Self-compassion and emotional invalidation mediate the effects of parental indifference on psychopathology

Maren Westphal a,b,* , Robert L. Leahy c , Andrea Norcini Pala b , Peggielee Wupperman d

a Department of Psychology, Pace University, 861 Bedford Road, Pleasantville, NY 10570, USA
b Department of Psychiatry, Columbia University, 1051 Riverside Dr, New York, NY 10032, USA
c American Institute for Cognitive Therapy, 136 East 57th Street, Suite 1101, New York, NY 10022, USA
d Department of Psychology, John Jay College/City University of New York, 524 West 59th Street, New York, NY 10019, USA

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A B S T R A C T

This study investigated whether self-compassion and emotional invalidation (perceiving others as indifferent to one’s emotions) may explain the relationship of childhood exposure to adverse parenting and adult psychopathology in psychiatric outpatients (N=326). Path analysis was used to investigate associations between exposure to adverse parenting (abuse and indifference), self-compassion, emotional invalidation, and mental health when controlling for gender and age. Self-compassion was strongly inversely associated with emotional invalidation, suggesting that a schema that others will be unsympathetic or indifferent toward one’s emotions may affect self-compassion and vice versa. Both self-compassion and emotional invalidation mediated the relationship between parental indifference and mental health outcomes. These preliminary findings suggest the potential utility of self-compassion and emotional schemas as transdiagnostic treatment targets.

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1. Introduction

Increasing evidence shows self-compassion to predict lower psychopathology (Barnard and Curry, 2011; MacBeth and Gumley, 2012) and better quality of life (Van Dam et al., 2011). Neff proposed that self-compassion comprises three main components: self-kindness, mindfulness, and a sense of common humanity (Neff, 2003). These theoretical facets are thought to protect against adversity by counteracting a harsh critical or judgmental attitude toward oneself, a sense of being alone in one’s suffering, and an over-identification with painful experiences. Experimental and correlational evidence demonstrates that individuals high in self-compassion are able to cope with experiences of pain and failure in a kind and self-respecting manner (Leary et al., 2007).

In contrast, emotional invalidation (the perception of others as indifferent to one’s emotions) is associated with difficulty accepting emotions, maladaptive coping with emotions, perceptions of negative emotions as less controllable and comprehensible, and less psychological flexibility (Leahy, 2002; Leahy et al., 2012; Tutch et al., 2012). These findings are consistent with research showing that emotional sharing and validation are important for acceptance and comprehension of emotions (e.g., Rime et al., 1991). However, although emotional invalidation is theorized to be negatively related to self-compassion (e.g., Leahy, 2015), research has yet to examine the relationship between the two constructs. In addition, little is known about mechanisms underlying the relationships between self-compassion, emotional invalidation, and psychopathology, particularly in relation to early adverse experiences. We propose that self-compassion and perceived emotional invalidation are transdiagnostic processes similar to, for example, cognitive distortions and selective memory (see Harvey, Watkins, Mansell and Shafran, 2004).

Self-compassion is thought to originate in early childhood interactions with caregivers who model compassion in the context of a secure attachment relationship, thereby facilitating the development of compassionate inner dialogues in the child (Neff and McGehee, 2010). In contrast, children exposed to environments characterized by abuse or neglect would be expected to develop critical, negative attitudes toward self and endorse low self-compassion (Neff and McGehee, 2010). Supporting these predictions, research on adolescents and young adults has linked healthy family functioning and maternal support to higher levels of self-compassion (Neff and McGehee, 2010). In addition, self-compassion was shown to mediate the relationships of both family functioning and maternal support to psychological well-being, as indexed by levels of depression, anxiety, and connectedness (Neff and McGehee, 2010). Conversely, emotional and physical abuse...
and neglect have been found to be inversely associated with self-compassion in adolescents (Tanaka et al., 2011) and young adults (ages 16–24; Vettese et al., 2011).

Childhood abuse and parental indifference may be considered prototypical experiences of invalidation of emotional experiences (e.g., Tanaka et al., 2011; Vettese et al., 2011). Childhood abuse and parental indifference communicate that the child’s internal experiences do not matter. Furthermore, abusive caregivers who routinely punish emotional displays convey that negative emotions are unacceptable, while indifferent caregivers who routinely ignore, minimize and dismiss emotional displays convey that they are unimportant. In turn, children may generalize parental perspectives on expressing emotions and assume that most or all other people disapprove of or are indifferent to their emotional experiences. Consistent with these ideas, individuals with invalidating parents are more likely to endorse fear of their emotions, engage in thought suppression, and have higher levels of emotional vulnerability compared to individuals with validating parents (Sauer and Baer, 2010). According to the emotional schema model (Leahy, 2002; Leahy, 2015), emotional invalidation (perceiving others as indifferent to one’s emotions) may result from childhood invalidation by parents; however, research has yet to investigate this potential relationship. To address this limitation, this study will examine whether exposure to adverse parenting is associated with self-compassion and with the expectation that others are indifferent to one’s emotion.

In investigating the relationships between self-compassion, emotional invalidation, and psychopathology, we chose to examine symptoms of posttraumatic stress disorder (PTSD) and borderline personality disorder (BPD) based on literature suggesting that (a) adverse early experience may increase vulnerability to both disorders, and (b) dysregulated emotion plays a central role in the development and maintenance of both PTSD symptoms and BPD traits (e.g., avoidance, emotional reactivity). We also included depression given its prevalence in psychiatric outpatients and high levels of comorbidity with PTSD and BPD.

According to a meta-analytic review, greater self-compassion is associated with lower scores on measures of depression (effect size: −0.52) and anxiety (effect size: −0.51; MacBeth and Gumley, 2012). However, the majority of studies in this review used non-clinical samples (with only 4 of 14 involving clinical samples; MacBeth and Gumley, 2012). The dearth of clinical samples is an important limitation of extant research investigating relationships of self-compassion to depression and anxiety.

Relatively few studies have examined the role of self-compassion in PTSD. Research with students has found that self-compassion was negatively associated with avoidance but not re-experiencing or hyperarousal (Thompson and Waltz, 2008). A trial of loving-kindness meditation in veterans with PTSD found that self-compassion mediated reductions in both PTSD and depressive symptoms at 3-month follow-up (Kearney et al., 2013). Additionally, research has found that self-compassion predicted PTSD symptom severity in combat veterans (Hiraoka et al., 2015), as well as decreased trauma-related symptoms in adolescents exposed to a fire (Zeller et al., 2015).

Despite the emphasis on validation in Dialectical Behavior Therapy, the BPD intervention with the strongest evidence base, research has yet to be published on the relation between self-compassion and BPD symptoms. However, some researchers view shame, an emotion that may be indicative of low self-compassion, as central to BPD psychopathology (Nicolas Rüsch et al., 2007). Consistently, shame is a key trigger of dysregulated behaviors such as self-harm and suicide attempts (Brown et al., 2009) and may also be central to the elevated emotional reactivity observed in patients with BPD (Gratz et al., 2010).

Research on the relation of emotional validation to psychopathology is also still in the early stages. Pilot research suggested that emotional invalidation may contribute to depressive symptoms by affecting processing of negative emotions, as opposed to having a direct relationship (Leahy, 2002); however, more recent research has found emotional invalidation to be directly related to depressive symptoms (Leahy et al., 2012). Thus, further research is needed to determine the relationship of emotional invalidation to depressive symptoms. Of note is that research has yet to examine emotional invalidation in relation to symptoms of PTSD or BPD. The reviewed literature suggests that self-compassion and perceived emotional invalidation may constitute pathways through which adverse parenting may impact psychological health. Self-compassion may buffer against the pathogenic impact of negative childhood experiences (such as parental abuse and indifference) by reducing self-critical and shame-inducing appraisals; conversely, perceived emotional invalidation may exacerbate self-critical and shame-inducing appraisals. Building on these ideas, the current study proposed a model wherein negative parental rearing experiences are associated with negative mental-health outcomes, in part through lowered self-compassion and raised perceptions of emotional invalidation. Additionally, we predicted that self-compassion would be inversely related to perceived emotional invalidation. We further hypothesized that self-compassion and emotional invalidation would mediate associations between negative parenting experiences and mental-health outcomes. Finally, we controlled for age and gender differences. Given the limited research on gender/age and self-compassion, we did not make predictions but instead considered this to be an exploratory aspect of our study.

2. Methods

2.1. Participants and Procedure

Participants were 326 adult psychotherapy patients at a private mental-health clinic in an urban area. Of the participants, 101 were men (31%) and 225 were female (69%); 63.5% were single, 5.5% separated/divorced, 6.1% cohabiting, 6.1% widowed, and 6.0% other (0.3% unanswered). Average age was 34.05 years (SD = 12.77). Participants endorsed the following race/ethnicity: White (85.3%), Black (1.5%), Hispanic (4.3%), Asian (5.2%), American Indian (0.3%), or “other” (2.8%; 0.6% unanswered).

All participants completed a package of self-report measures, including the Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon et al., 1994), Leahy Emotional Schema Scale (LESS; Leahy, 2002), the Self-Compassion Scale – Short Form (SCS-SF; Raes et al., 2011), and demographic information. The majority of participants completed the forms before their actual intake, with a few completing immediately following intake. This study was approved by the Institutional Review Board of John Jay College/City University of New York (CUNY). All participants received a description of the study and provided verbal and written informed consent before completing the measures described below, as well as additional measures not used in this study.

2.2. Assessment

2.2.1. Self-compassion

The Self-Compassion Scale – Short Form (SCS-SF; Raes et al., 2011) contains 12 items and employs a 5-point Likert scale (1 = almost never to 5 = almost always). Factor analysis supports a higher-order self-compassion factor and six subscales (Raes et al., 2011). Each subscale has two items designed to tap different aspects of self-compassion, including: self-judgment (‘I’m disapproving and judgmental about my own flaws and
inadequacies”), self-kindness (“I try to be understanding and patient towards those aspects of my personality I don’t like.”), shared humanity (“I try to see my failings as part of the human condition”), isolation (“When I fail at something that’s important to me, I tend to feel alone in my failure”), over-identification (“When I’m feeling down I tend to obsess and fixate on everything that’s wrong”), and mindfuzz (“When something upsets me I try to keep my emotions in balance”). Total SCS-SF scores have shown strong correlations with long-form SCS total scores, and each subscale correlates strongly with corresponding long-form scale (r = 0.89 to r = 0.91; Raes et al., 2011). The SCS-SF total score demonstrates good internal consistency, while subscales show variable internal consistency (Raes et al., 2011). Therefore, only the total score was used in the present study.

2.2.2. Perceived parental abuse and indifference

The Measure of Parenting Style (MOPS; Parker et al., 1997) is a 15-item self-report questionnaire measuring parenting styles of indifference, over-control, and abuse. The current study used only the Parental Indifference and Parental Abuse subscales. Questions were answered with reference to both mother and father, and scores on both were summed (Parker et al., 1997). The MOPS has shown high construct validity and convergent validity, as well as good reliability (Dalgleish et al., 2003; Ehnvall et al., 2008; Parker et al., 1997). Respondents endorse statements on a 4-point scale ranging from not true at all to extremely true, with higher scores denoting more-negative perceptions of parental rearing experiences. Sample statements include “physically violent or abusive of me” (abuse) and “ignored me” (indifference). Cronbach’s alphas for the subscales have range from 0.76 to 0.93 (Dalgleish et al., 2003).

2.2.3. Emotional invalidation

Perceived invalidation of emotional experience was assessed with the invalidation subscale from the Leahy Emotional Schema Scale (LESS; Leahy, 2002). The subscale consists of two items: “Others understand and accept my feelings” (reverse-scored) and “No one really cares about my feelings.” Questions were answered with a 6-point Likert-type scale ranging from very true of me to very untrue of me. The subscale has shown moderate relationships with measures of convergent and divergent constructs (Leahy, 2002; Leahy et al., 2012; Tich et al., 2012). Correlation between the two items in the current study was acceptable (0.54). The Cronbach’s alpha was 0.68.

2.2.4. Mental health outcomes

The Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon et al., 1994) is a widely utilized measure that assesses psychopathology symptoms. Normed and standardized on an adult clinical sample the MCMI-III includes 175 true/false items, which comprise 28 scales. The scales measuring symptoms of MDD, PTSD and BPD have all demonstrated adequate to good reliability, convergent and discriminant validity, positive predictive power, and Cronbach’s alpha (0.66–0.90) across clinical samples (e.g., Millon et al., 1994; Millon and Millon, 2008; Strack and Millon, 2008).

2.3. Data analysis

Descriptive analysis and t-tests were conducted with SPSS Version 22. Mplus 7.2 (Muthén and Muthén, 1998–2012) was used to examine variable distributions, perform zero-order correlations, and to conduct the path analysis. Path analysis has several advantages. It controls overlap among predictor variables to determine unique effects of these variables on the dependent variables; it also allows measurement of direct and indirect effects and their standard errors, as well as yielding overall indices of model fit.

Some variables analyzed were moderately non-normally distributed: skewness ranged from 0.18 to 1.57, and kurtosis ranged from 0.27 to 2.27. To account for this moderate violation of normality (cf. Finney and DiStefano, 2006), Maximum Likelihood with Robust standard errors (MLR) was used. The estimator has been demonstrated to be robust when moderately non-normal variables with missing data are analyzed (Byrne, 2012; Muthén and Muthén, 1998–2012).

The test of mediators was performed through the function “Model Indirect” (delta method; see MacKinnon, 2008 in Mplus 7.2). That is, we tested whether the association of X (independent variable) with Y (dependent variable) was mediated by a mediator (M). Results provide direct (association of X with Y) and indirect correlation effect of X on Y through M.

In our model, there were two mediators (M1 = Emotional Invalidation and M2 = Self-compassion); therefore, an overall indirect association (Mtotal = M1 + M2) and the individual indirect association (M1 and M2) were obtained. Age and gender were included as control variables. The fit of the model was assessed through the following indices: the Comparative Fit Index (CFI) and Tucker-Lewis Index (TLI), which should be both greater than 0.95; and the Root Mean Square Error of Approximation (RMSEA), which should be lower than 0.05 (Bentler, 1990; Hu and Bentler, 1999).

3. Results

3.1. Correlations and t-tests

Table 1 presents zero-order correlations between predictor and outcome variables, as well as means, standard deviations, and ranges. As hypothesized, parental abuse and indifference were significantly associated with perceived emotional invalidation. Parental indifference, parental abuse, and perceived emotional invalidation were also associated with higher scores on MDD, BPD, and PTSD symptoms. Self-compassion was significantly and inversely correlated with all variables except parental abuse. BPD, MDD, and PTSD symptoms were significantly and positively associated with each other.

Independent-samples t tests examined gender differences on variables. Results showed that men reported less parental abuse than women (t[313] = -2.45, p = 0.02; Mmen = 1.90, Mwomen = 2.83) but similar levels of parental indifference (t[313] = -1.09, p = 0.28; Mmen = 3.08, Mwomen = 3.59). Further, men endorsed lower emotional invalidation (t[314] = -2.05, p = 0.04; Mmen = 2.61, Mwomen = 2.96) and higher self-compassion (t[322] = 2.25, p = 0.03; Mmen = 2.50, Mwomen = 2.28) compared to women. In contrast,

<table>
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<th>Variable</th>
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<tr>
<td>Depression</td>
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<td>0.19*</td>
<td>0.43*</td>
<td>-0.56*</td>
<td>0.60*</td>
<td>1.00</td>
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<tr>
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<td>2.54</td>
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<td>2.35</td>
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<td>1–6</td>
<td>1–4.83</td>
<td>–1–10</td>
<td>0–11</td>
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*p < 0.05.

*p < 0.01.

*p < 0.001.

Table 1. Zero-order correlations and descriptives for predictor and outcome variables.
there were no significant differences between men and women in mental health outcomes: BPD (M men = 50.44, M women = 50.42), MDD (M men = 50.18, M women = 47.99), PTSD (M men = 49.69, M women = 44.72).

3.2. Path analysis

The model fit the data very well (CFI/TLI 1.00/1.00, RMSEA < 0.05); Fig. 1 displays statistically significant results. Statistically non-significant associations (β > 0.05) and control variables (gender and age) were excluded from display to improve readability of the figure.

Abusive parenting was not significantly associated with emotional invalidation (β = 0.07, p = 0.33) or self-compassion (β = 0.04, p = 0.62). However, abusive parenting was significantly related to BPD, MDD and PTSD. In contrast, indifferent parenting was associated with emotional invalidation and (negatively) self-compassion, but no longer statistically associated with BPD (β = 0.07, p = 0.25), MDD (β = 0.01, p = 0.88), or PTSD (β = 0.01, p = 0.84). Emotional invalidation and self-compassion correlated negatively: Those who felt that others did not care about their emotions also experienced less compassion for themselves.

Based on results, we tested indirect associations between parental indifference and mental health outcomes through emotional invalidation and self-compassion. The total indirect associations on BPD (β = 0.14, p = 0.00; individual indirect correlations: M1 = 0.08, p = 0.01 and M2 = 0.06, p = 0.02), MDD (β = 0.14, p = 0.00; individual indirect correlations: M1 = 0.05, p = 0.02 and M2 = 0.09, p = 0.01) and PTSD (β = 0.12, p = 0.00; individual indirect correlations: M1 = 0.04, p = 0.03 and M2 = 0.08, p = 0.01) were of moderate magnitude but statistically significant. Specifically, results showed that patients exposed to indifferent parenting displayed lower self-compassion and higher emotional invalidation, which mediated the risk for BPD, MDD, and PTSD.

Finally, results showed that when all other variables were accounted for, all mental disorders were significantly associated with gender (male = 1, female = 2): Men scored higher than women on MDD (β = −0.11, p = 0.01), BPD (β = −0.12, p = 0.01) and PTSD (β = −0.18, p < 0.00). Regarding age, older participants had lower levels of BPD (β = −0.17, p < 0.00) and PTSD (β = −0.12, p = 0.02). The association between age and MDD was not significant (β = 0.02, p = 0.59).

4. Discussion

Findings of this study provide preliminary support for the roles of self-compassion and emotional invalidation in explaining variability in symptoms of MDD, BPD, and PTSD in psychotherapy outpatients. Overall, the proposed model was an excellent fit for the data. Results supported the hypothesis that the relationship between negative parenting and mental-health problems is partially mediated by self-compassion and perceived emotional invalidation. Although parental abuse was not related to self-compassion or emotional invalidation, patients who reported more parental indifference tended to report lower self-compassion and higher perceived emotional invalidation as adults. A potential explanation is that parental indifference may be a form of emotional invalidation that establishes an expectation that others in one’s life will not validate painful emotions. In contrast, parental abuse (at least in the case of physical abuse) does not necessarily invalidate emotions in that it may reflect an awareness of, and actually occur as a punitive response to a child’s emotions.

Furthermore, both self-compassion and emotional invalidation were related to symptoms of MDD, BPD, and PTSD. Significant mediation analyses suggest that lower self-compassion and higher emotional invalidation accounted for the association of parental indifference to symptoms of MDD, BPD, and PTSD. Therefore, findings provide preliminary support for the role of self-compassion and emotional invalidation as factors that might influence the degree to which perceived parental indifference might lead to mental-health problems.

The inverse relationship between self-compassion and psychopathology is consistent with associations between self-compassion and depression and anxiety found in the literature (for reviews, see MacBeth and Gumley, 2012; Neff, 2012). The present study extends this research by examining depressive symptoms in a clinical sample, whereas most previous studies have examined non-clinical samples. Further, the positive association between emotional invalidation and psychopathology extends findings suggesting that emotional invalidation is associated with depressive symptoms and related processes. These results are consistent with literature on the association of depressive symptoms to negative views of self and the world (Pössel and Black, 2014) and suggest that a focus on self-compassion and emotional invalidation may be beneficial in the treatment of depressive symptoms.

A limitation of the study is that findings relate to retrospective self-reports of parenting experiences rather than independently corroborated reports. Although research shows a high correspondence between parent and child recollections of invalidation
(Sauer and Baer, 2010), replicating findings with studies including verified abuse and indifference is recommended. A second limitation is the cross-sectional nature of the data. Longitudinal studies would allow more definitive conclusions about the causal relationships between variables. A third limitation is that the authors only had access to total scores and subscales for most measures, and thus could not report internal consistencies. In addition, internal consistency for the 2-item emotional validation measure was merely adequate (.68). Finally, future research should include diagnostic interviews to provide diagnoses in addition to symptoms.

However, this study has substantial merit. This empirical study is the first to examine the relationship between self-compassion, emotional invalidation, and BPD symptoms. Although some studies have examined childhood invalidation and BPD symptoms (Cheavens et al., 2005; Sauer and Baer, 2010), the current study is the first to focus on perceived indifference by others as an adult (emotional invalidation). Results suggest the potential utility of targeting self-compassion and schemas about current emotional invalidation in BPD treatment.

Our finding of a strong inverse association between self-compassion and PTSD also fits with preliminary evidence in the literature that self-compassion may play a role in reducing shame and self-criticism in response to traumatic events (Gilbert and Procter, 2006). In contrast, perceived emotional invalidation may promote shame and self-criticism about one's emotional response to the traumatic event. Self-criticism and shame are prevalent in trauma-exposed individuals (Harman and Lee, 2010; Leskela et al., 2002), and shame may play an integral role in the development of PTSD in survivors of interpersonal trauma (La Bash and Papa, 2014).

The associations between self-compassion, emotional invalidation, and three important mental-health outcomes support ideas expressed by proponents of different psychotherapeutic approaches. Specifically, psychotherapy should involve a focus on modifying self-criticism and self-judgment, enabling a compassionate stance toward self, and modifying negative schemas about perception of others (Gilbert and Irons, 2005; Kabat-Zinn and Hanh, 2009; Linehan, 1993; Vaillant, 1997).

Additionally, although literature supports a link between dysfunctional parenting experiences and psychology, few studies have investigated self-compassion or current emotional invalidation in relation to these experiences. In contrast to two previous studies (Tanaka et al., 2011; Vettese et al., 2011), the present study did not find significant association between parental abuse and self-compassion. However, Tanaka’s study focused on adolescents receiving child protective services, while Vettese et al.’s (2011) study included a clinical sample of treatment-seeking youth with substance issues. Compared to the current study, both samples are likely to have been exposed to more-severe forms of parental abuse, as well as being in closer temporal proximity to these adverse events.

The findings that the mediating role of self-compassion and emotional invalidation was specific to parental indifference – and that these constructs were not significantly related to parental abuse – suggest that these constructs may be particularly important in the appraisal of childhood experiences that are less clearly identifiable as discrete traumatic events, but that may over time exert a corrosive effect on psychological health. In addition, studies using only childhood sexual and physical abuse as measures of invalidation may fail to capture the breadth of the construct given that invalidation can occur in the absence of such abuse (Sauer and Baer, 2010).

Of note, the associations between self-compassion and psychopathy were stronger than associations between invalidation and psychopathy. One potential reason may be differences in the extent to which each variable taps current and past interpersonal and intra-psychological dimensions of self. Given that emotional invalidation involves perceiving others as accepting or rejecting of one’s emotions, it is informed by interpersonal experiences (past and current). Self-compassion likely reflects both internalized interpersonal experience (past) and current levels of intra-psychological variables – such as self-esteem – that are known to be diminished in individuals with acute symptoms of psychopathology (especially depression). Further research is needed to determine whether the finding is a function of measurement effects or if the association of self-compassion with psychopathology is indeed stronger.

Another finding that merits exploration in future research is that associations between the three mental health outcomes were stronger than their respective associations with any of the mediating variables. This may be explained by the fact that the MCMI assesses current symptoms implicated in three disorders that are highly comorbid and have overlapping symptoms. From a psychometric perspective, this may point to a second-order latent factor such as “psychological distress.” Using a measure of general psychological distress in future studies may help clarify the presumed benefits of self-compassion for mental health and psychosocial functioning.

Clinically, results suggest a transdiagnostic role of self-compassion deficits and emotional invalidation in three common psychological disorders, while supporting the potential usefulness of both constructs as treatment goals in psychotherapy. Patients who reported more parental indifference endorsed lower self-compassion and expected others not to care about their emotional responses, which in turn mediated the relationship of parental indifference to symptoms of MDD, BPD, and PTSD. These findings provide preliminary support for the potential roles of self-compassion and emotional invalidation as factors that might influence the degree to which invalidating parenting experiences lead to mental health problems. Parental indifference may present a formative influence on the development of dysfunctional emotional schema. Exploring emotional invalidation and enhancing self-compassion may have therapeutic utility for modifying schema-related difficulties in emotion regulation across multiple disorders.

**Disclosure statement**

No potential conflict of interest was reported by the authors.

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