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Examining Pathways of Childhood Maltreatment and Emotional Dysregulation Using Self-Compassion

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ABSTRACT
Childhood maltreatment has well-documented relationships with emotional dysregulation. Emotional dysregulation confers heightened risk for psychopathology and therefore represents an important therapeutic target for survivors of childhood maltreatment. Emerging research suggests that deficits in self-compassion may be one pathway by which childhood maltreatment adversely impacts emotional regulation processes. The current study sought to replicate previous research by investigating the mitigating effects of self-compassion on emotional dysregulation in a nonclinical sample of women with varying degrees of childhood maltreatment (N = 245). Hierarchical regression analyses showed that self-compassion predicted emotional dysregulation above and beyond childhood maltreatment and current substance use (including current alcohol use). Additionally, mediation analyses revealed that self-compassion exerted an indirect effect on the relationship between childhood maltreatment and emotional dysregulation. Overall, these results replicate previous findings and further support self-compassion as an explanatory mechanism connecting childhood maltreatment with later emotional dysregulation. Clinical and research implications are discussed.

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Abuse; childhood maltreatment; coping; emotional regulation; self-compassion; self-kindness; substance use; trauma

Introduction
Links between childhood maltreatment and psychopathology across the lifespan are well established. Childhood maltreatment refers to harm inflicted upon a child by a parent or other caregiver in the form of physical abuse, psychological or emotional abuse, sexual abuse, or neglect (Slep, Heyman, & Foran, 2015). Individuals with histories of childhood maltreatment show higher rates of aggression, anxiety and depression, posttraumatic distress, suicidality, substance abuse, and eating disorders (Edalati & Krank, 2016; Fergusson, Boden, & Horwood, 2008; Manly, Kim, Rogosch, & Cicchetti, 2001; Molendijk, Hoek, Brewerton, & Elzinga, 2017; Nanni, Uher, & Danese, 2012; Newbury et al., 2018). Additionally, survivors of childhood maltreatment often exhibit deficits in emotional regulation (Cloitre, Miranda, Stovall-
McClough, & Han, 2005; Dvir, Ford, Hill, & Frazier, 2014; Ehring & Quack, 2010). Emotional regulation refers to the ability to influence the experience and expression of emotions (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Gross & Muñoz, 1995). Deficits in emotional regulation (i.e., emotional dysregulation) involve a lack of understanding and awareness of emotions, difficulty functioning when upset, nonacceptance of emotions, impulsivity or loss of control when upset, and/or the inflexible use of regulatory strategies (Gratz & Roemer, 2004). Emotional dysregulation is a known mechanism connecting maltreatment with adverse outcomes (Cloitre, Cohen, & Koenen, 2006; Heleniak, Jenness, Vander Stoep, McCauley, & McLaughlin, 2016; Jennissen, Holl, Mai, Wolff, & Barnow, 2016; Messman-Moore & Bhuptani, 2017; Moretti & Craig, 2013). For instance, childhood maltreatment was associated with later internalizing and externalizing behaviors as well as negative peer relations among children (ages 6–12) through emotional dysregulation (Kim & Cicchetti, 2010). Other studies have shown that emotional dysregulation predicts posttraumatic stress symptoms and functional impairment among adults with a history of childhood maltreatment (Burns, Jackson, & Harding, 2010; Cloitre et al., 2005; Lilly, London, & Bridgett, 2014). Together, these findings highlight the need to identify factors that promote adaptive emotional regulation to mitigate the long-term impact of childhood maltreatment. Emerging research suggests that self-compassion warrants consideration.

Self-compassion is defined as an acceptance of one’s suffering and involves responding to painful experiences with kindness and nonjudgmental understanding (Neff, 2003a). There are three interrelated components underpinning self-compassion—self-kindness, common humanity, and mindfulness. Self-kindness reflects exercising nonjudgmental kindness toward oneself and can be contrasted with self-criticism. Common humanity refers to viewing one’s experience as part of the human condition, thereby, reducing feelings of isolation. Lastly, mindfulness is the ability to regard one’s negative experiences as independent of oneself rather than as a reflection of one’s value or self-worth (Neff, 2003a). Evidence links self-compassion to numerous health benefits, including less anxiety and depression, greater psychological well-being, and more social connectedness (Neff, 2003b; Neff, Kirkpatrick, & Rude, 2007; Neff & McGehee, 2010; Neff, Pisitsungkagarn, & Hsieh, 2008). Self-compassion is believed to confer its protective effects by promoting adaptive emotional regulation (Finlay-Jones, Rees, & Kane, 2015; Leary, Tate, Adams, Batts Allen, & Hancock, 2007; Raes, 2010). Childhood experiences are formative in the development of self-compassion, which early life stressors (e.g., childhood maltreatment) can undermine.

Compassion for self and others is first shaped by early attachment experiences with caregivers (Gilbert, 2005, 2009, 2010). Secure parent–child attachments foster emotional security, calmness, and a sense of well-being within
children. These experiences later inform the ways in which children treat themselves (Bowlby, 1988; Raque-Bogdan, Ericson, Jackson, Martin, & Bryan, 2011). For instance, during times of stress, securely attached children can access positive emotional memories of being comforted by a caregiver that promote self-soothing and allow disengagement from self-criticism (Gilbert, 2009; Gilbert & Irons, 2005; Gilbert & Procter, 2006; Schanche, 2013). Conversely, abused or neglected children are deprived of feeling safe and reassured by caregivers, increasing sensitivity to threat and inhibiting the development of self-compassion (Gilbert, 2014; Gilbert & Procter, 2006). Not surprisingly, survivors of childhood maltreatment report low levels of self-compassion (Miron, Orcutt, Hannan, & Thompson, 2014; Miron, Seligowski, Boykin, & Orcutt, 2016; Tanaka, Wekerle, Schmuck, & Paglia-Boak, 2011; Vettese, Dyer, Li, & Wekerle, 2011). Vettese and colleagues (2011) further showed that self-compassion mediated the relationship between childhood maltreatment and emotional dysregulation. These findings highlight self-compassion as a relevant construct for further investigation as it relates to maltreatment-related impairments in emotional dysregulation and subsequent functioning.

The current study

Vettese et al. (2011) suggest that increasing self-compassion may buffer against emotional dysregulation following childhood maltreatment. However, one important limitation of their study was the exclusion of a potential confounding variable. Vettese et al. recruited a sample of 81 young adults seeking treatment for substance abuse. Their analyses showed that childhood maltreatment did not significantly predict emotional dysregulation after including addiction severity, with addiction severity predicting more variance in emotional dysregulation than childhood maltreatment. Yet, addiction severity was not included as a potential covariate in the mediation analysis that showed an indirect relationship between childhood maltreatment and emotional dysregulation through self-compassion. Given that individuals often use substances to regulate negative emotions (Axelrod, Perepletchikova, Holtzman, & Sinha, 2011; Ham & Hope, 2003; Kassel, Wardle, & Roberts, 2007; Kober & Bolling, 2014; McNally, Palfai, Levine, & Moore, 2003), it is possible that the magnitude of this mediation effect would have been weakened after controlling for addiction severity. To test this assumption, the present study sought to conceptually replicate Vettese et al.’s findings in a nonclinical sample. Similar to Vettese et al., we predicted that self-compassion would predict emotional dysregulation above and beyond that of other relevant predictors, such as childhood maltreatment (Burns et al., 2010; Cloitre et al., 2005; Ehring & Quack, 2010; Lilly et al., 2014) and substance use (Axelrod et al., 2011; Ham & Hope, 2003; Kassel et al., 2007; Kober & Bolling, 2014; McNally et al., 2003). Additionally, we
expected that childhood maltreatment would be indirectly associated with emotional dysregulation through deficits in self-compassion. We excluded participants endorsing problematic substance use (including alcohol use) to better understand the relationship between childhood maltreatment, self-compassion, and emotional dysregulation.

**Methods**

**Participants and procedure**

Potential participants were recruited from psychology courses at a large Midwestern university for a longitudinal study focused on reducing sexual revictimization among at-risk college women \((N = 306)\). Prerequisites included female gender, at least 18 years old, and fluent in English. A history of sexual victimization was not a requirement. Upon obtaining informed consent, participants completed a 30–45-min online survey. All participants were entered in a drawing for $50 awards. Participants who were enrolled in introductory psychology also received partial course credit. Permission to conduct this study and ethical approval were obtained by the university’s institutional review board.

In this study, a subset of 263 women was utilized after excluding participants for heavy drinking \((n = 36)\) and misuse of substances \((n = 7)\). Heavy drinking was defined as binge drinking at least four drinks more than once a week in the past month (Ham & Hope, 2003). Substance use was measured using the National Institute of Drug Abuse (NIDA2012) Quick Screen, which assesses misuse of a variety of drug types (e.g., cocaine, marijuana, stimulants) in the last 3 months. According to NIDA (2012) scoring rules, a high stimulant involvement score (i.e., SI score \(\geq 27\)) indicates high risk for substance abuse. Participants who scored in that range were excluded from this study. An additional 18 participants were removed as extreme outliers or due to missing data on all variables of interest (Tabachnick & Fidell, 2007). This resulted in a final sample of 245 participants. The average age of the final sample was 19.27 (SD = 1.50) years old with most participants self-identifying as first- or second-year college students (55.9% and 20.8%, respectively). Regarding race, 144 (58.8%) participants self-identified as White followed by 56 (22.9%) as Black, 9 (3.7%) as Asian, 26 (10.6%) as “other” or multiracial, and 10 (4.1%) who declined to respond. Approximately 18.8% of the sample self-identified as Hispanic/Latina.

**Measures**

**Substance use**

The NIDA Quick Screen assessed patterns of drug use for cannabis, cocaine, prescription stimulants, methamphetamine, inhalants, sedatives, hallucinogens,
opioids, and “other” drugs in the past 3 months. The first item asks about lifetime use of the aforementioned substances using a yes/no format. Follow-up questions inquire about frequency of use in the past 3 months, dependency or abuse of substances, and functional impairment relative to endorsed items. The final question concerns drug use by injection. An SI score was computed for each substance using NIDA scoring rules. As stated above, participants scoring in the high-risk range (i.e., SI score ≥27) for any substance were excluded. The single item regarding frequency of substance use was included as a predictor of emotional dysregulation. Given variations in use of different substances, an overall frequency mean was computed by averaging the frequency rating across substances.

Alcohol use
Two single items were used to assess alcohol use in past 30 days. The first item assessed drinking frequency (“During the past 30 days, how often did you usually have any kind of drink containing alcohol?”). This item was included as a predictor of emotional dysregulation. The second item screened for binge drinking patterns (“During the past 30 days, how often did you have 4 or more drinks containing any kind of alcohol within a two-hour period?”). Based on responses to this item, participants were excluded for heavy drinking if they endorsed having four or more drinks more than once a week in the past 30 days (i.e., 2 days a week, 3–4 days a week, 5–6 days a week, everyday). Of note, one drink constituted a 12-ounce can or bottle of beer, 5-ounce glass of wine, or drinks with one shot of liquor or spirits.

Childhood Trauma Questionnaire-Short Form
Childhood maltreatment was assessed using the Childhood Trauma Questionnaire-Short Form (CTQ-SF), which includes 28 items (Bernstein & Fink, 1998; Bernstein et al., 2003). Participants rated the extent to which they experienced different forms of childhood maltreatment (i.e., physical abuse or neglect, emotional abuse or neglect, sexual abuse) during childhood and adolescence on a scale from 1 (never true) to 5 (always true). A total childhood maltreatment score was computed by summing items. The CTQ-SF has shown good test–retest reliability, convergent validity with clinician-rated interviews for childhood abuse, and criterion validity in a sample of adolescents with corroborative data (Bernstein, Ahluvalia, Pogge, & Handelsman, 1997; Bernstein & Fink, 1998; Bernstein et al., 1994, 2003). Internal consistency was excellent (α = .93).

Self-compassion Scale
The Self-compassion Scale (SCS) (Neff, 2003a) is a 26-item measure of the degree to which individuals respond to their painful experiences with kindness and understanding. Negatively worded items were reverse coded before
computing a total score from subscale means (Neff, 2003a). A higher total score represented greater levels of self-compassion. The SCS has evidenced good internal consistency, test–retest reliability, and construct validity (Neff, 2003a). Internal consistency was high ($\alpha = .91$).

**Emotional dysregulation**

Emotional dysregulation was measured using a modified version of the Difficulties in Emotion Regulation Scale (DERS) (Gratz & Roemer, 2004). The DERS assesses emotional regulation difficulties along six dimensions: (1) lack of emotional awareness (awareness), (2) lack of emotional clarity (clarity), (3) nonacceptance of emotional responses (nonacceptance), (4) difficulty in engaging in goal-directed behaviors (goals), (5) difficulty controlling impulsive behaviors (impulse), and (6) limited access to effective strategies for emotional regulation (strategies). Notably, evidence suggests the awareness subscale may not represent the same higher order emotion regulation construct as the other five dimensions (Bardeen, Fergus, & Orcutt, 2012; Fowler et al., 2014). Compared to the other subscales, all items on the awareness are reverse-scored, which can increase systematic error and reduce scale validity (Hinkin, 1995). For this reason, a subset of awareness items (4 out of 6) were reworded using the stem, “When I’m upset” included in other subscales (Hannan & Orcutt, 2013). Participants rated items on a scale from 1 (almost never) to 5 (almost always). After reverse coding specified items, a total score was computed with higher scores indicating greater emotional dysregulation (Gratz & Roemer, 2004; Hannan & Orcutt, 2013). The DERS shows good test–retest reliability and internal consistency (Fox, Axelrod, Paliwal, Sleeper, & Sinha, 2007; Gratz & Roemer, 2004; Gratz, Tull, Baruch, Bornovalova, & Lejuez, 2008; Hannan & Orcutt, 2013; Johnson et al., 2008; Roemer et al., 2009). Internal consistency for the total score in this study was high ($\alpha = .96$).

**Data analytic plan**

First, a hierarchical regression was conducted to evaluate whether self-compassion accounted for unique variance in emotional dysregulation above and beyond that of other predictors (i.e., childhood maltreatment, substance use, alcohol use). Consistent with Vettese et al. (2011), predictors were entered as separate steps in the following order: childhood maltreatment, current substance use (including current alcohol use), and self-compassion. Next, a mediation analysis tested whether childhood maltreatment had an indirect effect on emotional dysregulation via self-compassion using the PROCESS macro (Hayes, 2013). The magnitude of the indirect effect was examined using bootstrap analysis with bias-corrected confidence intervals (CIs). Bias-corrected CIs are empirically derived and are preferable to percentile-based
CIs that are predicated on the assumption of normal distribution (Preacher & Hayes, 2008).

Results

Descriptive statistics

Variable means, standard deviations, ranges, and bivariate correlations are shown in Table 1. Less than 10% of present data were missing with most variables missing less than 4% of their total values. Current alcohol use was missing 6.5% of its total values. Only one significant difference was observed when comparing participants with and without missing data. Participants with missing data were less likely to report current substance use than those without missing data ($t[227] = 8.29, p < .001$). Missing values were corrected using mean substitution. Imputation approaches, such as mean substitution, are acceptable for data sets with small percentages of missing values (Saunders et al., 2006; Tabachnick & Fidell, 2007). Regarding sample characteristics, 40.8% of the total sample ($n = 120$) endorsed “moderate to extreme” levels of childhood maltreatment in at least one of the five categories based on established cutoff scores (Bernstein & Fink, 1998)—9.8% ($n = 24$) physical abuse (subscale score ≥10), 15.1% ($n = 37$) physical neglect (subscale score ≥10), 10.2% ($n = 25$) sexual abuse (subscale score ≥8), 24.5% ($n = 60$) emotional neglect (subscale score ≥12), and 23.7% ($n = 58$) emotional abuse (subscale score ≥11).

Hierarchical regression analyses

In the first step of the hierarchical regression model, childhood maltreatment predicted emotional dysregulation ($\beta = .37, p < .001$) and accounted for

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<th>Table 1. Bivariate correlations, means, standard deviations, and range among study variables.</th>
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<td>Age</td>
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<td>Childhood maltreatment</td>
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Note. $N = 245$.
*p < .05; **p < .001.
13.9% of its variance. Substance use (including alcohol use) was added in the next step. Not surprisingly, substance use ($\beta = .07$, $p = .311$) and alcohol use ($\beta = .11$, $p = .097$) were unrelated to emotional dysregulation and accounted for 2.3% additional variance in emotional dysregulation. Childhood maltreatment remained a significant predictor ($\beta = .37$, $p < .001$). In the final step, self-compassion was entered. As predicted, self-compassion predicted emotional dysregulation ($\beta = -.66$, $p < .001$) and accounted for an additional 39.5% of variance above and beyond that explained by other predictors. Childhood maltreatment also remained a significant predictor ($\beta = .24$, $p < .001$). Substance use ($\beta = -.01$, $p = .868$) and alcohol use ($\beta = .03$, $p = .591$) were unrelated. Altogether, these predictors explained a total of 55.7% of variance in emotional dysregulation.

**Mediation analyses**

Results for the mediation analysis testing the indirect effect of childhood maltreatment on emotional dysregulation through self-compassion are shown in Figure 1. The total effect of childhood maltreatment on emotional dysregulation was statistically significant ($B = .64$, $p < .001$). As shown in Figure 1, the magnitude of this effect was reduced, although still significant, when self-compassion was added to the model. As expected, childhood maltreatment was significantly associated with self-compassion and self-compassion was associated with emotional dysregulation. The indirect effect of childhood maltreatment on emotional dysregulation through self-compassion was significant (indirect effect: $B = .24$, 95% CI [.095, .397]).

**Discussion**

Despite preliminary evidence implicating self-compassion as a buffer against emotional dysregulation following childhood maltreatment (Vettese et al.,

![Figure 1](image-url)
research in this area is rather limited. Therefore, the purpose of the current study was to conceptually replicate and extend previous findings by Vettese et al. (2011). Specifically, we investigated the role of self-compassion in the relationship between childhood maltreatment and emotional dysregulation in a nonclinical sample with no self-reported substance abuse/misuse. Current findings indicate that deficits in self-compassion may be a potential mechanism by which childhood maltreatment contributes to emotional dysregulation (see also Vettese et al., 2011).

As predicted, self-compassion was a stronger predictor of emotional dysregulation than childhood maltreatment and substance use (including alcohol use). Further, childhood maltreatment continued to predict emotional dysregulation above and beyond self-compassion and substance use. Among a sample of problem substance users (Vettese et al., 2011), childhood maltreatment only predicted emotional dysregulation at the bivariate level. As previously mentioned, this may be attributable to links between emotional regulation and substance use disorders (e.g., Kober & Bolling, 2014). Self-compassion also exerted an indirect effect on the relationship between childhood maltreatment and emotional dysregulation. Thus, our conceptual replication of Vettese et al. (2011) demonstrates the generalizability of self-compassion’s effect on emotional regulation following childhood maltreatment to a nonclinical sample independent of substance use. Together, these findings highlight the critical role of childhood maltreatment on the development of both self-compassion and emotional regulation (Alink, Cicchetti, Kim, & Rogosch, 2009; Cloitre, Stovall-McClough, Zorbas, & Charuvastra, 2008; Neff & McGehee, 2010; Raque-Bogdan et al., 2011; Tanaka et al., 2011).

Emotional dysregulation following childhood adversity is likely to persist in the absence of protective factors such as self-compassion. Self-compassion may influence emotional regulation by promoting kindness and acceptance toward oneself when experiencing negative feelings. Such an orientation may diminish emotional reactivity (e.g., Leary et al., 2007) and in turn reduce the tendency to engage in maladaptive regulatory strategies (e.g., rumination). Indeed, self-compassion has been negatively associated with rumination (Krieger, Altenstein, Baettig, Doerig, & Holtforth, 2013; Neff, 2003a; Neff et al., 2007) and appears to improve depression and anxiety by decoupling one from perseverative thinking (Raes, 2010). Thus, self-compassion may alleviate an emotion’s intensity, thereby facilitating adaptive emotional regulation processes.

**Clinical implications**

Toward this end, clinicians treating patients with a history of childhood maltreatment may consider therapeutic approaches that foster self-compassion (e.g., compassion-focused therapy, mindful self-compassion program;
Gilbert, 2010; Neff & Germer, 2013). Several studies have demonstrated the appropriateness of compassion-based interventions for trauma-exposed populations, such as loving-kindness meditation (Kearney et al., 2013), compassion-based therapy (Au et al., 2017), and a combination of compassionate mind training with cognitive behavior therapy (Beaumont, Jenkins, & Galpin, 2012). Encouraging individuals to extend a loving, kind attitude toward their suffering through self-compassion skills training likely improves their overall ability to withstand aversive emotional experiences while employing adaptive coping strategies (for a review, see Barnard & Curry, 2011). Additionally, exercising self-compassion may engender feelings of social connectedness within patients by contextualizing their negative emotions as part of normal experience (e.g., Neff, 2003b; Neff et al., 2007). Thus, cultivating self-compassion may facilitate a willingness to approach (as opposed to avoid) aversive emotions in a way that seems conducive to working with maltreatment survivors.

Limitations

The current study had several limitations. Present data were based exclusively on women, and several studies have documented gender differences in emotionality and regulatory capacity (Domes et al., 2009; Garnefski, Teerds, Kraaij, Legerste, & van den Kommer, 2004; McRae, Ochsner, Mauss, Gabrieli, & Gross, 2008; Nolen-Hoeksema & Aldao, 2011; Zimmermann & Iwanski, 2014). However, our mediation analysis yielded results comparable to those found in Vettese and colleagues’ (Vettese et al., 2011) whose sample included a high percentage of men (65%). This indicates that present findings may be generalizable to male survivors of childhood maltreatment. With respect to the other sample characteristics, generalizability was also limited in race/ethnicity, age, and maltreatment severity. Thus, present findings may not reflect the broader adult population and individuals from diverse backgrounds. Additionally, although temporal relationships among study variables were inferred, causality cannot be definitively assumed from this study’s cross-sectional design. Related to this point, this study relied on retrospective reporting, which is susceptible to recall bias (Lalande & Bonanno, 2011). Lastly, although online studies have many advantages (e.g., cost-effective, timely), self-selection bias is a potential problem that may have influenced present results (Thompson, Surface, Martin, & Sanders, 2003).

Conclusions and future directions

A potential direction for future research would be to investigate how the dimensions of self-compassion (i.e., self-kindness, self-judgment, common humanity, isolation, mindfulness, overidentification) differentially relate to
emotional dysregulation following childhood maltreatment. For example, becoming engrossed in negative emotions (i.e., overidentifying) may lead individuals to attribute significant meaning to feelings such as shame, guilt, or anger (e.g., “I will never get better”). Consequently, overidentifying may restrict the ability to consider alternative coping strategies, as well as demotivate one from further attempts at emotional regulation. Together with self-criticism and feeling isolated, these processes may synergistically exacerbate an emotion’s intensity, thus rendering adaptive emotional regulation more difficult (e.g., Diedrich, Grant, Hofmann, Hiller, & Berking, 2014; Sheppes & Meiran, 2007). Given the multidimensional nature of self-compassion and emotional dysregulation, such research may be useful in further delineating the relationship between these constructs among individuals with childhood maltreatment.

Given the cross-sectional design of the current study, it is also important that future studies consider how emotional dysregulation might affect self-compassion. Survivors of childhood maltreatment with difficulties in regulating their emotions may have a limited capacity to exercise self-compassion. For instance, maltreatment can lead to increased feelings of shame and self-blame that evoke self-directed hostility and contempt, thus, facilitating self-deprecating views and active resistance of self-compassionate aims (Gilbert & Procter, 2006). This phenomenon has been termed “fear of self-compassion” (Gilbert, 2014; Gilbert, McEwan, Matos, & Rivis, 2011). Future research may investigate how emotional dysregulation following childhood maltreatment may influence the ability to be self-compassionate.

There are many pathways through which childhood maltreatment may contribute to subsequent emotional regulation difficulties. Our findings, similar to Vettese et al. (2011), suggest that deficits in self-compassion are one such mechanism. Thus, given its malleability, manipulating self-compassion may allow for a more precise understanding of its effects on emotional regulation. Additionally, prospective, longitudinal studies would provide valuable insight concerning the degree to which changes in self-compassion across time (and other related constructs) impact the persistence of emotional dysregulation secondary to childhood maltreatment. Future research would also benefit from continued investigation on the clinical utility of compassion-based interventions within trauma-exposed populations.

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