soothing effects of self-compassion on depressive mood were also found when the effect of self-compassion on depressive mood was examined in comparison with other emotional regulation strategies (Diedrich, Hofmann, Cuijpers, & Berking, 2016). When compared with other emotional regulation strategies, self-compassion shows a greater impact on the reduction of depressive symptoms in individuals with high levels of depressed mood than the other emotional regulation strategies (Diedrich, Hofmann, Cuijpers, & Berking, 2016). Similarly, randomized controlled studies show that symptoms of depression are reduced significantly after self-compassion interventions (Friis, Johnson, Cutfield, & Consedine, 2015; Friis, Johnson, Cutfield, & Consedine, 2016).

Second, studies show a significant negative correlation between levels of self-compassion and anxiety symptoms in both clinical and non-clinical samples (Barry, Loflin & Doucette, 2015; Hoge et al., 2013; Neff, & McGehee, 2010; Svendsen et al., 2016). Individuals with generalized anxiety disorder have been
found to have a significantly lower capacity for self-compassion compared to those without an anxiety disorder but who experience stress (Hoge et al., 2013).

Moreover, adolescents with higher levels of self-compassion have reported significantly lower levels of anxiety symptoms (Bluth, Campo, Futch, & Gaylord, 2016; Neff, & McGehee, 2010), and similar results have been found in young adults (Neff, & McGehee, 2010). In a study with three randomized conditions (i.e., self-compassion, attention, and no intervention), it was found that individuals who received a self-compassion intervention reported significantly lower anxiety symptoms than those in the control groups (Arch, Brown, Dean, Landy, Brown, & Laudenslager, 2014).

Furthermore, self-compassion plays a role in eating disorder pathology, with females with eating disorders reporting significant lower levels of self-compassion than females without an eating disorder (Ferreira, Pinto-Gouveia, & Duarte, 2013; Kelly, Vimalakanthan, & Carter, 2014). Low self-compassion appears to be a strong predictor of eating disorder symptoms in non-clinical populations (Kelly, Vimalakanthan, & Carter, 2014). Also, self-compassion appears to be a buffer between external shame and disordered eating (Ferreira, Pinto-Gouveia, & Duarte, 2013).

Finally, research studies suggest that self-compassion has a protective role in trauma-related psychopathology, with higher levels of self-compassion predicting lower levels of psychopathology symptoms such as panic, post-traumatic stress, and suicidality after a traumatic event (Zeller, Yuval, Nitzan-
Evidence indicates that individuals who experience severe interpersonal trauma also experience lower levels of self-compassion (Scoglio et al., 2015; Vettese, Dyer, Li, Wekerle, 2011). Additionally, self-compassion is thought to assist individuals who have experienced childhood maltreatment in better regulating their emotions (Vettese, Dyer, Li, Wekerle, 2011) while also decreasing the severity of post-traumatic stress disorder symptoms (Scoglio et al., 2015; Vettese, Dyer, Li, Wekerle, 2011).

**Self-Compassion and Self-Esteem**

Although self-compassion and self-esteem are different constructs, they both involve experiencing positive feelings towards one’s self (Neff & Vonk, 2009). However, while self-esteem requires a positive evaluation of the self and the need to feel special and above others, self-compassion brings acceptance of all experiences, and inadequacies are met without judgment (Neff & Vonk, 2009). While self-esteem is positively associated with narcissism (Neff, 2003a; Neff, & Vonk, 2009), there are inconclusive findings regarding self-compassion and narcissism, ranging from almost zero correlation to a significant negative correlation between the two (Barry, Loflin, & Doucette, 2015; Neff, 2003a; Neff & Vonk, 2009). Though self-compassion is significantly and positively correlated with self-esteem (Barry, Loflin, & Doucette, 2015; Johnson, & O’Brien, 2013; Leary, Tate, Adams, Allen, & Hancock, 2007; Neff, 2003a), significant differences are found between the two concepts (Krieger, Hermann, Zimmermann, & grosse Holtforth, 2015). Longitudinal research studies show that for individuals with high
self-compassion, having low self-esteem has only limited influence on their mental health whereas for those with less self-compassion, having a low self-esteem is a predictor of a significant decline in mental health, indicating that self-compassion and self-esteem have independent effects on mental health over time (Marshall, Parker, Ciarrochi, Sahdra, Jackson, & Heaven, 2015). Although self-compassion and self-esteem equally predict positive affect, optimism, and happiness, when things become difficult, self-compassion is more relevant to positive emotional states than self-esteem which is dependent on positive judgment of self (Leary, Tate, Adams, Allen, & Hancock, 2007; Neff & Vonk, 2009). Furthermore, self-compassion uniquely predicts symptoms of anxiety and depression after controlling for self-esteem (Neff, 2003a). Also, various studies show that unlike self-esteem, self-compassion acts as an emotional buffer when individuals are faced with their weaknesses, negative interpersonal feedback, or perceived stress (Breines & Chan, 2012; Krieger, Hermann, Zimmermann, & grosse Holtforth, 2015; Leary, Tate, Adams, Allen, & Hancock, 2007; Neff, Kirkpatrick, & Rude, 2007).

Differences between self-compassion and self-esteem are also found in physiological responses to psychosocial stress (Breines et al., 2014; Breines et al., 2015). When psychosocial stress is induced, self-compassion but not self-esteem has been found to significantly predict salivary alpha-amylase responses, an indicator of the activation of the sympathetic nervous system which is part of the autonomic nervous system that triggers the flight, fight, or freeze response.
under stress (Breines et al., 2015). Also, self-compassion, but not self-esteem, has been found to predict lower stress-induced inflammatory responses to new psychosocial stressors (Breines et al., 2014). These findings are in line with evidence suggesting that self-esteem is threatened by social evaluation while self-compassion is related to emotional resiliency in difficult situations (Neff & Vonk, 2009).

**Self-Compassion and Physiological Functioning**

Although there is limited research examining the link between self-compassion and physiological functioning, preliminary evidence suggests that self-compassion is related to physiological and autonomic responses.

First, experimental research shows that self-compassion produces psychobiological reactions that indicate a balanced activation of the sympathetic and parasympathetic nervous system, suggesting that self-compassion acts as a protector against social stress (Arch et al., 2014). Self-compassion levels significantly predict salivary alpha-amylase responses, an indicator of the activation of sympathetic nervous system, which is part of the autonomic nervous system that triggers the flight, fight, freeze response under stress as mentioned above (Arch et al., 2014; Breines et al., 2015). Self-compassionate individuals show lower levels of salivary alpha-amylase responses than individuals with lower levels of self-compassion (Arch et al., 2014; Breines et al., 2015).

Second, in an experimental study with three control groups, individuals with higher levels of self-compassion have been found to have stable cardiac
responses as measured by heart rate variability during the recovery time after induced social stress, indicating that self-compassion may assist individuals with a faster recovery from a social stress (Arch et al., 2014). Self-compassion is also significantly correlated with vagal mediated heart rate variability (vmHRV), an indicator of the parasympathetic nervous system response (Svendsen et al., 2016). Increased levels of self-compassion are related to higher levels of vmHRV, indicating a soothing effect of the parasympathetic nervous system (Svendsen et al., 2016).

Third, there is also some preliminary evidence that self-compassion has a negative impact on stress-induced inflammatory responses to new psychosocial stressors (Breines et al., 2014; Pace et al., 2009). Evidence from a research study using three controlled groups suggests that the amount of time spent practicing self-compassion meditation is related to the physiological response (measured through levels of blood pro-inflammation cytokine interleukin-6 [IL-6]) to induced social stressors (Pace et al., 2009). The more time individuals spent practicing self-compassion meditation, the lower their level of IL-6 (Pace et al., 2009).

Finally, there is evidence indicating that self-compassion predicts decreased feelings of distress related to diabetes self-management which impacts metabolic responses such as lower glycemic levels in those diagnosed with diabetes (Friis, Johnson, Cutfield, & Consedine, 2015). Also, results of both subjective and objective measures show that self-compassion can be linked to
physical health in individuals diagnosed with Type 1 and Type 2 diabetes: individuals diagnosed with Type 1 and 2 diabetes who received self-compassion intervention showed lower glycemic levels after a period of 3 months compared to individuals who did not receive self-compassion intervention (Friis, Johnson, Cutfield, & Consedine, 2016). Thus, self-compassion can serve as a coping tool for managing diabetes-related stress (Friis, Johnson, Cutfield, & Consedine, 2015).

Self-Compassion and Interpersonal Relationships

Self-compassion is associated with increased relational well-being; individuals with higher levels of self-compassion report increased levels of happiness, worth, sense of authenticity, and ability to express opinions in their relationships with significant others (Neff & Beretvas, 2012). Individuals with higher levels of self-compassion compared to those with lower levels are more likely to behave in line with their true self (Gerber, Tolmacz, & Doron, 2015), are seen by their partners as being more accepting and caring towards them (Neff & Beretvas, 2012), and they tend to not repress and deny their own needs or overinvest in satisfying another’s needs (Gerber, Tolmacz, & Doron, 2015). Instead, they are more likely to acknowledge their needs as well as others’ needs as equally important and keep a balance between them (Yarnell & Neff, 2013). The increased tendency of individuals with high levels of self-compassion to compromise in interpersonal relationship conflicts is linked to increased relational well-being (Yarnell & Neff, 2013).
Self-compassion also plays a significant role in romantic relationships, with high self-compassionate wives reporting less severe marital problems and increased marital satisfaction over time compared with wives with lower levels of self-compassion (Baker & McNulty, 2011). For husbands, however, self-compassion influenced their marital satisfaction and their willingness to engage in problem-solving relationship issues only when they also had high levels of conscientiousness (e.g., self-discipline, achievement-striving, dutifulness) (Baker & McNulty, 2011). Individuals with high levels of self-compassion also have increased trust that their significant others will respond to their needs (Gerber, Tolmacz, & Doron, 2015); they also feel more connected to their partners and provide them more autonomy in the relationship (Neff & Beretvas, 2012) compared with those with lower levels of self-compassion.

Self-compassion also plays a significant role in the way individuals approach interpersonal problems (Arslan, 2016). Individuals lower in self-compassion tend to approach interpersonal problems in a negative way, and they lack confidence that they can solve the problem and are less willing to take responsibility in solving the problem (Arslan, 2016). On the other hand, high self-compassionate individuals have been found to approach interpersonal problems in a constructive way and are more likely to persevere in the process of solving the problem (Arslan, 2016). Individuals with high self-compassion also experience less emotional turmoil and increased relational well-being when resolving an interpersonal conflict with loved ones (Yarnell & Neff, 2013), and
since they are more likely to recognize that their needs are as important as others’ needs, they are more likely to compromise and feel authentic when solving the conflict compared to those with lower levels of self-compassion (Yarnell & Neff, 2013).

Furthermore, levels of self-compassion have been found to predict intention to help others: individuals high in self-compassion are more likely to help someone in need (and feel less distress in doing so) than those with low levels of self-compassion (Neff, & Pommier, 2013; Welp, & Brown, 2014).

Also, after a moral transgression, individuals with higher levels of self-compassion are less likely to accept and tolerate their moral transgression compared with those with lower levels of self-compassion (Wang, Chen, Poon, Teng, & Jin, 2016). Further, they are motivated to avoid making the same mistake and to make amends about their wrongdoing (Breines & Chan, 2012).

**Summary**

In sum, self-compassion has a significant impact on many aspects of psychological, physical, and interpersonal well-being. Given its impact and psychological significance, understanding its origins is warranted.

**Origins of Self-Compassion**

Preliminary evidence suggests that it is the early caregiving environment that significantly impacts the development of self-compassion (e.g., Peter & Gazelle, 2017). To summarize research findings to date, it appears that early caregiving environments characterized by positive family relationships, parental
warmth, kindness, undivided attention to the child, emotional attunement, emotional closeness, compassion, a non-judgmental attitude, and early memories of safety and warmth within the family are positively related to individuals' later levels of self-compassion (Gouveia, Carona, Canavarro, & Moreira, 2016; Jiang, You, Zheng, & Lin, 2017; Kelly & Dupasquier, 2016; Kearney & Hicks, 2016; Marta-Simoes, Ferreira, & Mendes, 2018; Matos, Carvalho, Cunha, Galhardo, & Sepodes, 2017; Moreire, Gouveia, & Canavarro, 2018; Neff & McGehee, 2010; Pepping, Davis, O'Donovan, & Pal, 2015; Peter & Gazelle, 2017; Wu, Chi, Lin, & Du, 2018). By contrast, early caregiving environments characterized by parental rejection (Pepping, Davis, O'Donovan, & Pal, 2015), parental indifference (Westphal, Leahy, Pala, & Wupperman, 2016), childhood maltreatment, emotional abuse and neglect (Tanaka, Wekerle, Schmuck, Paglia-Boak, & MAP Research Team, 2011; Vettese, Dyer, Li, & Wekerle, 2011; Wu, Chi, Lin, & Du, 2018), conflictual and stressful families, maternal criticism (Neff & McGehee, 2010), childhood memories of shame induced by a caregiver (Matos, Carvalho, Cunha, Galhardo, & Sepodes, 2017), unclear roles and boundaries between family members and emotional-over involvement (Berryhill, Hayes, & Lloyd, 2018) have been found to be negatively related to later levels of self-compassion.

Utilizing the lens of attachment science, the above findings suggest a strong link between early attachment security and the subsequent development of self-compassion. Preliminary studies to date, as discussed below, support
such a link between early parent-child relationships characterized by emotional
attnement, parental warmth and kindness, safety, parental responsiveness, and
a non-judgmental parental attitude and later self-compassion. Following is a
review of attachment research highlighting its potential links to the development
of self-compassion.

Overview of Attachment Research

Infants’ early need for the security and responsiveness of caregivers to
their physical and emotional needs is the centerpiece of attachment theory as
originally developed by Bowlby (1969, 1983) and extensively researched over the
past eight decades (e.g., Cassidy & Shaver, 2016; Mikulincer & Shaver, 2017;
Schore, 2017). Bowlby’s original theory of attachment has its roots in ethology
and suggests that infants are biologically wired to seek safety and care from their
primary caregivers for survival (Bowlby 1969, 1983). Bowlby’s theory is
supported and extended by recent neurobiological research showing that an
attachment bond develops through the psychobiological attunement between the
infant and the caregiver (Schore, 2017). The affective communication between
the infant and the caregiver assists the infant in coping with early life stressors
(Schore, 2017).

The parent-child attachment relationship can be either secure or insecure
depending on the quality of the caregivers’ responsiveness to their infants’ needs
and signals (Bowlby, 1969, 1983; Schore, 2017). Attachment to the primary
caregiver, usually the mother, becomes “secure” if the caregiver responds with
sensitivity and responsive, warm care towards the infants’ psychobiological needs over the first 6-8 months of an infant’s life (Ainsworth, 1979; Schore, 2017). If the primary caregiver ignores the infant’s needs or reacts in ways that are not in sync with those needs, the attachment becomes “insecure” since the infant learns that the caregiver is not a reliable source of comfort, calming, or safety (Ainsworth, 1979).

The infant internalizes this early relationship with the primary caregiver, which later becomes the individual’s “internal working model” of the world (Bowlby, 1969, 1983; Schore, 2017). According to attachment research, this “internal working model” significantly influences the expectations and quality of an individual’s future relationships, mental health, perception of self, and capacity for emotional regulation (Mikulincer & Shaver, 2017; Schore, 2017; Sroufe, Duggal, Weinfield, & Carlson, 2000).

**Attachment Classifications and Child Outcome**

Ainsworth, Blehar, Waters, and Wall (1978) proposed three categories of infant-caregiver attachment based on her observation of infants’ responses in the Strange Situation, an experimental procedure used to observe infants’ pattern of responses to separation and reunion episodes with their caregivers. The three attachment style categories proposed by Ainsworth et al. (1978) are Secure, Insecure – Anxious, and Insecure – Avoidant. A fourth attachment style, the Insecure - Disorganized/Disoriented was later added by Main and Solomon (1990).
**Secure Attachment.** A secure attachment develops in the context of a consistent safe, warm, caring, and responsive caregiving environment (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969; Cassidy & Shaver, 2016). Mothers of securely attached infants are described in research studies as cooperative and sensitive toward their infants, and they consistently respond to the infants’ signs of distress (e.g., crying, frets) appropriately and in a timely manner (Ainsworth, Blehar, Waters, & Wall, 1978; McElwain & Booth-LaForce, 2006). The caregiver’s sensitive attunement to the infant’s needs and state of mind, and an immediate response to the infant’s distress (e.g., picking the infant up, using a soothing voice) provide the infant with a sense of security (Bowlby, 1969; Schore, 2017). Moreover, caregivers of these children are encouraging and supportive of their independent exploration and provide them with assistance when needed (Karen, 1998).

Since infants need to rely on adults for emotional regulation, this immediate, warm, and consistent responsiveness of the caregiver to the infants’ distress assists the infant with emotional regulation (Bowlby, 1969; Gerhardt, 2015; Schore, 2017). Recent neurobiological research shows that the right hemisphere of the brain develops through a secure attachment relationship during infancy, and with maturation it assists babies in coping with new and stressful situations (Schore, 2017). Schore (2017) makes the argument that emotional regulation is the hallmark of a secure attachment which is in line with the results of a 30-year longitudinal study indicating that securely attached
individuals have an increased capacity to regulate their emotions as they mature because their caregivers were responsive and comforting towards them as infants (Sroufe, 2005). This capacity for emotional regulation assists individuals in remaining anchored in the present moment and in tolerating distress in difficult situations in adulthood (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006; Mikulincer, 1995; Mikulincer, Florian, & Weller, 1993). As children mature, those with a secure attachment have increased “ego-resiliency,” i.e., the flexibility to adapt their emotions to different situational contexts (Sroufe, 2005).

Having a sense of safety and support within the relationship with the attachment figure leads to increased positive feelings and well-being (Mikulincer & Shaver, 2012). Having a secure attachment is also a buffer against psychopathology (Sroufe, 2005): securely attached children experience fewer symptoms of anxiety and depression than insecurely attached children (Muris, Mayer, & Meesters, 2000). Securely attached children also have an increased capacity to manage stress and recover faster from difficult situations (Mikulincer & Shaver, 2012; Sroufe, 2005). Attachment security provides infants and young children with feelings of emotional balance and support, which assists them in becoming more resilient in difficult situations as they mature (Cassidy & Shaver, 2016; Mikulincer & Shaver, 2017). As children become older, those with secure attachments have a realistic but positive sense of themselves, and have the capacity to acknowledge both their positive and negative aspects (Mikulincer,
1995). Thus, the securely attached individual’s view of self remains consistent, even in time of distress (Mikulincer, 1998).

Moreover, as they mature, securely attached children demonstrate increased social competence: they are able to develop and maintain close and appropriate social relationships, and they show flexibility and persistence in managing interpersonal problems (Landry, Smith, & Swank, 2003; Sroufe, 2005). Further, they also express empathy towards others’ distress (Sroufe, 2005). Their social competence is maintained and valued by their peers during adolescence when they are more likely than those with insecure attachments to become group leaders (Englund, Levy, Hyson, & Sroufe, 2000). Also, children who experience consistent warmth, responsiveness, and support in their relationship with their mothers have increased cognitive and language skills in their school age years (Landry, Smith, & Swank, 2003). Overall, the benefits of secure attachment provide individuals with increased psychological and social well-being.

Insecure - Ambivalent/Anxious Attachment. An insecure – anxious attachment develops when caregivers are insensitive and inconsistent in their responsiveness towards infants’ distress (Ainsworth, Blehar, Waters, & Wall, 1978; Cassidy & Berlin, 1994). Caregivers of these children often ignore their child’s needs and fail to respond to their signals for closeness (e.g., not picking them up or holding them close to their bodies) (Davies, 2011). Caregivers of these children fail to respond consistently to their children’s needs and do not support their children’s need for exploration (Cassidy & Berlin, 1994). Moreover,
these caregivers struggle with tolerating their children’s distress which often leads them to engaging in intrusive behaviors (e.g., they solve the child’s problem before allowing the child to figure a way of solving the problem) (Karen, 1998).

Insecure – anxiously attached infants are difficult to soothe by the caregiver, and they have ambivalent behaviors towards the caregiver, e.g., being very clingy and then immediately rejecting the caregiver (Ainsworth, Blehar, Waters, & Wall, 1978). This ambivalent behavior develops due to their lack of certainty of their caregiver’s availability and the resulting frustration (Cassidy & Berlin, 1994). Infants with insecure – ambivalent attachment become preoccupied with the caregiver at the expense of environmental exploration which becomes inhibited (Ainsworth, Blehar, Waters, & Wall, 1978; Cassidy & Berlin, 1994), a pattern that continues into their adult relationships (Shaver & Mikulincer, 2012). During the preschool years they have difficulties maintaining peer relationships and they continuously seek the teacher’s proximity; further, they easily become dysregulated and struggle with self-regulation (Sroufe, Duggal, Weinfield, & Carlson, 2000). Moreover, due to their incoherent ways of maintaining attachment to their caregiver, preschoolers tend to show behavioral problems that are difficult to control by their caregivers (Moss, Bureau, Cyr, Mongeau, & St-Laurent, 2004). Their unpredictable and frequent aggressive behavior makes them less well liked by their peers and they are often viewed as being mean (Karen, 1998). During childhood and adolescence they are at risk
for developing symptoms of depression, anxiety disorders, and feelings of shame (Muris, Mayer, & Meesters, 2000; Muris et. al, 2014; Sroufe, Duggal, Weinfield, & Carlson, 2000), experiences that continue in their adulthood life (Gross & Hansen, 2000; Muris et. al, 2014; Wei, Shaffer, Young, & Zakalik, 2005). Their experiences in early childhood are similar to their adult experiences in close relationships where they tend to be overly dependent on and preoccupied by others, holding the belief that others cannot love them (Shaver & Mickulincer, 2012). They also hold negative beliefs of self and others, thus their relationships are filled with insecurities and hyper-vigilance which leads to the erosion of their relationships (Mikulincer & Shaver, 2017). In love relationships, they are relentlessly seeking the proximity of their partners, and they often act helpless and incompetent in order to elicit their partners’ support and affection (Shaver & Mickulincer, 2012). Their hyper-activating emotional regulation strategy (Cassidy & Kobak, 1988), which entails exaggerating their distress and inadequacies, is used in an effort to maintain emotional closeness and receive others’ affection, support, and compassion (Mikulincer, 1998).

Insecure – Avoidant Attachment. An insecure – avoidant attachment develops when a caregiver responds to their infant’s distress with anger, intolerance, or active rejection (Ainsworth, Blehar, Waters, & Wall, 1978). These caregivers are unresponsive and are often disengaged from their child both physically and emotionally (Davies, 2011; Karen, 1998), and they tend to punish the distressed infant instead of providing comfort and calming, perceiving the
infant as being bad or acting out with the intention to irritate the caregiver (Davies, 2011). These caregivers express anger and make negative comments about the infant, and also avoid physical contact with the infant (Davies, 2011).

Infants with an avoidant attachment internalize the caregiver’s active rejection and anger, and they develop an expectation that adults are not a source of comfort in difficult times, thus suppressing their emotions in an effort to maintain the proximity to the caregiver (Davies, 2011). Although insecure–avoidant attached individuals present as self-contained, the lack of expressed emotion is not congruent with their physiological state of distress (Mikulincer, 1998a; Spangler & Grossmann, 1993).

An insecure–avoidant attachment style also has a significant negative impact on individuals' relationships, mental health, and emotional regulation capacity (Mikulincer & Shaver, 2017). During the preschool years, these children display aggressive behaviors, fail to connect with their peers, and avoid seeking help from teachers, especially in times of distress (Sroufe, Duggal, Weinfield, & Carlson, 2000). They have the expectation of being rejected in times of distress which leads to withdrawal behavior, impacting their social interactions since others often misinterpret their behavior as arrogant and self-sufficient (Karen, 1998). Later, during early childhood and adolescence, they experience anxiety and depression (Muris, Mayer, & Meesters, 2000) and display aggressive behaviors (Davies, 2011; Sroufe, Duggal, Weinfield, & Carlson, 2000). Their anger related to rejection in their early relationship with their caregiver manifests
in behavior problems during childhood (Sroufe, 2005). As adults, insecure – avoidant individuals do not hold a clear and coherent representation of self, and they tend to inflate their self-worth, exaggerate their abilities, and display narcissistic tendencies (while experiencing self-criticism) (Mikulincer, 1998; Mikulincer & Shaver, 2017a). In love relationships they are not attuned to their partners’ feelings and thoughts (Izhaki-Costi & Schul, 2011) and are more likely to assess their partners in a negative way when in conflict situations (Pietromonaco & Barret, 1997). Moreover, they perceive others as being unsupportive, and they thus maintain emotional distance from others and act self-reliant (Mikulincer & Shaver, 2017).

When it comes to emotional regulation, individuals with insecure – avoidant attachment use deactivation, an emotional regulation strategy that assists them in maintaining emotional distance when feeling distress (Cassidy & Kobak, 1988; Collins, Clark, & Shaver 1996). During stressful times, they present as self-reliant by exaggerating their positive characteristics and minimizing their flaws, fearing rejection if their inadequacies are discovered (Collins, Clark, & Shaver 1996; Mikulincer, 1998).

**Disorganized Attachment.** Finally, **insecure – disorganized/disoriented attachment** develops within a confusing infant-caregiver relationship where the caregiver from whom the infant seeks security and comfort is also the source of terror (Cyr, Euser, Bakermans-Kranenburg, & Van Ijzendoorn, 2010; Main & Hesse, 1990). Caregivers with unresolved trauma or severe mental illness often
have abusive, frightening, neglectful, or extreme contradictory behaviors towards the infant/child, becoming a source of fright (Beebe et. al, 2010; Main & Hesse, 1990; Schuengel, Bakermans-Kranenburg, & Van Jizendoorn, 1999). These behaviors of the caregiver are rooted in unresolved attachment traumas of their own (e.g., unresolved loss of parent to death), struggles with substance abuse, severe depression, or bipolar disorder (DeMulder & Radke-Yarrow, 1991; Main & Solomon, 1990; O'Connor, Bureau, McCartney, & Lyons-Ruth, 2011). These caregivers are at high risk of neglecting and maltreating their children (Carlson, 1998; Main & Solomon, 1990).

Infants with insecure –disorganized/disoriented attachment continuously initiate and inhibit attachment with the caregiver (Main & Hesse, 1990) and experience fright without resolution (Cyr, Euser, Bakermans-Kranenburg, & Van Ijzendoorn, 2010). This infant’s state of continuous dysregulation is expressed through odd and out of context disorganized behavior, as well as distressed emotional expression such as confusion, fear, or trance (Main & Solomon, 1990). They might appear disoriented, have rapid and almost simultaneous contradictory behaviors, and move very slowly or remain completely still (Main & Solomon, 1990).

Developing an insecure –disorganized/disoriented attachment style has a significant negative impact on individuals’ quality of interpersonal relationships, mental health, and capacity for emotional regulation. As early as preschool, these children display both externalizing and internalizing behaviors (DeMulder &
Radke-Yarrow, 1991; O’Connor, Bureau, McCartney, & Lyons-Ruth, 2011; Van Ijzendoorn et al., 1999) including behavior problems such as impulsive, aggressive, and controlling behaviors (Sroufe, 2005). They also have poor relationships with peers and teachers, and they display hostility and frustration towards their caregivers (O’Connor, Bureau, McCartney, & Lyons-Ruth, 2011). Throughout childhood and adolescence, they often experience episodes of dissociation, i.e., a defensive mechanism developed during infancy that helped them detach from the unbearable frightening situation (Carlson, 1998; Schore, 2003, 2017; Sroufe, Duggal, Weinfield, & Carlson, 2000). During adolescence, they are at high risk of developing psychopathologies (Carlson, 1998) such as personality disorders (e.g., Borderline Personality Disorder), self-harm, and suicidal behavior (Agreawal, Gunderson, Holmes, & Lyons-Ruth, 2004; Carlson, Egeland, & Sroufe, 2009; Lyons-Ruth, Bureau, Holmes, Easterbrooks, & Brooks, 2013; Sroufe, 2005). The continuous dysregulation induced by the attachment trauma also has a significant negative impact on the development of the right hemisphere of the brain, where emotion regulation takes place, later interfering with individuals’ ability to cope with social-emotional stressors (Schore, 2017).

Summary. The developmental outcomes of the different attachment styles suggest a link between early attachment and the subsequent development of self-compassion; this is outlined more specifically below (i.e., how the three facets of self-compassion [mindfulness, self-kindness, and common humanity] relate to attachment research findings).
Attachment and Self-Compassion

Attachment and Mindfulness. As discussed previously, mindfulness refers to the ability to maintain the attention to the present moment, with awareness of self and others (Kabat-Zin, 2009). In stressful times, mindful individuals are open to their own suffering without dismissing difficult feelings (Bishop et al., 2004; Brown & Ryan, 2003; Holahan & Moos, 1987; Kabat-Zinn, 2009). The opposite of mindfulness is over-identification, which is the tendency to become identified with negative emotions, thoughts, and sensations that arise in difficult situations (Neff, 2003b).

Studies have found that during difficult situations, securely attached individuals are better able to tolerate distress and maintain the belief that they can overcome stressful situations, and thus they do not become overwhelmed by their distress (Mikulincer, 1998a, 1995; Mikulincer, Florian, & Weller, 1993). This capacity of securely attached individuals for tolerating distress assists them in remaining present in the moment, regardless of the situation encountered (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006). Neurobiological research suggests that the capacity to cope with new and stressful situations as demonstrated by securely attached individuals has its roots in the optimal development of the right hemisphere of the brain, the part of the brain where emotional information is processed (Schore, 2017). The right hemisphere of the brain develops during the first year of life with optimal development occurring in the context of mother-infant emotional attunement (Schore, 2017). This in turn assists securely attached
individuals in developing an awareness of self and others (Decety & Chaminade, 2003), which is a core element of mindfulness.

In contrast, both anxious and avoidant individuals experience low levels of mindfulness due to difficulties regulating their emotions (Pepping, Davis, O’Donovan, 2012). For instance, when distressed, individuals with an anxious attachment ruminate on and become preoccupied with negative emotions, often exaggerating their distress in order to maintain emotional closeness to others (Mikulincer, 1998, 1998a) which is the opposite of mindfulness state. When faced with cues of stressors, individuals with an avoidant attachment use emotional detachment as a regulation strategy (Ainsworth, Blehar, Waters, & Wall, 1978; Cassidy & Kobak, 1988; Collins, Clark, & Shaver 1996). This tendency to detach emotionally in difficult times is an adaptive emotional coping strategy developed during infancy in an effort to maintain proximity to the primary caregiver (Ainsworth, Blehar, Waters, & Wall, 1978; Brumariu, 2015). Although avoidant individuals may appear to be self-contained in stressful situations, they nonetheless show physiological signs of distress (Mikulincer, 1998a). Finally, disorganized individuals are unable to maintain awareness in the present moment in times of distress due to their early experience of continuous dysregulation (Schore, 2017). They tend to experience episodes of dissociation from the present moment when faced with social-emotional stressors (Schore, 2017).
Attachment and Self-Kindness. Self-kindness involves being accepting and loving towards oneself even when experiencing difficult situations or faced with personal inadequacies (Neff & Knox, 2017). This is in contrast to self-judgment, which involves being critical towards self, which leads to such painful emotions as feelings of unworthiness or perception of being defective (Brown, 1999, 2006; Tangney & Dearing, 2002).

Securely attached individuals are more likely than insecure individuals to be kind towards themselves when things go wrong, and they are less likely to be self-critical (Irons, Gilbert, Baldwin, Baccus, & Palmer, 2016). Self-kindness has its roots in early attachment security since it develops within the early secure relationship with caregivers who are sensitively attuned and responsive towards the child’s needs (Shaver, Mikulincer, Sahdra, & Gross, 2016). Securely attached individuals internalize their caregivers’ support and responsiveness, and are more likely to develop the ability to self-care when needed (Mikulincer & Shaver, 2004).

In contrast, anxious individuals are likely to be self-critical (Cantazaro & Wei, 2010) and experience feelings of shame (Chen, Hewitt, Flett, 2015; Muris et. al, 2014; Wei, Shaffer, Young, Zakalik, 2005), which are painful feelings of unworthiness (Brown, 1999, 2006). Due to the inconsistent responsiveness from their primary caregivers, they have a negative “working model” of themselves (Pietromonaco & Feldman, 2000) which leads them to look outside of themselves for comfort and compassion (Mikulincer, 1998). Moreover, individuals with an
insecure-avoidant attachment tend to be self-critical (Cantazaro & Wei, 2010); however, they protect themselves by exaggerating their positive characteristics and minimizing their inadequacies in an effort to hide their deficiencies (Collins, Clark, & Shaver 1996; Mikulincer, 1998). Those who have the most insensitive and severe negative reactions towards themselves are those with an insecure – disorganized attachment (Lyons-Ruth, Bureau, Holmes, Easterbrooks, & Brooks, 2013). Their early experiences of fright without resolution in relationship with their primary caregiver significantly impact their capacity for emotional regulation (Cyr, Euser, Bakermans-Kranenburg, & Van Ijzendoorn, 2010; Schore, 2017). Disorganized individuals are likely to engage in self-harming behavior (Lyons-Ruth, Bureau, Holmes, Easterbrooks, & Brooks, 2013) as an anti-dissociation strategy (Hamza, Willoughby, & Good, 2013) due to their ineffectiveness to self-regulate when experiencing emotional distress (Mikolajczak, Petrides, & Hurry, 2009).

**Attachment and Common Humanity.** Finally, common humanity refers to recognizing that suffering is part of the human experience, and that what makes us feel separate is what we actually have in common (Neff, 2003b). It involves acknowledging that failure and perceived imperfections are common human experiences and that all human beings struggle with feelings such as shame or imperfection (Neff, 2003b). When individuals have the ability to recognize that vulnerability is part of the human experience, they feel less isolated (Neff, 2003b; Neff & Germer, 2017).
Results of neurobiological studies indicate that the development and maintenance of a secure attachment can be observed in the development of the right brain hemisphere, the part of the brain that assists individuals in experiencing a sense of connectedness with others (Decety & Chaminade, 2003; Schore, 2017). Securely attached individuals see their imperfections and faults as part of human limitations, thus they remain connected and hold the belief that they are valued despite their imperfections (Mikulincer & Shaver, 2004). Moreover, securely attached individuals see the similarities between self and others in a realistic manner, regardless of their emotional state (Mikulincer, Orbach, & Iavnieli, 1998).

By contrast, when in distress, insecurely-anxious individuals overemphasize their similarities with others; however, this is not a realistic view of the shared humanity but a hyper-activation emotional regulation strategy intended to maintain a sense of emotional closeness to others (Mikulincer, Orbach, & Iavnieli, 1998). Conversely, insecure–avoidant attached individuals underestimate the similarities between themselves and others, emphasizing the differences between self and others, and differentiating themselves from others through exaggerating their unique traits (Mikulincer, Orbach, & Iavnieli, 1998). Finally, since insecure–disorganized/disoriented individuals cope with social-emotional stressors through dissociation (Schore, 2017), they are unable to maintain awareness of self and others which is necessary in recognizing the common human experiences.
Summary. According to the research studies summarized above, securely attached individuals have the ability to tolerate distress and remain in the present moment (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006), internalize their caregiver responsiveness and be kind to themselves in difficult situations (Irons, Gilbert, Baldwin, Baccus, & Palmer, 2016; Mikulincer & Shaver, 2004), and see similarities between themselves and others regardless of their emotional state (Mikulincer, Orbach, & Iavnieli, 1998). All these abilities are characteristics of the three facets of self-compassion: mindfulness, self-kindness, and common humanity (Neff, 2003b). Moreover, studies suggest an emotional regulation effect of self-compassion (Diedrich, Hofmann, Cuijpers, & Berking, 2016; Vettese, Dyer, Li, Wekerle, 2011), which is also the hallmark of secure attachment (Schore, 2017; Sroufe, 2005). Additionally, a strong sense of self characterizes securely attached individuals (Mikulincer, 1995; Mikulincer, 1998; Mikulincer & Shaver, 2004), which is also a characteristic of self-compassionate individuals (Neff & Vonk, 2009).

Summary and Purpose of Study

As demonstrated above, self-compassion is associated with many positive outcomes related to psychological, physical, and relational well-being; therefore, understanding its origins is essential to furthering our understanding of how it takes root and develops over time. While research to date suggests a relationship between self-compassion and early parent-child attachment security, no study has thoroughly examined this relationship, including how it may extend
its impact into early adulthood. Studies to date have examined adult romantic partner/peer attachment (not early parent-child attachment) (Neff & Beretvas, 2012; Neff & McGehee, 2010; Pepping, Davis, O’Donovan, & Pal, 2015) and early attachment and self-compassion in adolescents with and without self-harm behaviors (Jiang, You, & Zheng, 2017; Moreira, Gouveia, & Canavarro, 2018; Peter & Gazelle, 2017). Further, none of these studies have examined the mediator variables of emotional regulation and shame in a causal model examining the relationship between early attachment and self-compassion.

The purpose of the present study is, in general, to examine the indirect impact of early attachment on self-compassion in early adulthood utilizing a causal model to examine the mediating effects of emotional regulation and shame on the relationship between early attachment and self-compassion (Figure 1).

This study aims to better understand the origins of self-compassion which will add an important component to the existing research literature on self-compassion. The findings will add to the current knowledge base of the significant impact of early attachment on development and behavior, including psychological well-being. Further, they will assist clinicians in their therapeutic work with individuals and families. Finally, these findings will broaden our understanding of psychological processes and their effect on mental health.
Figure 1. Model of the Relationship Among Early Attachment, Shame, Emotional Regulation, and Self-Compassion.
CHAPTER THREE:

METHOD

Participants

Two hundred thirty-three female (n = 143; 61.4%) and male (n = 90; 38.6%) college students between 18 and 28 years old (M = 22.7 yrs.) from a southern California state university participated in this study. Participants’ ethnicity was as follows: Hispanic (64.8%), Caucasian (18.5%), Other (13.7%), Biracial (11.2%), Asian (6.4%), Black (5.6%), Middle Eastern (2.6%), and Native American (0.4%). Two-thirds of participants were from lower middle-class households based on father’s educational level (66.0% had a high school diploma or less; 17.6% had some college; 15.8% had college/professional degree).

Measures

Early Attachment

Three scales were used to assess early attachment security. First, The Parent Scale of the Inventory of Parent and Peer Attachment (IPPA) (Armsden & Greenberg, 1987) was used to measure participants’ attachment security towards their mother/mother figure. This measure was developed based on Bowlby’s attachment theory and it measures the affective/cognitive dimensions of attachment towards parents/primary caregivers (Armsden & Greenberg, 1987). The IPPA is a self-report instrument that includes 25 items that assess three
dimensions: mutual trust (e.g., “When we discussed things, my mother/mother figure cared about my point of view”), quality of communication (e.g., My mother/mother figure helped me to understand myself better”), and extent of anger and alienation (e.g., “I didn’t get much attention from my mother/mother figure”). Responses are rated on a 5-point Likert-scale (1 = Almost Never or Never True, 5 = Almost Always or Always True). Higher scores indicate higher amounts of Trust, Communication, and Alienation. The Cronbach’s alphas are ranging from .87 to .92 (Amsden & Greenberg, 1987) (APPENDIX A).

Second, the Expressive Encouragement (EE) subscale from the Coping with Children’s Negative Emotions Scale – Adolescent Perception of Parents (CCNES-APP) (Fabes & Eisenberg, 1998) was used to assess the degree of participants’ perception of their mother/mother figure’s encouragement to express negative affect and the degree to which their negative emotional states were validated (e.g., “When my mother/mother figure saw me become angry at a close friend, s/he usually encouraged me to express my anger,” “When I got down because I had a bad day, my mother/mother figure usually listen to me talk about my feelings”). The central aspect of the secure attachment relationship is for the parent/caregiver to see the child’s experience through the child’s perspective and help the child process negative emotions (Gold, 2011). The Expressive Encouragement (EE) subscale includes nine scenarios; each response is rated on a 7-point Likert scale (1 = Very Unlikely, 7 = Very Likely). Higher score indicates higher encouragement to express negative emotions.
Cronbach’s alpha is .89 for the mother version of the scale (Lugo-Candelas, Harvey, Breaux, & Herbert, 2016) *(APPENDIX B).*

Third, the “Care” subscale from the Parental Bonding Instrument (PBI) (Parker, Tupling, & Brown, 1979) was used to measure participants’ perceived caregiving attitudes and behaviors of their mother/mother figure within their first 16 years of life. The 12-item Care subscale measures individuals’ perceptions of mother/mother figure’s warmth, responsiveness, and understanding (e.g., “Spoke with me in a warm and friendly voice,” “Enjoyed talking things over with me”). Each of the 12 items is rated on a 4-point Likert scale (0 = Very Likely, 4 = Very Unlikely). Higher scores indicate a higher level of perceived care through understanding, responsiveness, and warmth. Internal consistency (using Cronbach’s alpha) for the Less Care subscale is .90 for mother form (Xu, Morin, Marsh, Richards, & Jones, 2018) *(APPENDIX C).*

**Emotional Regulation**

The Difficulties in Emotion Regulation Scale (DERS) (Gratz & Roemer, 2004) was used to measure participants’ emotional regulation ability. Emotional regulation defined by the authors as the awareness of emotions, the ability to inhibit impulsive behaviors related to negative emotions, the ability to regulate the intensity and durations of their emotions, and acceptance of negative emotions as being part of life (Gratz & Tull, 2010). The DERS measures elements of emotional regulation such as non-acceptance of emotional responses (e.g., “When I’m upset, I feel irritated for feeling that way”); difficulties engaging in goal-
directed behavior (e.g., When I’m upset, I have difficulties concentrating”); impulse control difficulties (e.g., When I’m upset, I lose control over my behaviors”), lack of emotional awareness (e.g., “I am attentive to my feelings”); limited access to emotional regulation (e.g., “When I’m upset, I believe I will remain that way for a long time”); and lack of emotional clarity (e.g., “I have no idea how I am feeling”). Responses are rated on a 5-point scale (1 = Almost never, 5 = Almost always). The DERS provides a global score for emotional regulation as well as six subscales scores; lower scores on DERS indicate increased ability for emotional regulation. Gratz and Roemer (2004) cite an internal consistency (using Cronbach’s alpha) of .93 (APPENDIX D).

Shame

The Test of Self-Conscious Affect – 3 – Short Form (TOSCA-3 -SF) (Tangney, Dearing, Wagner, & Gramzow, 2000) was used to assess participants’ tendency to react to situations with shame. Shame is a painful emotion that leads individuals to perceive themselves as being unworthy and defective, i.e., having negative view of themselves (Brown, 1999, 2006; Tangney & Dearing, 2002). The TOSCA-3 -SF presents 11 scenarios that are likely to occur in daily life (e.g., “You make plans to meet a friend for lunch. At 5 o’clock, you realize you stood up your friend. You would think: I’m inconsiderate”), each response being rated on a 5-point Likert scale (1 = Not likely, 5 = Very likely) for shame reaction to the situations Higher scores indicate greater shame. Internal consistency (using
Cornbach’s alpha) was found to be .77 - .88 for shame proness (Tangney & Dearing, 2002) (APPENDIX E).

Self-Compassion

The Self-Compassion Scale (SCS; Neff, 2003a) was used to assess participant’s current level of self-compassion. The SCS is a 26-item scale that is comprised of 6 subscales: Mindfulness (4 items, i.e., “When something upsets me I try to keep my emotions in balance”); Over-Identification (4 items, i.e., “When something upsets me I get carried away with my feelings”); Self-Kindness (5 items, i.e., “I try to be loving towards myself when I’m feeling emotional pain”); Self-Judgment (5 items, i.e., “I’m disapproving and judgmental about my own flaws and inadequacies”); Common Humanity (4 items, i.e., “When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people”); Isolation (4 items, i.e., “When I’m really struggling, I tend to feel like other people must be having an easier time of it”). Responses are rated on a 5-point scale (1 = Almost never to 5 = Almost always). Higher scores indicate higher levels of self-compassion. Internal consistency (using Cronbach’s alpha) was found to be ranging from .90 to .92 (Neff & Beretvas, 2012; Neff & McGehee, 2010) (APPENDIX F).

Demographics

Participants completed a background information form that requested information about the following items: participants’ age, gender, ethnicity, and the level of education of their mother/mother figure and father/father figure.
(APPENDIX G). Table 1 below summarizes the scales, the subscales, definitions, and scoring information.

Table 1. Scales, Subscales, Definitions, and Scoring Information

<table>
<thead>
<tr>
<th>Scales</th>
<th>Definition</th>
<th>Score Guide</th>
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<tr>
<td><strong>Early Attachment:</strong></td>
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<tr>
<td>a) Inventory of Parent and Peer Attachment (IPPA) – The Parent (Mother) Scale.</td>
<td>Measures the affective/cognitive dimensions of attachment towards mother/mother figure</td>
<td>Higher scores indicate higher amounts of Trust, Communication, and Alienation</td>
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<td><strong>Subscales:</strong></td>
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<tr>
<td>Trust</td>
<td>Measures mutual trust between mother/mother figure and child</td>
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<td>Communication</td>
<td>Measures quality of communication between mother/mother figure and child</td>
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<tr>
<td>Alienation</td>
<td>Measures the extend of anger and alienation between mother/mother figure and child</td>
<td></td>
</tr>
<tr>
<td>b) Expressive Encouragement</td>
<td>Measures individual’s perception of mother/mother figure’s encouragement to express negative affect and the degree to which the individual's negative emotional states were validated</td>
<td>Higher score indicates higher encouragement to express negative emotions</td>
</tr>
<tr>
<td>c) Care</td>
<td>Measures individual’s perception of mother/mother figure’s</td>
<td>Higher scores indicate a higher level of perceived care.</td>
</tr>
</tbody>
</table>
warmth, responsiveness, and understanding within their first 16 years of life.

**Emotional Regulation:**

**Difficulties with Emotional Regulation Scale (DERS)**
- Measures ability for emotional regulation
- Lower scores indicate increased ability for emotional regulation

**Subscales:**
- **Non-Accepting**
  - Measures non-acceptance of emotional responses

- **Goals**
  - Measures difficulties engaging in goal-directed behavior

- **Impulse**
  - Measures impulse control difficulties

- **Awareness**
  - Measures lack of emotional awareness

- **Strategy**
  - Measures limited access to emotional regulation

- **Clarity**
  - Measures lack of emotional clarity

**Shame:**

**Shame subscale of Test of Self-Conscious Affect - 2 Short Form (TOSCA-3-SF)**
- Measures individual's tendency to react to situations with shame
- Higher scores indicate higher shame

**Self-Compassion:**

**Self-Compassion Scale (SCS)**
- Measures individual's levels of self-compassion
- Higher scores indicate higher levels of self-compassion

**Subscales:**
- **Mindfulness**
  - Measures capacity to keep one's attention in the present moment with
no judgment

Over-identification Measures tendency to become identified with negative thoughts/emotions

Self-Kindness Measures tendency to react with self-kindness when facing personal limitations

Self-Judgment Measures tendency to react with self-criticism when facing own inadequacies

Common Humanity Measures ability to recognize that suffering is part of human experience

Isolation Measures tendency to feel isolated when faced with own vulnerabilities

Procedure

Volunteer participants were solicited from in-class announcements. Packets of hard copies of the survey were distributed to participants. The researcher returned the next class session to pick up the completed packets. Some participants received extra course credit for their participation in the study at the discretion of their course instructor.

Planned Analysis

Structural equation modeling (SEM) using EQS (version 6.1) was used to analyze the data.
CHAPTER FOUR:  
RESULTS

Prior to analysis, the measures used in the present study were examined through various IBM SPSS 23 procedures for accuracy of data entry, missing values, and fit between their distributions and the assumptions of analysis. Results from these examinations indicated that there were no issues with meeting assumptions. Table 1 indicates descriptive statistics for all of the continuous variables utilized in the study and the reliability coefficients for the factors and subscales.

Structural equation modeling (SEM) using EQS (version 6.1) was used to analyze the data. The hypothetical model (Figure 1) was tested to determine the type of relationships among Early Attachment, Emotional Regulation, Shame, and Self-Compassion. The circles in the model represent the latent variables and the rectangles represent measured variables. The study examined the relationship among Early Attachment (F1), a latent variable with five indicators (Trust, Communication, Alienation, Expressive Encouragement, and Care) (standardized coefficient ranged from .74 to .91); Emotional Regulation (F2), a latent variable with six indicators (Non-Acceptance, Goals, Impulse, Awareness, Strategy, and Clarity), (standardized coefficient ranged from -.39 to -.94); Shame (V1), measured variable; and Self-Compassion (F3), a latent variable with six indicators (Mindfulness, Over-Identification, Self-Kindness, Self-Criticism,
Common Humanity, and Isolation), (standardized coefficient ranged from .39 to .85).

Preliminary Analysis

Mardia’s coefficient, a general measure of multivariate kurtosis used to examine normality, was included in the preliminary analysis of the data. The hypothesis of multivariate normality was rejected (normalized coefficient = 6.85).

Model Estimation

The study’s hypothesized model was tested using three primary fit statistics: the Comparative Fit Index (CFI), the root mean square of error approximation (RMSEA), and Sattora-Bentler scaled $\chi^2$. For CFI, an ideal value is greater than .95. For RMSEA, a good model fit indicator is a value less than .06. For Sattora-Bentler scaled fit statistic a $\chi^2$ to df ratio of two or less is ideal. The hypothesized model was supported by Sattora-Bentler scaled $\chi^2$ test statistic, the CFI, and RMSEA, $\chi^2 (120) = 213.56$, CFI = .96, RMSEA = .06.

The model was evaluated and the variables were found to be good indicators for the latent constructs. Early Attachment (F1) was a strong latent construct of the early attachment security towards their mother/mother figure, which included Trust (standardized coefficient = .91), Communication (standardized coefficient = .90), Alienation (standardized coefficient = -.83), Expressive Encouragement (standardized coefficient = .74), and Care (standardized coefficient = -.81).
Emotional Regulation (F2) was a strong latent construct for emotional regulation ability, which included Non-Acceptance (standardized coefficient = - .81), Goals (standardized coefficient = -.67), Impulse (standardized coefficient = -.79), Strategy (standardized coefficient = -.94), and Clarity (standardized coefficient = -.60), and it was moderately and directly predicted by Awareness (standardized coefficient = -.39).

Self-Compassion (F3) was a strong latent construct for self-compassionate attitude, which included Mindfulness (standardized coefficient = .59), Over-Identification (standardized coefficient = .82), Self-Kindness (standardized coefficient = .68), Self-Judgment (standardized coefficient = .85), and Isolation (standardized coefficient = .75), and it was directly and moderately predicted by Common Humanity (standardized coefficient = .39).

Direct Effects

The validity of the full structural model was assessed by testing the direct effects of Early Attachment on Emotional Regulation, Early Attachment on Shame, Emotional Regulation on Self-Compassion, and Shame on Self-Compassion. The model (Figure 1) shows the found effects. Early Attachment moderately predicted Emotional Regulation (standardized coefficient = .39). That is, as the attachment security increased, capacity for emotional regulation also increased. Early Attachment moderately predicted Shame (standardized coefficient = -.24). That is, as the attachment security increased, the tendency to respond to situations with shame decreased. Emotional Regulation largely
predicted Self-Compassion (standardized coefficient = .77). That is, the higher the capacity for emotional regulation, the higher the levels of self-compassion. Shame moderately predicted Self-Compassion (standardized coefficient = -.23). That is, as shame decreased, self-compassion increased.

Indirect Effect

An indirect relationship between Early Attachment and Self-Compassion, mediated by Emotional Regulation and Shame, was hypothesized. This indirect relationship was supported. Early Attachment moderately and indirectly predicted Self-Compassion through Emotional Regulation and Shame (standardized coefficient = .36).

Table 2. Scales, Number of Participants, Number of Items, Means, Standard Deviations, and Reliability Coefficients

<table>
<thead>
<tr>
<th>Scales</th>
<th>N</th>
<th>Number of Items</th>
<th>Mean</th>
<th>SD</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Attachment:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust</td>
<td>233</td>
<td>10</td>
<td>38.76</td>
<td>8.52</td>
<td>.91</td>
</tr>
<tr>
<td>Communication</td>
<td>231</td>
<td>9</td>
<td>30.26</td>
<td>9.31</td>
<td>.92</td>
</tr>
<tr>
<td>Alienation</td>
<td>232</td>
<td>6</td>
<td>14.95</td>
<td>5.52</td>
<td>.81</td>
</tr>
<tr>
<td>Expressive Encouragement</td>
<td>233</td>
<td>9</td>
<td>26.85</td>
<td>10.38</td>
<td>.92</td>
</tr>
<tr>
<td>Care</td>
<td>231</td>
<td>12</td>
<td>26.91</td>
<td>10.39</td>
<td>.93</td>
</tr>
<tr>
<td>Emotional Regulation:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Accepting</td>
<td>233</td>
<td>6</td>
<td>15.63</td>
<td>6.81</td>
<td>.91</td>
</tr>
<tr>
<td>Goals</td>
<td>233</td>
<td>5</td>
<td>15.64</td>
<td>5.41</td>
<td>.89</td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>SE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>------</td>
<td>-----</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Impulse</td>
<td>13.10</td>
<td>5.89</td>
<td>.89</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness</td>
<td>14.56</td>
<td>5.18</td>
<td>.84</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategy</td>
<td>19.70</td>
<td>7.83</td>
<td>.89</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarity</td>
<td>12.16</td>
<td>4.73</td>
<td>.86</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Shame:**

| Shame        | 33.74| 6.89| .70 |

**Self-Compassion:**

| Mindfulness  | 13.90| 3.60| .78 |
| Over-identification | 10.05| 3.69| .73 |
| Self-Kindness | 15.14| 4.62| .82 |
| Self-Judgment | 12.60| 4.71| .81 |
| Common Humanity | 13.95| 3.67| .79 |
| Isolation    | 10.57| 4.08| .77 |
Figure 2. Model of the Relationship Among Early Attachment, Shame, Emotional Regulation, and Self-Compassion with SEM Results.
CHAPTER FIVE: DISCUSSION

The purpose of this study was to examine the impact of early attachment on self-compassion in early adulthood. Utilizing a causal model, the mediating effects of emotional regulation and shame on this relationship were examined. The resulting model suggests that early caregiving experiences impact self-compassion through their impact on emotional regulation and degree of experienced shame. In other words, early attachment directly impacts individuals’ capacity for emotional regulation and their belief that they are worthy despite imperfections; these in turn impact their level of self-compassion.

Direct Effects

Early Attachment and Emotional Regulation

Results of the analyses showed that early attachment has a moderate, direct effect on emotional regulation. That is, as attachment security increases, the capacity for emotional regulation also increases. These results are consistent with previous research showing that the quality of the early parent-child relationship influences an individual’s capacity to regulate their own emotions (Schore, 2017; Sroufe, 2005, Sroufe et al., 2000). Studies have repeatedly found that securely attached individuals have an increased capacity for emotional regulation compared to those who are insecurely attached (Mikulincer & Shaver, 2017; Shore, 2017; Sroufe, 2005; Sroufe et. al, 2000). This assists them with tolerating distress in difficult situations (Baer, Smith, Hopkins, Kriete...
Toney, 2006; Mikulincer, 1995; Mikulincer, Florian, & Weller, 1993) and enables them to adapt their emotions to different situational contexts (Sroufe, 2005).

When the caregiver, usually the mother, responds to the infant’s psychobiological needs appropriately, promptly, and with sensitivity and warmth, the infant’s attachment becomes secure, since the infant learns that the caregiver is a reliable source of safety and comfort (Ainsworth, 1979; Schore, 2017). This early emotional attunement between the caregiver and infant leads to the optimal development of the right hemisphere of the brain where emotional information is processed, leading to an increased capacity for emotional regulation (Schore, 2017). The primary caregiver’s sensitive attunement to the infant’s distress is essential since the infant depends completely on the caregiver for stress regulation and safety (Schore, 2017). Thus, when the caregiver ignores the infant’s psychobiological needs or becomes overly intrusive, the infant experiences danger instead of safety which sends the infant in an intense state of distress or dissociation; this in turn has major short and long-term negative effects on the infant’s psychobiology (Schore, 2017).

As infants, anxiously attached individuals experience their caregivers as being insensitive and inconsistent which results in an infant’s ambivalence (e.g., clingy and then immediately rejecting) towards caregiver (Ainsworth, Blehar, Waters, & Wall, 1978; Cassidy & Berlin, 1994), thus developing an incoherent way to maintain attachment (Moss, Bureau, Cyr, Mongeau, & St-Laurent, 2004). Anxiously attached individuals become preoccupied with caregivers at their own
expense (Ainsworth, Blehar, Waters, & Wall, 1978; Cassidy & Berlin, 1994), and they struggle with emotional regulation from childhood on (Sroufe et al., 2000). As adults they develop hyper-activating emotional strategies (Cassidy & Kobak, 1988), an exaggeration of distress in an effort to maintain closeness to others (Mikulincer, 1998). Avoidant individuals also struggle with emotional regulation (Mikulincer & Shaver, 2017), and they use a deactivation emotional strategy which entails maintaining emotional distance in time of distress (Cassidy & Kobak, 1988; Collins, Clark, & Shaver 1996). This emotional strategy developed during infancy within the relationship with their caregivers who responded to them with anger and rejection instead of comfort when the infant experienced stressful situations (Davies, 2011). Finally, due to the caregivers’ failure to provide safety for the infant in times of distress, instead being a source of terror (Cyr, Euser, Bakermans-Kranenburg, & Van Ijzendoorn, 2010; Main & Hesse, 1990; Schore, 2017), individuals with a disorganized attachment status experience continuous emotional dysregulation (Cyr, Euser, Bakermans-Kranenburg, & Van Ijzendoorn, 2010; Main & Hesse, 1990; Schore, 2017).

**Early Attachment and Shame**

Results also show that early attachment has a direct, moderate effect on shame. That is, the higher the attachment security, the lower the shame. These results are consistent with previous studies indicating that insecurely attached individuals develop feelings of shame during childhood and adolescence (Muris et al., 2014), experiences also found in the adult life of those insecurely attached
(Chen, Hewitt, & Flett, 2014; Gross & Hansen, 2000; Wei, Shaffer, Young, & Zakalik, 2005). By contrast, shame is negatively correlated with secure attachment (Gross & Hansen, 2000) as securely attached individuals have a consistent positive view of self even in time of distress (Mikulincer, 1998), and they maintain the belief that they are valued despite their imperfections (Mikulincer & Shaver, 2004). Moreover, while insecurely attached individuals are likely to experience feelings of shame (Chen, Hewitt, Flett, 2015; Muris et. al., 2014; Wei, Shaffer, Young, Zakalik, 2005) and be self-critical (Cantazaro & Wei, 2010), securely attached individuals have the ability to recognize both their positive and negative aspects of themselves, remain anchored in their belief that they are worthy despite their imperfections, and their view of self although realistic remains positive (Mikulincer, 1995; Mikulincer & Shaver, 2004).

Poor quality parenting during the early years of individuals’ lives interferes with the development of individuals’ positive view of self (Sroufe et al., 2000). Unfortunately, shaming is one of the most common and acceptable methods used by caregivers to regulate children’s behavior (Grille, 2005, 2015). The child’s “internal working model” is created through the early relationship with the caregiver, so positive early caregiving experiences create the child’s perception that they are worthy of love, care, and attention (Bowlby, 1969, 1983; Schore, 2017). When the caregiver fails to attend to the child’s intense internal emotional state with warmth, care, and love and instead reacts with distress, disappointment, or anger, the child’s adaptive reaction is shame (Karen, 1998;
Siegel & Bryson, 2012). Shame is a learned emotion; the child learns this emotion through the shaming verbal or non-verbal messages used by the caregiver (Grille, 2014). When the caregiver uses shaming messages, the child feels judged as being “bad” or defective, thus feeling diminished (Grille, 2014). Even as adults, when individuals recall their caregivers as being overprotective or rejecting, they experience feelings of inadequacies and self-hate (Irons, Gilbert, Baldwin, Baccus, & Palmer, 2006). By contrast, those who recall their caregivers’ warmth tend to have a sense of concern towards own self even when things go wrong (Irons, Gilbert, Baldwin, Baccus, & Palmer, 2006). A caregiver’s sensitive attunement and responsiveness towards the child validates the child’s “self,” and without this validation the child feels invisible, unworthy, and not valued (Karen, 1998).

Emotional Regulation and Self-Compassion

Results demonstrated that emotional regulation had a direct, large effect on self-compassion. These finding indicate that individuals with an increased capacity to self-regulate their emotions have higher level of self-compassion compared to those with a decreased capacity for self-regulation. This finding is congruent with previous findings suggesting that self-compassionate people have the capacity to maintain awareness of self and others in the present moment without judgment and without becoming over-identified with negative thoughts and emotions when experiencing difficult situations (Neff, 2003b). Since self-compassion requires mindfulness of one’s own emotions, having the ability self-
regulate one’s emotions in stressful situations provides the opportunity for the possibility of recognizing that suffering is part of the human experience and thus they might feel less isolated (Neff, 2003b). Moreover, by keeping difficult feelings in mindful awareness, instead of ignoring, avoiding, or becoming over-identified with them, a clearer understanding of what is needed in that situation emerges (e.g., meeting their suffering with kindness) (Neff, 2003a, 2003b).

These results are also in line with previous research findings indicating a significant impact of self-compassion on emotional regulation in individuals with a history of childhood maltreatment (Vettese, Dyer, Li, Wekerle, 2011). Having a history of childhood maltreatment leads to lower levels of self-compassion which, in turn, affects individuals’ capacity for emotional regulation (Vettese, Dyer, Li, Wekerle, 2011). Also, individuals with high levels of self-compassion typically experience decreased emotional turmoil (Yarnell & Neff, 2013), and when used as an emotional regulation strategy for depressive symptoms, a great reduction in symptoms has been found in highly depressed individuals (Diedrich, Hofmann, Cuijpers, & Berking, 2016).

Shame and Self-Compassion

Results showed that shame has a direct, moderate effect on self-compassion. That is, the higher the tendency to experience shame, the lower the levels of self-compassion. These results are consistent with previous research findings suggesting a relationship between self-compassion and shame; individuals with higher levels of self-compassion have been found to experience
less feelings of shame (Kelly & Tasca, 2016). Moreover, by fostering a self-compassionate attitude, the tendency to react to situations with shame decreases significantly (Candea & Tatar, 2018; Johnson & O’Brien, 2013).

Shame-prone individuals judge their own self in a negative manner, and they experience intense feelings of being defective and unworthy (Brown, 1999, 2006; Tangney & Dearing, 2002). When individuals experience these painful feelings, they have a desire to disappear and tend to hide from others (Tangney & Dearing, 2002). Thus, shame can lead to isolation which is the opposite of the awareness that such painful feelings are common human experiences (Neff, 2003a, 2003b). Moreover, individuals experiencing shame in stressful situations tend to ruminate on negative aspects of themselves (Orth, Berkin, & Burkhardt, 2006) or use avoidance of difficult feelings as a coping strategy (De Rubeis & Hollenstein, 2009) instead of acknowledging their feelings with a nonjudgmental attitude. The ability to maintain awareness of the present moment with acceptance rather than criticism provides space for individuals to recognize that they can meet their difficult feelings with kindness, even when things go wrong (Neff, 2003a, 2003b).

Indirect Effects

Early Attachment and Self-Compassion

As hypothesized, the relationship between early attachment and self-compassion was mediated by emotional regulation and shame. That is, as attachment security increases, the capacity for emotional regulation increases
and feelings of shame decrease which, in turn, impact self-compassion. These data suggest that the capacity for emotional regulation and positive view of self develop at least in part through an early secure attachment (as indicated in previous research). In turn, these psychological functions impact individuals’ ability to remain anchored in the present moment in difficult situations, enable one’s capacity self-care and kindness, and increase one’s awareness that imperfections are part of being human. Attachment security, developed within the early caregiving environment characterized by warmth, comfort, and responsiveness develops infants’ capacity for emotional regulation, a capacity that assists them to remain anchored in the present moment and tolerate distress as they mature (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006; Mikulincer, 1995; Mikulincer, Florian, & Weller, 1993; Sroufe, 2005). Attachment security also provides individuals with a sense that they are worthy of being loved and cared for despite their inadequacies (Mikulincer & Shaver, 2004), so that when faced with their own imperfections, they have the ability to remain anchored in the present moment without becoming overwhelmed by the situation. They see imperfections as human limitation (Mikulincer & Shaver, 2004), and acknowledge the similarities between themselves and others (Mikulincer, Orbach, & Iavnieli, 1998); further, they tend to be kind and caring towards themselves when things go wrong instead of being self-critical (Irons, Gilbert, Baldwin, Baccus, & Palmer, 2016 Mikulincer & Shaver, 2004). This tendency for self-kindness and self-care
develops within the early secure relationship with a responsive and caring
caregiver (Shaver, Mikulincer, Sahdra, & Gross, 2016).

Previous studies have also found that early experiences with caregivers
significantly predict levels of self-compassion: individuals experiencing
harmonious family relationships and maternal support show higher levels of self-
compassion compared to those experiencing stressful familial relationships and
maternal criticism (Neff & McGee, 2010). Moreover, parental emotional
closeness, compassion, kindness and warmth, as well as safety within the family,
undivided attention to the child, and a non-judgmental parental attitude are
positively related to individuals’ later levels of self-compassion (Gouveia, Carona,
Canavarro, & Moreira, 2016; Jiang, You, Zheng, & Lin, 2017; Kelly & Dupasquier,
2016; Kearney & Hicks, 2016; Marta-Simoes, Ferreira, & Mendes, 2018; Matos,
Carvalho, Cunha, Galhardo, & Sepodes, 2017; Moreire, Gouveia, & Canavarro,
2018; Neff & McGehee, 2010; Pepping, Davis, O’Donovan, & Pal, 2015; Peter &
Gazelle, 2017; Wu, Chi, Lin, & Du, 2018). However, these studies did not go in
depth in examining this relationship, and they either measured attachment by
using adult romantic partner/peer attachment (not early parent-child attachment)
(Neff & Beretvas, 2012; Neff & McGehee, 2010; Pepping, Davis, O’Donovan, &
Pal, 2015) or they used adolescent population with and without self-harming
behaviors (Jiang, You, & Zheng, 2017; Moreira, Gouveia, & Canavarro, 2018;
Peter & Gazelle, 2017). This is the first study which examines the impact of early
parent-child attachment on subsequent self-compassion in early adulthood, and it
provides evidence on the linkages between early caregiving and self-compassion through the mediating effects of emotional regulation and shame.

Limitations of Study and Future Directions
There are several limitations to this study that are highlighted below, as well various directions for future studies. First, the study was conducted on a college sample; therefore, the results may not be representative of general population. Future studies could utilize samples more representative of the general population, as well as investigate adolescent or clinical samples.

Second, the attachment measures used in the current study did not differentiate between the types of insecure attachment. Neff and Brevetas (2013) found a significant relationship between secure and anxious attachment styles and self-compassion, but not between the dismissive attachment style and self-compassion. Future studies might utilize measures that differentiate between attachment styles to contribute to the literature on these linkages.

Third, the present study did not address potential gender differences. Results from an earlier meta-analysis on self-compassion indicated that females have slightly lower levels of self-compassion compared to males (Yarnell, Stafford, Neff, Reilly, Knox, & Mullarkey, 2015). Future studies could further address gender, early attachment, and self-compassion.
Conclusions and Implications

The findings of this study provide insight into the relationship between early attachment and subsequent self-compassion through the mediating effects of emotional regulation and shame. The findings suggest that the capacity for emotional regulation and a positive view of self developed through an earlier secure attachment directly impact levels of self-compassion.

The findings of this study have a number of implications. First, it provides clinicians who work with young adults a greater understanding of the impact of early attachment as influencing not only their capacity for emotional regulation (Mikulincer & Shaver, 2017; Shore, 2017; Sroufe, 2005; Sroufe et al, 2000) and their tendency to experience shame (Muris et al, 2014), but also their levels of self-compassion. Thus, focusing on increasing these individuals’ levels of mindfulness, capacity for self-care, and understanding of common human experiences is essential since these elements of self-compassion have a significant impact on so many aspects of psychological, physical, and interpersonal well-being. Moreover, since shame was found to have a significant impact on levels of self-compassion, increasing individuals’ awareness that mistakes and feelings of inadequacies are a common human experience may be therapeutically beneficial. This awareness can assist individuals in becoming aware that what makes us feel disconnected is, in fact, what makes us the same. Equally important is the focus on increasing insecurely attached individuals’
capacity for responding with self-love and self-care when they are faced with feelings of their own shortcomings and inadequacies.

Second, the knowledge gained from this study could be utilized in parenting programs to increase caregivers’ awareness that the quality of their caregiving has such long-lasting effects on children. Previous research has demonstrated that a sense of safety and support in caregiver-child relationship assists children in maintaining a positive sense of self which acts like a buffer against poor mental health (Sroufe, 2005, Muris, Mayer, & Meesters, 2000), while poor quality parenting impedes the development of a positive self (Sroufe et al., 2000). The findings of this study add to this that the quality of early caregiving also influences levels of self-compassion.

Finally, this study can inform educators that students’ view of self, ability to regulate their emotions, and/or their capacity for self-care when faced with difficulties at school are significantly impacted by their early home environment. This awareness could be used to meet the student’s need for self-compassion by developing social-emotional learning curriculum that emphasizes development of self-compassion in the K-12 school system. Moreover, schools could provide evidence-based self-compassion courses and programs (e.g., Mindful Self-Compassion program (Neff & Germer, 2013) at high school and college levels. These programs have been found to increase students’ levels of self-compassion, well-being, and ability for emotional regulation, and also to decrease their test anxiety, self-criticism, psychopathology, and perceived stress
(Bluth, Gaylord, Campo, Mullarkey, & Hobbs, 2016; Dundas, Binder, Hansen, & Stige, 2017; Ko, Grace, Chavez, Grimlev, Dairymple, & Olson, 2018; McEwan, Elander, & Gilbert, 2018) Additionally, self-compassion programs could also be provided to educators, especially for those serving in communities with high levels of trauma, since they can reduce secondary trauma and burnout symptoms (Delaney, 2018; Eriksson, Germundsjö, Åström, & Rönnlund, 2018).
APPENDIX A:

INVENTORY OF PARENT AND PEER ATTACHMENT (IPPA) – MOTHER SCALE
This questionnaire asks about your relationship your mother/mother figure. Please read the directions to each part carefully.

Some of the following statements ask about your feelings about your mother or your mother figure. If you have more than one person acting as your mother (e.g. a natural mother and a step-mother) answer the questions for the one you feel has most influenced you.

Please read each statement and circle the **ONE** number that tells how true the statement is for you now.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Almost Never or Never True</th>
<th>Not Very Often True</th>
<th>Sometimes True</th>
<th>Often True</th>
<th>Almost Always or Always True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My mother/mother figure respected my feelings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. It felt my mother/mother figure did a good job as my mother.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I wish I had a different mother/mother figure.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. My mother/mother figure accepted me as I am.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I liked to get my mother/mother figure’s point of view on things I was concerned about.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I felt it was no use letting my feelings show around my mother/mother figure.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>7. My mother/mother figure was able to tell when I was upset about something.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Talking over my problems with my mother/mother figure made me feel ashamed and foolish.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. My mother/mother figure expected too much from me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I got upset easily around my mother/mother figure.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. I got upset a lot more than my mother/mother figure knew about.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. When we discussed things, my mother/mother figure cared about my point of view.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. My mother/mother figure trusted my judgment.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. My mother/mother figure had her own problems, so I didn’t bother her with mine.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. My mother/mother figure helped me to understand myself better.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. I told my mother/mother figure about my problems and troubles.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. I felt angry with my mother/mother figure.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
18. I didn’t get much attention from my mother/mother figure.  
19. My mother/mother figure helped me to talk about my difficulties.  
20. My mother/mother figure understood me.  
21. When I got angry about something, my mother/mother figure tried to be understanding.  
22. I trusted my mother.  
23. My mother/mother figure didn’t understand what I was going through.  
24. I could count on my mother/mother figure when I needed to get something off my chest.  
25. If my mother/mother figure knew something was bothering me, she asked me about it.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>I didn’t get much attention from my mother/mother figure.</td>
<td></td>
<td></td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My mother/mother figure helped me to talk about my difficulties.</td>
<td></td>
<td></td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My mother/mother figure understood me.</td>
<td></td>
<td></td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>When I got angry about something, my mother/mother figure tried to be understanding.</td>
<td></td>
<td></td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I trusted my mother.</td>
<td></td>
<td></td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My mother/mother figure didn’t understand what I was going through.</td>
<td></td>
<td></td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I could count on my mother/mother figure when I needed to get something off my chest.</td>
<td></td>
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<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>If my mother/mother figure knew something was bothering me, she asked me about it.</td>
<td></td>
<td></td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

APPENDIX B:

EXPRESSIVE ENCOURAGEMENT (EE) SUBSCALE: ADOLESCENTS' PERCEPTION OF PARENT ATTITUDE/BEHAVIOR QUESTIONNAIRE
Instructions: In the following items, please indicate on a scale from 1 (very unlikely) to 7 (very likely) the likelihood that your mother/mother figure responded to you in the ways listed for each item within the first 16 years of your life.

Please read each item carefully and respond as honestly and sincerely as you can. For each response, please circle a number from 1-7.

<table>
<thead>
<tr>
<th></th>
<th>Very Unlikely</th>
<th>Medium</th>
<th>Very Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1. When my mother/mother figure saw me becoming angry at a close friend, she usually encouraged me to express my anger.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. When I was down because I've had a bad day, my mother/mother figure usually listened to me talk about my feelings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. When I was getting anxious about performing in a recital or a sporting event, my mother/mother figure usually encouraged me to talk about what was making me so anxious.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
4. When I was getting angry because I couldn’t get something I really wanted, my mother/mother figure usually encouraged me to talk about my angry feelings.

5. When I got sad because I’ve had my feelings hurt by a friend, my mother/mother figure usually encouraged me to talk about what was bothering me.

6. When my mother/mother figure saw me become anxious about something at school, she usually encouraged me to talk about what was making me nervous.

7. When I got angry at a family member, my mother/mother figure usually encouraged me to let my angry feelings out.

8. When I got upset because I missed someone I cared about, my
mother/mother figure usually encouraged me to talk about my feelings for this person.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
</table>

9. When I became nervous about some social situation that I had to face (such as a date or a party), my mother/mother figure usually encouraged me to express my feelings.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
</table>

APPENDIX C:

PARENTAL BONDING INSTRUMENT – CARE SUBSCALE
This questionnaire lists various attitudes and behaviors of parents. As you remember your **mother/mother figure** in your first 16 years would you place a tick in the most appropriate box next to each question.

<table>
<thead>
<tr>
<th></th>
<th>Very like</th>
<th>Moderately like</th>
<th>Moderately unlike</th>
<th>Very unlike</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spoke to me in a warm and friendly voice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not help me as much as I needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seemed emotionally cold to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appeared to understand my problems and worries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was affectionate to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enjoyed talking things over with me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequently smiled at me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not seem to understand what I needed or wanted</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Made me feel I wasn’t wanted</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Could make me feel better when I was upset</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Did not talk with me very much</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Did not praise me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


*British Journal of Medical Psychology, 52*, 1-10.
APPENDIX D:

DIFFICULTIES IN EMOTIONAL REGULATION
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:

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I am clear about my feelings.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>2</td>
<td>I pay attention to how I feel.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>3</td>
<td>I experience my emotions as overwhelming and out of control.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>4</td>
<td>I have no idea how I am feeling.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>5</td>
<td>I have difficulty making sense out of my feelings.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>6</td>
<td>I am attentive to my feelings.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>7</td>
<td>I know exactly how I am feeling.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>8</td>
<td>I care about what I am feeling.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>9</td>
<td>I am confused about how I feel.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>10</td>
<td>When I’m upset, I acknowledge my emotions.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>11</td>
<td>When I’m upset, I become angry with myself for feeling that way.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>12</td>
<td>When I’m upset, I become embarrassed for feeling that way.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>13</td>
<td>When I’m upset, I have difficulty getting work done.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>14</td>
<td>When I’m upset, I become out of control.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>15</td>
<td>When I’m upset, I believe that I will</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
</tbody>
</table>
remain that way for a long time.

16) When I’m upset, I believe that I’ll end up feeling very depressed. A B C D E

17) When I’m upset, I believe that my feelings are valid and important. A B C D E

18) When I’m upset, I have difficulty focusing on other things. A B C D E

19) When I’m upset, I feel out of control. A B C D E

20) When I’m upset, I can still get things done. A B C D E

21) When I’m upset, I feel ashamed at myself for feeling that way. A B C D E

22) When I’m upset, I know that I can find a way to eventually feel better. A B C D E

23) When I’m upset, I feel like I am weak. A B C D E

24) When I’m upset, I feel like I can remain in control of my behaviors. A B C D E

25) When I’m upset, I feel guilty for feeling that way. A B C D E

26) When I’m upset, I have difficulty concentrating. A B C D E

27) When I’m upset, I have difficulty controlling my behaviors. A B C D E

28) When I’m upset, I believe there is nothing I can do to make myself feel better. A B C D E

29) When I’m upset, I become irritated at myself for feeling that way. A B C D E

30) When I’m upset, I start to feel very A B C D E
bad about myself.

31) When I’m upset, I believe that wallowing in it is all I can do. A B C D E
32) When I’m upset, I lose control over my behavior. A B C D E
33) When I’m upset, I have difficulty thinking about anything else. A B C D E
34) When I’m upset, I take time to figure out what I’m really feeling. A B C D E
35) When I’m upset, it takes me a long time to feel better. A B C D E
36) When I’m upset, my emotions feel overwhelming. A B C D E

APPENDIX E:

TEST OF SELF-CONSCIOUS AFFECT – 3 – SHORT FORM (TOSCA – 3 – SF)
Below are some situations that people are likely to encounter in their day-to-day life, followed by several common reactions to these situations.

As you read each scenario, try to imagine yourself in that situation. Then indicate how likely you would be to react in each of the ways described. Please rate ALL responses since people may feel or react more than one way to the same situation, or they may react in different ways at different times.

Please do not skip any items and rate ALL responses by marking the appropriate letter from the scale below on the scantron.

A) You make plans to meet a friend for lunch. At 5 o’clock, you realize you stood your friend up.

1) You would think: "I'm inconsiderate."
   Not Likely Neutral Very Likely
   A   B   C   D   E

2) You would think: "Well, my friend will understand."
   A   B   C   D   E

3) You’d think you should make it up to your friend as soon as possible.
   A   B   C   D   E

4) You would think: "My boss distracted me just before lunch."
   A   B   C   D   E

B) You break something at work and then hide it.

5) You would think: "This is making me anxious. I need to either fix it or get someone else to."
   A   B   C   D   E

6) You would think about quitting.
   A   B   C   D   E

7) You would think: "A lot of things aren't made very well these days."
   A   B   C   D   E

8) You would think: "It was only an accident."
   A   B   C   D   E
C) At work, you wait until the last minute to plan a project, and it turns out badly.

9) You would feel incompetent.
Not Likely Neutral Very Likely
A B C D E
You would think: “There are never enough hours in the day”.
A B C D E

10) You would feel: “I deserve to be reprimanded for mismanaging the project.”
A B C D E

11) You would think: “What’s done is done”.
A B C D E

D) You make a mistake at work and find out a coworker is blamed for the error.
You would think the company did not like the coworker.

13) You would feel inadequate that you can’t even throw a ball.
Not Likely Neutral Very Likely
A B C D E
You would think maybe your friend needs more practice at catching.
A B C D E

14) You would think: "It was just an accident".
A B C D E

15) You would keep quiet and avoid the coworker.
A B C D E
You would feel unhappy and eager to correct the situation.
A B C D E

E) While playing around, you throw a ball, and it hits your friend in the face.
You would think the animal shouldn't have been on the road.

17) You would feel inadequate that you can’t even throw a ball.
A B C D E
You would think maybe your friend needs more practice at catching.
A B C D E

18) You would think: "It was just an accident".
A B C D E
You would apologize and make sure your friend feels better.
A B C D E

F) You are driving down the road, and you hit a small animal.
You would think the animal shouldn't have been on the road.

21) You would think: "I'm terrible".
A B C D E

23) You would feel: "Well, it was an accident".
   A   B   C   D   E
   You’d feel bad you hadn’t been more alert
driving down the road.
   A   B   C   D   E

24) G) You walk out of an exam thinking you
did extremely well. Then you find out you
did poorly.
   Not Likely  Neutral  Very Likely
   You would feel bad you hadn’t been more alert
driving down the road.
   A   B   C   D   E

25) You would think: “Well, it’s just a test.”
   A   B   C   D   E
   You would think: “The instructor doesn’t
like me.”
   A   B   C   D   E

26) You would think: “I should have studied
harder.”
   A   B   C   D   E

27) You would feel stupid.
   A   B   C   D   E
   H) While out with a group of friends, you
   make fun of a friend who’s not there.
   You would think: “It was all in fun; it’s
   harmless.”
   A   B   C   D   E

28) You would feel small... like a rat.
   A   B   C   D   E

29) You would think that perhaps that friend
should have been there to defend
her/himself.
   A   B   C   D   E
   You would apologize and talk about that
person’s good points.
   A   B   C   D   E

30) I) You make a big mistake on an important
project at work. People were depending
on you, and your boss criticizes you.
   Not Likely  Neutral  Very Likely
   You would think your boss should have
been more clear about what was expected
of you.
   A   B   C   D   E

31) You would feel like you wanted to hide.
   A   B   C   D   E

32) You would think: "I should have recognized
the problem and done a better job."
   A   B   C   D   E
You would think: "Well, nobody's perfect".

J) You are taking care of your friend’s dog while your friend is on vacation, and the dog runs away. You would think: “I am irresponsible and incompetent.”

37) You would think your friend must not take very good care of the dog or it wouldn’t have run away.

38) You would vow to be more careful next time.

39) You would think your friend could just get a new dog.

K) You attend your coworker’s housewarming party and you spill red wine on a new cream-colored carpet, but you think no one notices.

40) You think your coworker should have expected some accidents at such a big party.

41) You would stay late to help clean up the stain after the party.

42) You would wish you were anywhere but at the party.

43) You would wonder why your coworker chose to serve red wine with the new light carpet.

APPENDIX F:

THE SELF-COMPASSION SCALE
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:

<table>
<thead>
<tr>
<th>Almost never</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Almost always</th>
<th>5</th>
</tr>
</thead>
</table>

_____ 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 G:

DEMOGRAPHIC QUESTIONNAIRE
1. Your age __________

2. Your gender (circle one)
   Female     Male     Other (specify: _________________________)

3. What is your ethnic background?
   ___ Asian
   ___ Black
   ___ Caucasian
   ___ Hispanic
   ___ Native American
   ___ Middle Eastern
   ___ Biracial
   ___ Other

4. The “mother/mother figure” you referred to in responding to this survey was:
   ___ Biological mother
   ___ Stepmother
   ___ Adoptive mother
   ___ Foster mother
   ___ Other (specify: _________________________)
5. What was the highest grade in school (or level of education) your mother/mother figure completed? (Check one)

___ Did not finished high school
___ Graduated from high school
___ Trade school
___ Some college (includes A.A. degree)
___ Graduated from college (B.A. or B.S. degree)
___ Some post graduate work
___ Graduate or professional degree (specify: ________________________)

6. What was the highest grade in school (or level of education) your father/father figure completed? (Check one)

___ Did not finished high school
___ Graduated from high school
___ Trade school
___ Some college (includes A.A. degree)
___ Graduated from college (B.A. or B.S. degree)
___ Some post graduate work
___ Graduate or professional degree (specify: ________________________)

Developed by author.
APPENDIX H:
IRB APPROVAL LETTER
April 17, 2019

CSUSB INSTITUTIONAL REVIEW BOARD
Administrative/Exempt Review Determination
Status: Determined Exempt
IRB-FY2019-222

Nicoleta Dragan and Prof. Laura Kamptner
COE - Doctoral Studies, CSBS - Psychology
California State University, San Bernardino
5500 University Parkway
San Bernardino, California 92407

Dear Nicoleta Dragan and Laura Kamptner:

Your application to use human subjects, titled “ORIGINS OF SELF-COMPASSION: THE IMPACT OF THE EARLY CAREGIVING ENVIRONMENT” has been reviewed and approved by the Chair of the Institutional Review Board (IRB) of California State University, San Bernardino has determined that your application meets the requirements for exemption from IRB review Federal requirements under 45 CFR 46. As the researcher under the exempt category you do not have to follow the requirements under 45 CFR 46 which requires annual renewal and documentation of written informed consent which are not required for the exempt category. However, exempt status still requires you to attain consent from participants before conducting your research as needed. Please ensure your CITI Human Subjects Training is kept up-to-date and current throughout the study.

The CSUSB IRB has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval notice does not replace any departmental or additional approvals which may be required.

Your responsibilities as the researcher/investigator reporting to the IRB Committee the following three requirements highlighted below. Please note failure of the investigator to notify the IRB of the below requirements may result in disciplinary action.

- Submit a protocol modification (change) form if any changes (no matter how minor) are proposed in your study for review and approval by the IRB before implemented in your study to ensure the risk level to participants has not increased,
- If any unanticipated/adverse events are experienced by subjects during your research, and
• Submit a study closure through the Cayuse IRB submission system when your study has ended.

The protocol modification, adverse/unanticipated event, and closure forms are located in the Cayuse IRB System. If you have any questions regarding the IRB decision, please contact Michael Gillespie, the Research Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at mgillessp@csusb.edu. Please include your application approval identification number (listed at the top) in all correspondence.

If you have any questions regarding the IRB decision, please contact Michael Gillespie, the Research Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at mgillessp@csusb.edu. Please include your application approval identification number (listed at the top) in all correspondence.

Best of luck with your research.

Sincerely,

Donna Garcia

Donna Garcia, Ph.D., IRB Chair
CSUSB Institutional Review Board

DG/MG
REFERENCES


http://dx.doi.org/10.1016/S1053-8100(03)00076-X


validation of the difficulties in emotion regulation scale. *Journal of psychopathology and behavioral assessment, 26*(1), 41-54.


Mikulincer, M., & Shaver, P. R. (2017). Attachment-related mental representations of self and others. In *Attachment in Adulthood* (pp. 147-


*British Journal of Medical Psychology, 52*, 1-10.


doi:10.1093/geronb/gbs091


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