

Male Survivors of Childhood Maltreatment:
Examining the Relationship between Self-Compassion and Psychological Well-Being
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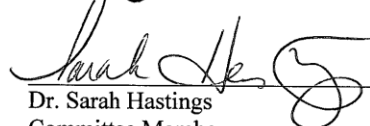
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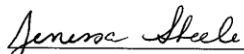
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Abstract

Current literature presents contrasting views on the effects of childhood maltreatment. These effects range from no negative impact in adulthood to the development of psychopathology or death by suicide (Vetteses, Dryer, Li, & Wekerle, 2011). In order to conceptualize these differing impacts, factors contributing to the development of negative symptoms have been explored. Sex (being male or female) has been identified as a contributing factor associated with an increase in negative symptoms following the experience of childhood maltreatment. Research indicates that being male may exacerbate negative symptoms following childhood maltreatment and results in a decreased sense of psychological well-being (Mejia, 2005). Self-compassion, however, has been suggested to aid in the improvement of psychological well-being and in the recovery from traumatic events (Neff, 2003a). Current literature on the influence of self-compassion on psychological well-being is quite limited, and even more so when examining the relationship between self-compassion and psychological well-being after having experienced childhood maltreatment. This study examined the relationship between self-compassion and psychological well-being among a sample of men who have and have not experienced childhood maltreatment.

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Chapter 1: Overview

Prevalence rates surrounding childhood abuse and neglect vary. However, the most recent data from the National Child Abuse and Neglect Data System (NCANDS) suggest that between 695,000 and 754,000 children experienced abuse or neglect in 2010. The United States Census Bureau, *Current Population Reports*, indicates that in 2010 there were approximately 74 million children in the United States (United States Census Bureau, 2010). Although prevalence rates are likely to vary slightly, this represents an approximate prevalence rate that reflects, on average, 10% of children between the ages of 0-17 experiencing abuse or neglect.

Within the current literature, there are two distinct bodies of literature regarding the impact of childhood maltreatment. One body of literature asserts that having endured childhood maltreatment likely results in some negative impacts, but those impacts will be less severe than asserted by others (Afifi & MacMillan, 2011). This collection of literature posits that confounding variables and methodological techniques result in skewed findings. In contrast, the other literature asserts that having endured maltreatment as a child results in enduring, chronic, life-long consequences. These consequences include: anxiety, depression, increased substance use and abuse, as well as increased risk of suicidal behaviors (Kendall-Tackett, 2002).

One of the possible negative consequences as a result of childhood maltreatment is a decrease in psychological well-being (Dhaliwal, Gauzus, & Ross, 1996). Current literature suggests that a lower level of psychological well-being is likely to be associated with many negative effects such as increased negative self-appraisals, increased maladaptive coping strategies, and increased negative affect. Additionally, findings suggest that a number of variables may influence perceptions of well-being, including: sense of autonomy, positive relations with others, and self-acceptance (Ryff & Keyes, 1995). However, there is little

available research that examines the relationship between self-compassion and psychological well-being among survivors of childhood maltreatment. Moreover, there is no literature when considering this relationship among male survivors of childhood maltreatment.

Understanding the unique experience of men is particularly important when exploring the literature and potential inconsistencies surrounding the impact of childhood maltreatment. Mejia (2002) suggests that gender may play a key role in recovery from childhood maltreatment in that men are likely to have different needs, understandings, and interpretations after having endured abuse or neglect. One reason for this difference is likely to be the lasting effects of gender socialization in which male children are groomed to act in accordance with societal views of masculinity which include being strong, stoic, and emotionally controlled. Psychologically, boys are groomed to constrict the display of emotions. Thus, the experience for boys who have experienced childhood maltreatment who grow into men may be unique. Therefore Levant (1996) and Lui (2005) argue that it is important that men be examined independently from women given the role of gender socialization and the impact of being male.

Childhood Maltreatment

One noted inconsistency in the literature is the use of the term *abuse* over the more inclusive term *childhood maltreatment*. Childhood maltreatment refers to the occurrence of one or multiple incidences of childhood physical and/or emotional abuse or neglect, and/or sexual abuse occurring prior to the age of 18 and perpetrated by a parent or other caregiver of the individual who endured the maltreatment (Bernstein et al., 1994; Cook, Chaplin, Sinha, Tebes, & Mayes, 2012). *Abuse* (whether this involves physical, sexual, or emotional abuse) is defined as active harm that is perpetrated against a child, while *neglect* refers to a caregiver's failure to provide developmentally appropriate and supportive environments (Tanaka, Wekerle, Schmuck,

& Paglia-Boak, 2011). Although the term childhood maltreatment refers to both abuse and neglect, current literature does provide a distinction between the two. However, the term *childhood maltreatment* allows for multiple incidences of either childhood abuse or neglect and as a result, possible negative effects endured are not limited to one type of abuse or neglect in the absence of other forms of abuse or neglect. Evaluating the compounding impact of maltreatment as a child is important.

In a study conducted by Felitti and colleagues (2001), male and female survivors were assessed for childhood sexual abuse. The endurance of childhood sexual abuse was then compared to incidences of other adverse childhood events (ACES), including emotional abuse, physical abuse, having seen one's mother battered, household substance abuse, household mental illness, parental separation/ divorce, criminal household member, emotional neglect, and physical neglect. Felitti and colleagues found that having experienced childhood sexual abuse greatly increased the likelihood that children had experienced one or more additional ACES as well. Felitti and colleagues assert that if a child has experienced maltreatment, it is likely that they have experienced more than one form of abuse and/or neglect. Data from the ACES study indicated that of the 64 percent of participants who reported adverse childhood events, 38 percent endured two or more events. Therefore, for the most comprehensive understanding of the effect of childhood abuse and neglect, studying maltreatment (which includes both abuse and neglect) is preferable to studying one form of abuse or neglect alone.

Negative consequences of childhood maltreatment. In examining the literature on childhood maltreatment, Kendall-Tackett (2002) argues that the possible negative consequences can be classified into four broad categories: (a) behavioral effects, (b) social effects, (c) cognitive effects, and (d) emotional effects (Kendall-Tackett).

Behavioral effects. The negative behavioral effects studied among survivors of childhood maltreatment are multiple and include substance abuse and misuse, risky sexual behavior, and suicidal ideation and para-suicidal behaviors.

Substance abuse and misuse. Individuals who have experienced negative childhood events are more likely to use psychoactive drugs, intravenously administered drugs, and alcohol than those who have not endured childhood maltreatment (Bartholow et al., 1994; Felitti et al., 2001, Kendall-Tackett et al., 2000). Not only has research noted a relationship between childhood maltreatment and increased substance use, literature also indicates that survivors are likely to have an earlier onset of drug and alcohol use when compared to those who have not endured childhood maltreatment (Ford, 2005). Research indicates that those who experienced childhood maltreatment are generally heavier drinkers when compared to individuals who experienced maltreatment in their adult years (Fisher, Gunnar, Chamberlain, & Reid, 2000; Waldrop et al., 2007). When looking specifically at gender differences, Shand, Degenhart, Slade, and Nelson (2011) found that male survivors were more likely than female survivors to have prevalent lifetime substance dependence diagnoses. Although the precipitating traumatic event was not identified, a diagnosis of Post-traumatic Stress Disorder was found to be a significant predictor for substance misuse for males but not females (Shand, Degenhart, Slade, & Nelson). The relationship between childhood maltreatment and increased substance abuse has been examined by many researchers and supports the understanding that having endured childhood maltreatment is associated with increased substance use and abuse (Asberg & Renk, 2012, Brems, Johnson, & Freeman, 2004; Drapalaski, Youngman, Stuewig, & Tangney, 2009; Enoch, 2011; Young-Wolf, Kendler, & Prescott, 2012).

Risky sexual behavior. When examining male survivors, childhood sexual abuse has been linked to an increase in risky sexual practices including high numbers of sexual partners and unprotected sexual intercourse (Schraufnagel, Davis, George, & Norris, 2010) among both adolescent and adult male survivors. Male survivors of childhood sexual abuse have also been found to engage in earlier consensual sexual initiation than their female counterparts, and are typically younger when first engaging in sexual intercourse than female survivors (Wilsnack, Vogeltanz, Klassen, & Harris, 1997; Chandy, Blum & Resnick, 1996).

Suicidal ideation and para-suicidal behaviors. In a study examining the relationship between suicide attempts and adverse childhood experiences, it was found that enduring adverse childhood experiences increased the risk of attempted suicide by two to five percent (Dube, Anda, Felitti, Chapman, Williamson, & Giles, 2001). Similar findings from Dhaliwah, Gauzas, Antonowicz, and Ross (1996) support the conclusions of Dube et al. (2001) when looking specifically at male survivors of childhood abuse. Dhaliwah, Gauzas, Antonowicz, and Ross (1996) conducted a critical literature review of research relevant to male survivors of childhood sexual abuse. The literature reviewed indicated not only that male survivors of childhood abuse had higher levels of depression than their non-victimized counterparts but that these survivors were more likely to attempt suicide (Dhaliwah, Gauzas, Antonowicz & Ross, 1996). The behavioral consequences presented in the literature are compelling and extensive, overwhelmingly supporting the need to further investigate potential protective factors. Behavioral consequences are not the only possible negative outcome of having endured childhood maltreatment.

Social effects. The negative social consequences of having endured childhood maltreatment are important to examine. Current research findings suggest that the formation of

social relationships and the ability to get along with others is essential to psychological well-being and that without good social support, individuals are likely to have negative outcomes, including exploitive or victimizing relationships, dissatisfaction with current relationships, and even compromised health (Allgower, Wardle, & Steptoe, 2001; Fleming et al., 1999; Vitaliano et al., 2001).

Adult survivors of childhood maltreatment are likely to have limited social abilities, may reduce their interactions with others, and may have fewer relationships (Kendall-Tackett, 2002). Adult survivors are at an increased likelihood of engaging in relationships that are exploitive or victimizing (Fleming et al., 1999), likely to have higher rates of divorce (Felitti, 1991), and general satisfaction with present relationships is likely to be lower than for men in general (Fleming). Increased relationship and interpersonal dysfunction has also been examined and supported in existing literature (Beckner-Lausen & Mallon- Kraft, 1997). Beckner-Lausen and Mallon-Kraft found that survivors of childhood abuse with interpersonal difficulties adapted either an avoidant or intrusive interpersonal style. These personality styles resulted in survivors being less interdependent on others, having low self-disclosure, and little warmth, which resulted in few interpersonal connections and friends. In contrast, there may also be an extreme need for closeness with others, excessive self-disclosure, and overly warm relationships. Both styles were characterized as dysfunctional and were likely to result in loneliness (Beckner-Lausen & Mallon-Kraft, 1997). Decreased or compromised social connectedness may be linked to later revictimization.

Zanarini et al. (1999) found that there were five types of childhood maltreatment that predicted later victimization: physical neglect by a caretaker, emotional withdrawal by a caretaker, a caretaker's failure to provide needed protection, sexual abuse by a non-caretaker,

and sexual abuse. Findings by Kendall-Tackett (2002) indicated that revictimization was related to an increase in negative outcomes such as injury, death, increase in stress and substance abuse, eating disorders, or smoking as a result of chronic stress. In addition to behavioral and social consequences, research also provides information about the possible negative cognitive consequences that result from having experienced or endured childhood maltreatment.

Cognitive effects. Negative cognitive consequences refer to the unhealthy beliefs and attitudes that influence one's perceptions and interpretations of situations that occur during daily existence. Essentially, an individual's internal mental framework involved in interpreting interactions with others and the interpretation of one's own life events can be compromised and may serve to promote negative cognitions about the individual and the world. Research indicates that individuals who are mistreated as children may develop internal interpretations of the world as overly dangerous and adversarial and such appraisals can directly influence an individual's perception of psychological well-being and may relate to mood states such as depression, self-efficacy, and even perceptions of physical health (Kendall-Tackett, 2002).

One cognitive effect of enduring childhood maltreatment seen specifically among male survivors is sexual dysfunction. Findings have suggested that male survivors of childhood sexual abuse have higher levels of sexual dysfunction than their non-abused counterparts. These problems are linked to their cognitions and include sexual identity concerns or confusion, lower sexual self-esteem, and fear of negative emotions after having acceptable sexual experiences (Dhaliwal, Gauzas, Antonowicz , & Ross, 1996).

Reduced self-efficacy is another negative cognitive consequence of enduring maltreatment. Briere and Elliot (1994) found that adult survivors of maltreatment are likely to underestimate their sense of self-efficacy or self-worth when dealing with real or perceived

danger, which in turn may increase perceptions of helplessness, powerlessness, and danger. Research findings by Gauthier, Stollak, Messe, and Aronoff, (1996) indicated that individuals who experienced childhood abuse were more likely to be distrusting of themselves and others and had increased levels of anxiety, paranoia, and hostility. Survivors of childhood maltreatment may be more likely to see themselves as flawed and have a sense of shame regarding the maltreatment that they have endured (Dhaliwal, Gauzas, Antonowicz , & Ross, 1996). Self-criticism and rumination are also possible negative cognitive consequences of having endured childhood maltreatment (Zuroff, Koestner, & Powers, 1994). Zuroff, Koestner, and Powers (1994) and Murphy, Nierenber, Monson, Laird, Sobol, and Leighton (2002) found that such negative cognitions can be linked to negative mood states as well.

Emotional effects. Emotional dysregulation, or difficulty in controlling or stabilizing one's mood, is a commonly identified consequence of childhood maltreatment. Emotional regulation difficulties can be understood as a decreased awareness, understanding, and acceptance of one's emotions (Vetters, Dryer, Li, & Wekerle, 2011).

Brier and Elliot (1994) asserted that depression is the most commonly occurring sequelae of childhood abuse. Survivors of childhood maltreatment have also been found to have an increased risk for developing symptoms associated with post-traumatic stress disorder (Kendall-Tackett, 2002). When examining male survivors of childhood maltreatment, Dhaliwal, Gauzas, and Ross (1996) found that male survivors had significantly lower levels of well-being and greater emotional adjustment concerns than those who had not endured maltreatment. Male survivors were also found on average to have higher scores on Minnesota Multiphasic Personality Inventory (MMPI) subscales measuring hypochondriasis, hysteria, psychopathic deviate, paranoia, psychasthenia, and schizophrenia (Dhaliwal, Gauzas, & Ross, 1996). While

the negative effects of childhood maltreatment can be seen in many areas of the survivors' social, cognitive, behavioral, and emotional functioning, literature also suggests that the effects may not be as severe as the previous literature may suggest.

Contradictory Findings

The other body of literature on recovery from childhood maltreatment suggests findings that present conflicting views of the impact of childhood maltreatment may be due to a variety of explanations. Ferguson, Boden, and Horwood (2008) assert that much of the research is conducted with specialized populations (e.g., self-referred for counseling, psychiatric patients, and prisoners) and the extent to which findings from specialized populations can be generalized to an entire population of individuals who experienced childhood maltreatment is not yet clear.

The use of retrospective accounts to assess the impact of childhood maltreatment may be somewhat inaccurate at adequately capturing the events that occurred in childhood (Femina, Yeager, Lewis, 1990). This is referred to as recall bias, which asserts that individuals who are more likely to have a psychiatric disorder may be more likely to report childhood sexual abuse or childhood physical abuse. This bias calls into question the accuracy of these reports in that there is a possibility of observing a false relationship between childhood physical or sexual abuse and later adjustment, being that individuals may be more willing to recall or report these events (Fergusson & Mullen, 1999). In addition to recall bias, literature asserts that there may be other factors that better explain the negative consequences that have been observed in the research.

Higgins and McCabe (2003) conducted studies examining maltreatment and family dysfunction in childhood. The findings suggested that while childhood maltreatment scores predicted later maladjustment and psychopathology, childhood family variables such as family structure and family support were better predictors of later adjustment. Pitzer and Fingerman

(2010) also explored the impact of possible negative consequences of childhood maltreatment and results indicated that “very severe” parental abuse in childhood does not always lead to poor health and well-being outcomes.

In addition to perceptual biases, the role of gender, and the influence of family, other variables have been identified that may influence findings. Current research on protective factors associated with recovery from childhood maltreatment provides insight into the possibility that the endurance of childhood maltreatment is not exclusively predictive of negative outcomes. Negative outcomes of having endured childhood maltreatment may actually be decreased or lessened as a result of increasing other cognitive, psychological, and interpersonal resources. Increasing such factors may serve to promote resilience, which is conceptualized as a process of buffering that does not eliminate risks and stressors but enables the individual to deal with them more effectively (Rutter, 1987). Some identified protective factors that promote wellness after enduring childhood maltreatment include social support, positive coping strategies, and religious beliefs (Dervic, Grunebaum, Burke, Man, & Oquendo, 2006; Runtz & Schallow, 1997). One variable that holds promise as a protective factor is self-compassion.

Self-Compassion

Neff (2009) defines self-compassion as involving a personal desire to improve one’s health and well-being and is associated with a greater personal initiative to make needed or necessary life changes. A central theme of self-compassion is that one must experience one’s suffering without avoiding or disconnecting from the suffering. When suffering is experienced, one can act in a way that is kind and gentle toward oneself. Rather than seeing oneself as flawed and of poor character, the individual is more able to understand that suffering and flaws are a part of the greater human experience.

Self-compassion can occur through individual adherence to three specific components of self-compassion: (a) self-kindness versus self-judgment, (b) a sense of common humanity versus isolation, and (c) mindfulness versus over-identification (Neff, 2003).

Components of self-compassion. Self-kindness refers to the tendency to be caring and understanding with oneself rather than being harshly critical or judgmental (Neff, 2009). Given that suffering is not avoidable, it is essential that individuals learn to respond to themselves with self-kindness. Common humanity involves understanding and accepting that all human beings are imperfect. Common humanity can help to remind an individual that suffering is a shared human experience and is not limited to them alone (Neff, 2009). Mindfulness, the final component of self-compassion, promotes the awareness of an individual during each moment in time. The goal is to become purposefully aware of the present moment as opposed to operating in “autopilot,” so that life circumstances can be more clearly experienced and processed in a balanced way (Neff, 2009). Self-compassion has been associated with perceptions of well-being in the literature.

Psychological Well-Being

Psychological well-being is a broad construct that is theorized differently depending on the researcher. Essentially, psychological well-being focuses on existential concerns and how individuals feel about the world around them (Wood & Joseph, 2010). Ryff and Keyes (1995) provide a thorough definition of psychological well-being in which six domains of wellness are conceptualized: (a) autonomy, (b) environmental mastery, (c) personal growth, (d) positive relations with others, (e) purpose in life, and (f) self-acceptance. Ryff and Keyes assert that when examined together, these domains represent psychological well-being. Research indicates that psychological well-being may be compromised among survivors of childhood maltreatment

(Dhaliwal, Gauzus, & Ross, 1996). However, some factors have been associated with moderating the relationship between lower well-being and childhood maltreatment. Of these “protective factors,” self-compassion has shown particular promise in ameliorating the impact of childhood maltreatment.

Self-compassion and psychological well-being. Gilbert (2005) asserted that a positive association between self-compassion and psychological well-being is to be expected. Literature suggests that self-compassion promotes well-being through helping an individual feel cared for and connected to others, as well as being emotionally calm. Neff (2004) posited that self-compassion may help individuals cultivate an increased sense of psychological well-being, increased happiness, increased positive affect, and increased social connectedness (Wei, Liao, Ku, & Shaffer, 2011).

Self-compassion has been associated with a number of measures of psychological well-being. Specifically, individuals with higher levels of self-compassion have been found to have lower levels of depression, anxiety, better emotional coping skills, less frightened by potential failure, and tend to be more intrinsically motivated to grow and change (Neff, 2003). Higher levels of self-compassion have been associated with individuals who are more socially and interpersonally connected with others and who have less pervasive patterns of self-criticism, rumination, thought suppression, and neurotic perfectionism (Neff, 2003a; Neff, Leary, & Hoyle, 2009; Neff, Rude, & Kirkpatrick, 2007).

Leary, Tate, Adams, Allen, and Hancock (2007) conducted five studies to examine the connection between self-compassion and psychological well-being. Leary et al. (2007) conducted five studies investigating the processes by which self-compassion helps individuals better manage unpleasant life events. The results indicated that when individuals encounter daily

stressors, those who reported higher levels of self-compassion were able to approach these stressors in a way that was more cognitively and emotionally adaptive than those who were lower in reported levels of self-compassion. Results also indicated that self-compassion served to buffer against negative feelings directed at the self when imagining distressing life events.

Neely et al. (2009) also conducted two studies to explore the relationship between self-compassion and psychological well-being. Results suggest that an individual's level of self-compassion serves to predict how they will likely respond when experiencing negative life events and how their sense of well-being may be affected. Based on the findings of Neely et al., individuals higher in self-compassion were likely to respond in a way that was more adaptive. The need and availability of social support was examined as a predictor for how one might respond to negative and stressful life events. Findings assert that social support and self-compassion were found to account for differing levels of psychological well-being, suggesting that self-compassion is a reliable correlate to psychological well-being.

In a study conducted by Neff and McGehee (2010) using a sample of adolescents, it was found that self-compassion was strongly associated with one's sense of psychological well-being. Self-compassion was also found to partially mediate the interaction between positive or negative family/cognitive factors and how psychological well-being was impacted as a result of family/cognitive factors. Findings from the study suggest that even in the presence of difficult family situations, adolescents higher in levels of self-compassion had an increased sense of psychological well-being. Based on these findings, Neff and McGehee (2012) suggest that self-compassion may be an effective intervention for individuals suffering from negative self-views as a result of difficult life circumstances.

Self-compassion and maltreatment-related symptoms. Research also indicates that self-compassion can be helpful for those recovering from childhood maltreatment. Gilbert and Procter (2006) conducted a compassionate mind training that involved the integration of self-compassion into therapy for individuals who had psychological disorders that occur as a result of shame and self-criticism. After having experienced the compassionate mind training, participants reported a significant reduction in anxiety, depression, and a reduction of self-criticism. Gilbert and Procter asserted that self-compassion infused therapy could be helpful in treating individuals with traumatic histories.

Thompson and Waltz (2008) also explored the relationship between self-compassion and post-traumatic symptoms. Thompson and Waltz found that those who had lower levels of self-compassion were more likely to engage in avoidant behaviors in an attempt to avoid emotional triggers of past traumas. As a result, it was suggested that abuse survivors and those that suffer from post-traumatic stress disorder may benefit from therapy that includes aspects of self-compassion. Although current literature asserts that there is likely a relationship between self-compassion and psychological well-being, this literature is limited (Gilbert, 2005; Neff, 2004, Tate, Adams, Allen, and Hancock, 2007). Literature is even more limited when considering the relationship between self-compassion and psychological well-being among individuals who have experienced childhood maltreatment and even more so when this sample is composed of a traditionally understudied population (male survivors). It is important to explore the available research to postulate as to how these constructs may fit together in such a sample.

Self-compassion, childhood maltreatment, and psychological well-Being. Literature provides some insight into how the endurance of childhood maltreatment may affect a survivor's ability to be self-compassionate in the future. Individuals are likely to learn how to treat

themselves by observing and modeling their parent's behavior (Neff & McGehee, 2010). When a child experiences a time of suffering, he/she is likely to learn how to relate to themselves by observing how their parents relate to them. If caregivers are supportive and nurturing, a child may learn to treat him/herself in the same manner; if, however, the parents are neglectful or abusive, the child may learn to be harsh, self-critical, and self-loathing (Neff & McGehee, 2010). Inconsistent, neglectful, or abusive parenting may result in a child who has learned a compromised or negative view of self. In turn, this compromised view of self likely results in a compromised development of self-compassion (Neff & McGehee, 2010; Wei, Laio, Ku, & Shaffer, 2011). When individuals possess more self-criticism than self-compassion, they are more likely to exaggerate their distress, becoming consumed by painful thoughts and feelings (Mikulincer et al., 2003).

One observed negative symptom expression following childhood maltreatment is an inability to regulate one's emotions (Vettese, Dryer, Li, & Wekerle, 2011). When studying individuals who experienced childhood maltreatment, it was found that as self-compassion increased, the severity of emotional dysregulation decreased. Self-compassion was also found to mediate the relationship between childhood abuse and later emotional dysregulation (Vettese, Dryer, Li, & Wekerle, 2011).

Self-compassion and reduction of PTSD symptoms. It has been suggested that self-compassion may promote psychological well-being through a reduction of maltreatment-related symptoms. Thompson and Waltz (2008) assert that survivors of childhood maltreatment, particularly those with PTSD, would likely benefit from the incorporation of the concepts of self-compassion into treatment to minimize the negative symptoms that result from the endurance of a traumatic event such as self-criticism and rumination. Self-criticism and rumination may

reduce an individual's ability to be self-accepting. There may also be decreased feelings of autonomy, and a decrease in perceived environmental mastery, being that the highly critical individual may not feel competent or efficacious. Self-compassion may help to decrease some of the cognitive consequences of childhood maltreatment and serve to promote or increase psychological well-being (Thompson & Waltz).

Baer, Lynkins, and Peters (2012) conducted a study to examine the relationship between psychological health, mindfulness, and self-compassion. The study tested three hypotheses. The first hypothesis suggested that mindfulness and self-compassion would be significantly positively correlated with each other and that mindfulness and self-compassion would be significantly positively correlated to psychological well-being and meditation experience. The second hypothesis suggested that mindfulness and self-compassion would account for independent variance in psychological well-being. The third hypothesis suggested that a significant relationship between meditation experience and psychological well-being could be accounted for by mindfulness and self-compassion.

When scores on measures of self-compassion, psychological health, and mindfulness were examined, Baer, Lynkins, and Peters (2012) concluded that self-compassion was a stronger predictor of psychological well-being than mindfulness. Results also indicate that the significant association between meditation and increased psychological well-being was completely accounted for by a combination of mindfulness and self-compassion scores. Overall, these results indicate that self-compassion may greatly enhance psychological well-being.

Although research provides data to suggest self-compassion and psychological well-being may be related, this literature is limited and the relationship has not been thoroughly explored in the context of having endured childhood maltreatment. With the understanding that

being male may serve to exacerbate the negative symptoms following childhood maltreatment and result in a compromised sense of psychological well-being (Mejia, 2005), it is also important to explore this relationship specifically in a male sample. To date there are no studies that examine the relationship between self-compassion and psychological well-being among a sample of male survivors of childhood maltreatment.

Hypotheses

Although current research is beginning to explore the relationship between self-compassion and psychological well-being (Baer, Lynkins, & Peters, 2012; Neely et al., 2009; Van Dam et al., 2011), there is little understanding of the relationship between self-compassion and psychological well-being for male survivors of childhood maltreatment. Given the void, the following research questions and hypotheses are proposed:

1. Is there a relationship between trauma symptom severity following childhood trauma and self-compassion? It was hypothesized that there would be a significant negative relationship between trauma symptom severity following childhood trauma and self-compassion.
2. Is there a relationship between trauma symptom severity and psychological well-being? It was hypothesized that there would be a significant negative relationship between trauma symptom severity and psychological well-being.
3. Is there a relationship between self-compassion and psychological well-being? It was hypothesized that there would be a significant positive relationship between self-compassion and psychological well-being.

4. Does self-compassion influence the relationship between trauma symptom severity and psychological well-being? It was hypothesized that self-compassion would mediate the relationship between trauma symptom severity and psychological well-being.

Methods

Participants. Participants were all men, 18 years of age or older. In an attempt to understand the impact of childhood abuse, self-compassion, and perceptions of well-being, this study compared males who had experienced childhood maltreatment with males who had not experienced childhood maltreatment.

Measures. Respondents completed 6 measures. These measures included: Demographic Questionnaire, Self-Compassion Scale Short Form (2003), Zung Self-Rating Depression Scale (1965), Satisfaction with Life scale (1985), Scales of Psychological Well-Being (1995), and the Trauma Symptom Checklist- 40 (1989).

The Demographic Questionnaire was a 5-item form that assessed the participant's sex, ethnicity, age, type of maltreatment experienced, approximate duration of the maltreatment experienced. The Self-Compassion Scale Short form is a psychometrically sound, 12-item measure that yields data on 6 subscales of self-compassion: self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification (Neff, 2003). The Zung Self-Rating Depression Scale is a psychometrically sound 20-item measure used to rate four common symptoms of depression: the pervasive effect, the physiological equivalents, other disturbances, and psychomotor activities (Zung, 1965). The Zung Self-Rating Depression Scale has been found to be psychometrically sound and exhibits good reliability and validity. In a community survey of 1,173 subjects, $\alpha=0.79$ (Knight et al., 1983). When considering the validity of this measure, there was correlation between scores of the Zung Self-Rating Depression Scale and the Minnesota Multiphasic Personality Inventory Depression Scale ($r=0.65$). The Satisfaction with Life Scale is a psychometrically sound 5-item measure used to assess a respondent's satisfaction with life as a whole (Diener et al., 1985). This scale has been found to be psychometrically

sound with good reliability and validity. Diener et al. (1985) reported a reliability coefficient of $\alpha=0.87$. When considering validity, the Satisfaction with Life Scale has been shown to be negatively correlated with other measures of distress. The Satisfaction with Life Scale has been shown to be strongly negatively correlated with the Beck Depression Inventory with $r=-0.72$ (Pavot & Diener, 1993). This measure has been used by other researchers to explore the relationship between psychological well-being and childhood maltreatment (Chaudhury, Murthy, Banerjee, Kumari, & Alreja, 2011; Galea, 2012). The Scales of Psychological Well-Being are psychometrically sound measures of six domains of well-being: autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance. This measure contains 54 items (Ryff & Keyes, 1995). Overall, this scale has been reported to be psychometrically sound and have good reliability and validity. Internal consistency and correlation with 20-item parent scales are reported for each of the six domains assessed by the Psychological Scales of Well-Being. The autonomy scale was reported to have an internal consistency of $\alpha=.83$ and a correlation with the 20-item parent scale of $r=.97$. The environmental mastery scale was reported to have an internal consistency of $\alpha=.86$ and a correlation with the 20-item parent scale of $r=.98$. The personal growth scale was reported to have an internal consistency of $\alpha=.85$ and a correlation with the 20-item parent scale of $r=.97$. The positive relations with others scale was reported to have an internal consistency of $\alpha=.88$ and a correlation with the 20-item parent scale of $r=.98$. The purpose in life scale was reported to have an internal consistency of $\alpha=.88$ with a correlation to with the 20-item parent scale of $r=.98$. The self-acceptance scale was reported to have an internal consistency of $\alpha=.91$ and a correlation with the 20-item parent scale of $r=.99$ (Ryff, 1989). The final measure used was the Trauma Symptom Checklist-40. This is a psychometrically sound 40-item measure of symptomology in

adults associated with childhood or adult traumatic experiences. The complete measure consisted of 136 items. This is a psychometrically sound measure with studies indicating reliability typically ranging from $\alpha=.66$ to $\alpha=.77$ for subscales and reliability for the full scale averaging between $\alpha=.89$ and $\alpha=.91$. A number of prior studies use this checklist for measuring symptom severity, including Bagley, Wood, and Young (1994) and Briere, Evans, Runtz, and Wall (1988), which look specifically at male survivors of childhood maltreatment.

Procedure. Recruitment for research participants was conducted using Internet-based methods, recruitment through websites serving male survivors of childhood maltreatment, and email recruitment announcements via websites and chain sampling. Chain sampling is a technique that has been identified as a valid means for gaining access to populations that may be difficult to access (Patton, 2002). This sampling process entails identifying organizations, list servers, or websites and asking these organizations to forward this information to others who may be interested in taking the survey.

Data Analyses

Scores on the Self-Compassion Scale, Scales of Psychological Well-Being, Trauma Symptom Checklist-40, Zung Self-Rating Depression Scale, and the Satisfaction with Life Scale were calculated, as well as subscale scores on the Self-Compassion Scale and the Scales of Psychological Well-Being. Statistical analyses were conducted to test the mediated relationship between self-compassion, maltreatment-related symptom severity, and psychological well-being. The model of mediation asserts that a construct intervenes between stimulus and response. There are several analytic considerations that must be made before asserting that a variable has a mediating effect (Barron & Kenny, 1986).

Testing mediation. Testing mediation requires four regression equations. The first is a simple regression analysis with the first variable predicting the third variable. For this study this regression equation will examine the predictive ability of childhood maltreatment-related symptom severity for predicting psychological well-being. This regression analysis establishes a relationship between the severity of symptoms following childhood maltreatment and psychological well-being later in life. This equation represents path c in the mediation model (see Figure 1).

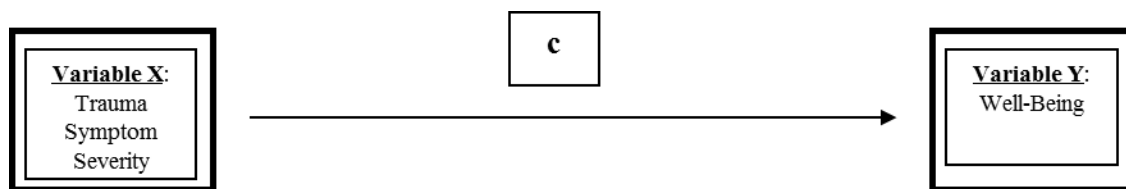


Figure 1: Mediation Model

The second regression equation involves conducting a simple regression analysis with the first variable predicting the second variable. For the purposes of this study, this equation will examine the relationship between childhood maltreatment-related symptom severity and self-compassion. This equation will establish a predictive relationship between childhood maltreatment-related symptom severity and self-compassion. This equation represents path a in the regression model.

The third equation involves conducting a simple regression analysis with the second variable predicting the third variable. This equation will involve conducting a regression analysis with self-compassion predicting psychological well-being. This equation represents path b in the regression model.

The first three regression equations are conducted to establish that zero-order relationship among the variables exists (MacKinnon, Fairchild, & Fritz, 2007). If significance is found, the fourth equation will be conducted. The fourth equation conducts a multiple regression analysis

with the first variable predicting the second variable. This equation will conduct a multiple regression analysis with childhood maltreatment-related symptom severity predicting self-compassion. A form of mediation (full or partial) will be supported if effect of path b is still significant once childhood maltreatment-related symptoms are controlled for.

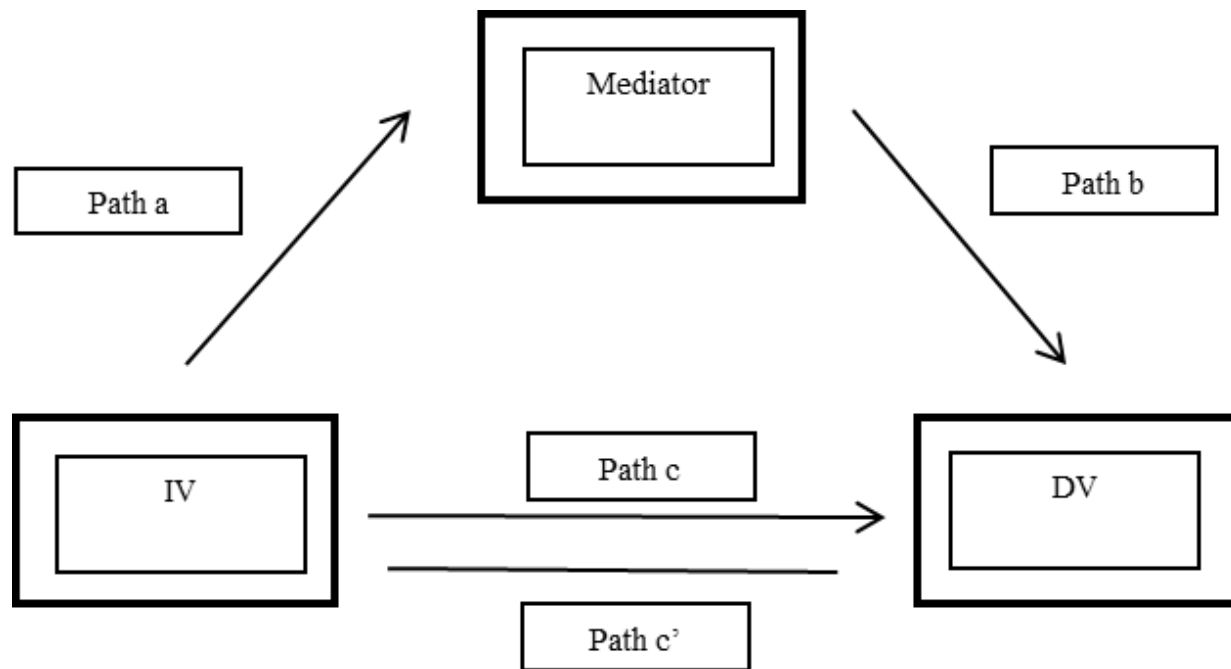


Figure 2: Mediation Model Pathways

Sobel (1982) provided an approximate significant test for effects of the mediator variable on the independent and dependent variables. This must be done so that the investigator can examine the absolute effect size in addition to the level of significance in the regressions. This relationship was explored in both sample groups (males who have endured childhood maltreatment and males who have not endured childhood maltreatment).

Results

To test the mediating effect of self-compassion on the relationship between trauma symptom severity and psychological well-being, correlations were conducted. Prior to conducting mediation analyses it is imperative that a relationship between the variables be

established. The relationship between trauma symptom severity and psychological well-being was examined first. Three measures of psychological well-being were used in this study (scales of Psychological Well-Being, Satisfaction with Life Scale, and Zung Depression Scale).

Correlations. Within the childhood maltreatment group, the correlation between trauma symptom severity and psychological well-being was strong when psychological well-being was measured by the Scales of Psychological Well-Being, $r(63) = -.55, p < .01$; strong when measured with the Satisfaction with Life Scale, $r(63) = -.55, p < .01$; and strong when measured with the Zung Depression Scale, $r(63) = .69, p < .01$. Within the no childhood maltreatment group, the correlation between trauma symptom severity and psychological well-being was strong when psychological well-being was measured by the Scales of Psychological Well-Being (PWB), $r(102) = -.45, p < .01$; moderate when measured with the Satisfaction with Life Scale (SWL), $r(102) = -.39, p < .01$; and strong when measured with the Zung Depression Scale (ZDS), $r(102) = .56, p < .01$ (see Table 1).

Table 1: Correlation Matrix (Trauma Symptom Severity and Measures of Well-Being)

	PWB	SWL	ZDS
TSC ^a	-.55	-.55	.69
TSC ^b	-.45	-.39	.56

Note: ^a denotes childhood maltreatment group, ^b denotes no childhood maltreatment group

The relationship between trauma symptom severity and self-compassion was then explored. Within the childhood maltreatment group, the correlation between trauma symptom severity and self-compassion was strong, $r(63) = -.58, p < .01$. Within the no childhood maltreatment group, the correlation between trauma symptom severity and self-compassion was weak, $r(102) = -.34, p < .01$.

Lastly, the relationship between psychological well-being and self-compassion was examined. Three measures were used to measure psychological well-being (Scales of Psychological Well-Being, Satisfaction with Life Scale, and Zung Depression Scale). Within the childhood maltreatment group, the correlation between self-compassion and psychological well-being was strong when psychological well-being was measured by the Scales of Psychological Well-Being, $r(63) = .66, p < .01$; strong when psychological well-being was measured with the Satisfaction with Life Scale, $r(63) = .62, p < .01$; and strong when measured with the Zung Depression Scale, $r(63) = -.71, p < .01$. Within the no childhood maltreatment group, the correlation between self-compassion and psychological well-being was strong when psychological well-being was measured by the Scales of Psychological Well-Being, $r(102) = .62, p < .01$; strong when psychological well-being was measured with the Satisfaction with Life Scale, $r(102) = .50, p < .01$; and strong when measured with the Zung Depression Scale, $r(102) = -.65, p < .01$ (Table 2).

Table 2: Correlation Matrix (Self-Compassion and Measures of Well-Being)

	PWB	SWL	ZDS
SCS ^a	.66	.62	-.71
SCS ^b	.62	.50	-.65

Note: ^a denotes childhood maltreatment group, ^b denotes no childhood maltreatment group

Reliability. In addition to an examination of the correlation between measures, the internal consistency was also assessed prior to conducting the mediation analyses. The internal consistency of each measure was assessed to determine the reliability of each psychometric measure within the research sample ($n=165$). It was found that internal consistency of the Trauma Symptom Checklist was excellent ($\alpha=.939$). The internal consistencies of the Satisfaction with Life Scale ($\alpha=.894$), the Self-Compassion Scale ($\alpha=.802$), and the Scales of

Psychological Well-Being ($\alpha=.782$) were found to be good. The internal consistency of the Zung Depression Inventory was found to be poor ($\alpha=.534$).

Effect size. Analyses were also conducted to determine effect size using Eta squared. Eta squared reflects what percentage of the dependent variable is accounted for by the independent variable. Higher numbers (Eta squared cannot exceed 1) indicate greater control. Analysis of variance showed a main effect of trauma symptom severity (TSC) on satisfaction with life (SWL) among males who have experienced childhood maltreatment $F(1,106) = 2.47, p=.000, \eta = .575$. This indicates that trauma symptom severity explained 57% of satisfaction with life within this sample. Analysis of variance showed a main effect of trauma symptom severity (TSC) on depression (ZDS) among males who have experienced childhood maltreatment $F(1, 106) = 3.93, p = .000, \eta = .683$. This indicates that trauma symptom severity explained 68% of depression within this sample. Analysis of variance showed a main effect of trauma symptom severity (TSC) on Psychological well-being (PWB) among males who have experienced childhood maltreatment $F(1, 106) = 2.08, p = .001, \eta = .532$. This indicates that trauma symptom severity explained 53% of psychological well-being within this sample.

Descriptive statistics. Three-hundred and ninety-nine individuals completed the online survey that was available for an 8-week period. Prior to performing data analysis, respondents who were not appropriate to include were removed. These respondents included those who did not self-identify as male, those who did not identify as over 18 years of age, and those who did not complete the entire survey. Two-hundred and thirty-participants were removed resulting in a sample of 165 participants included in the data analysis. The mean age of the sample was 26.75 years ($SD= 11.16$). Respondents in this sample who reported having experienced childhood maltreatment ($n=63$) were slightly older on average ($M= 28.00, SD= 11.86$) than those who did

not report having experienced ($n=102$) childhood maltreatment ($M= 26.00$, $SD= 10.71$). As shown in Table 3, the racial/ethnic diversity of this sample was representative of the current racial/ethnic diversity observed in the United States of America according to the 2010 United States Census Bureau (U.S. Census Bureau, 2010).

Table 3: Racial/Ethnic Comparison of the Study Sample to the 2010 United States Census

Race/Ethnicity	Frequency	Percentage	2010 U.S. Census Bureau
African American/Black	22	13.3	12.6
Asian American/ Pacific Islander	0	0.0	4.8
Caucasian	124	75.2	72.4
Middle Eastern	1	0.6	--
Multiracial	6	3.6	2.9
Latino/a	5	3.0	16.3
Native American	1	0.6	1.2
Other	2	1.2	6.2
No response	5	3.1	--

Note: -- denotes that this information was not provided by the 2010 U.S Census

The racial/ethnic percentages remained comparable when examining respondents who reported no experience of childhood maltreatment with individuals who identified as Caucasian/ White or African American/Black representing the largest percentage (Table 4).

Table 4: Racial/Ethnic Comparison of the Childhood Maltreatment and No Childhood Maltreatment Groups

Race/Ethnicity	Frequency	Percent
----------------	-----------	---------

African American/ Black ^a	16	9.5
African American/ Black ^b	6	15.7
Asian American/ Pacific Islander ^a	0	0.0
Asian American/ Pacific Islander ^b	0	0.0
Caucasian/ White ^a	51	81.0
Caucasian/ White ^b	73	71.6
Middle Eastern ^a	1	1.6
Middle Eastern ^b	0	0.0
Multiracial ^a	2	3.2
Multiracial ^b	4	3.9
Latino/a ^a	2	3.2
Latino/a ^b	3	2.9
Native American ^a	0	0.0
Native American ^b	0	0.0
Other ^a	0	0.0
Other ^b	2	2.0
No Response ^a	1	1.6
No Response ^b	4	3.9
Total ^a	63	100.0
Total ^b	102	100.0

Note: ^a denotes childhood maltreatment group, ^b denotes no childhood maltreatment group

In addition to age and ethnic/racial identity of male respondents, data was also collected to better understand how the respondents became aware of the survey, being that the survey was a widely distributed web-based survey. The survey was distributed through a variety of web-based forums including e-mail, SONA (an online research informational site provided through the University), list servers, social networking sites such as Facebook, and websites for survivors

of trauma. Over half of the respondents (65%) reported having accessed the survey through SONA. Thirty-five percent of respondents endorsed having accessed through “other” online resources, Facebook, emails from various organizations, or list servers. This trend remained consistent when examining the responses of participants who did not endorse childhood maltreatment, with SONA being the most highly endorsed advertisement method. The average response time to complete the study was 18 minutes and 50 seconds.

Childhood maltreatment assessment. Within this research sample, 38% of the respondents endorsed having experienced childhood maltreatment (n=63). For the purpose of this research, a positive endorsement of childhood maltreatment includes one or more instances of physical abuse, physical neglect, emotional abuse, emotional neglect, and/or sexual abuse occurring before the age of 18. Of the 38% of respondents that endorsed childhood maltreatment, 22% reported physical abuse, 7% reported physical neglect, 22% reported emotional abuse, 21% reported emotional neglect, and 8% reported sexual abuse. Respondents were able to endorse as many instances of maltreatment as they had experienced. While 62% of the sample (n=102) endorsed no instance of maltreatment, of the 38% who experienced maltreatment (n=63), the majority of respondents reported more than one type of abuse or neglect experienced prior to the age of 18. Table 5 identifies the frequency with which respondents endorsed various types of childhood maltreatment. Respondents who endorsed having experienced no childhood maltreatment were placed in the “0” category, respondents who reported one form of maltreatment were placed in the “1” category, respondents who endorsed two types of maltreatment were placed in the “2” category and so forth.

Table 5: Types of Abuse/Neglect Endorsed by Respondents

Type of Abuse/Neglect Endorsed	Frequency	Percent
0	102	61.8

1	22	13.3
2	22	13.3
3	12	7.3
4	5	3.0
5	2	1.2

Descriptive analyses. Participants in this study were asked to complete five measures. These measures were the Self-Compassion (SCS), Zung Depression Scale (ZDS), Satisfaction with Life Scale (SWL), Trauma Symptom Checklist (TSC), and the Scales of Psychological Well-Being (PWB). Each measure yields a total score with several measures also yielding subscale scores.

Self-Compassion Scale. Scores for the Self-Compassion Scale range from 1 to 5, with 1 indicating a low level of self-compassion and 5 indicating a higher level of self-compassion. Scores for the Self-Compassion Scale for the childhood maltreatment group ($M=2.83$, $SD= 0.63$) were lower than Self-Compassion Scale scores for the no childhood maltreatment group ($M=3.40$, $SD= 0.63$). An independent-samples t test was conducted to evaluate the difference between these two groups on levels of self-compassion. The test was significant, $t(163) = -5.68$, $p = .00$. Respondents in the childhood maltreatment group on average reported lower levels of self-compassion than those in the no childhood maltreatment group.

Zung Depression Scale. When examining scores for depression using the Zung Depression Scale the highest possible score is 80 with most individuals scoring between 50 and 69. Higher scores on this measure correspond with a higher reported level of depressive symptoms. Scores for the Zung Depression scale for the childhood maltreatment group ($M=42.75$, $SD= 9.35$) were higher than the depression scale scores for the no childhood maltreatment group ($M=34.50$, $SD= 7.65$). An independent-samples t test was conducted to evaluate the difference between these two groups on levels of depression. The test was

significant, $t(163) = 6.17, p = .00$. Respondents in the childhood maltreatment group, on average, reported higher levels of depression than those in the no childhood maltreatment group.

Satisfaction with Life Scale. The Satisfaction with Life Scale yields scores that indicate low, moderate, or high life satisfaction. Scores from 5-17 indicate a low level of life satisfaction, 18-29 indicate a moderate level of life satisfaction, 30-35 indicate high levels of life satisfaction. Scores for the Satisfaction with Life Scale for the childhood maltreatment group ($M=20.44, SD=6.77$) were lower than the Satisfaction with Life Scale scores for the no childhood maltreatment group ($M=25.97, SD=6.18$).

An independent-samples t test was conducted to evaluate the difference between these two groups on levels of satisfaction with life. The test was significant, $t(163) = -5.38, p = .00$. Respondents in the childhood maltreatment group, on average, reported lower levels of satisfaction with life than those in the no childhood maltreatment group.

The Trauma Symptom Checklist-40. The trauma symptom checklist yields scores that indicate trauma symptom severity. Higher scores on this measure indicate higher symptom severity with lower scores corresponding with lower symptom severity. Scores for the trauma symptom checklist for the childhood maltreatment group ($M=76.67, SD=23.29$) were higher than the trauma symptom severity scores for the no childhood maltreatment group ($M=60.06, SD=16.59$).

An independent-samples t test was conducted to evaluate the difference between these two groups on levels of symptom severity. The test was significant, $t(163) = 5.34, p = .00$. Respondents in the childhood maltreatment group, on average, reported higher levels of trauma symptom severity than those in the no childhood maltreatment group.

Although the childhood maltreatment group on average reported higher levels of trauma symptom severity, it is important to note that the no maltreatment group on average did report a mean score of 60.6. This score may be accounted for by the type of measure used to assess symptom severity. The Trauma Symptom Checklist assesses 6 subscales including: anxiety, depression, dissociation, sexual abuse trauma index, sexual problems, and sleep disturbances (Brier & Runtz, 1989). Although an individual may not have experienced trauma during childhood, it is possible that an individual experienced traumatic experiences during adulthood that may account for an increase in symptoms. Additionally, it is possible that respondents may have concerns with any given subscale without having endured maltreatment in childhood.

Scales of Psychological Well-Being. Lastly, the Scales of Psychological Well-Being yield scores that indicate psychological well-being with higher scores indicating higher well-being. Scores for the scales of psychological well-being for the childhood maltreatment group ($M=35.79$, $SD= 6.23$) were lower than the psychological well-being scores for the no childhood maltreatment group ($M= 40.56$, $SD= 6.340$). An independent-samples t test was conducted to evaluate the difference between these two groups on levels of psychological well-being. The test was significant, $t(163) = -4.70$, $p=.00$. Respondents in the childhood maltreatment group, on average, reported lower levels of psychological well-being than those in the no childhood maltreatment group.

To assess the extent to which self-compassion mediates the relationship between trauma symptom severity and psychological well-being, it was necessary to conduct a number of steps. In the first step, a simple regression analysis was conducted with childhood maltreatment-related symptom severity predicting psychological well-being. The second regression analysis consisted of a simple regression analysis with childhood maltreatment-related symptom severity predicting

self-compassion. Next, a simple regression analysis was conducted with self-compassion predicting psychological well-being. The first three regression equations were conducted in order to establish a zero-order relationship among the variables. Since significance was found, the fourth and final analysis was conducted. A multiple regression analysis was conducted with childhood maltreatment-related symptom severity predicting self-compassion.

Mediation analyses. Mediation was conducted using the four steps proposed by Baron and Kenny. This mediation model proposes four paths to mapping mediation (see Figure 2). The mediation hypothesis used to guide this research states that two variables are correlated through one or more mediating variables. This mediation hypothesis asserts that two variables are correlated (for example variable A is correlated with variable B) and that this correlation is because variable A is related to variable B through one or more additional variables known as the mediating variables (Baron & Kenny, 1986). Mediation was conducted in this study to examine the relationship between trauma symptom severity and psychological well-being and how this relationship may be occurring through a third mediating variable, self-compassion.

According to the mediation model, the initial step is conducted to determine whether or not the independent variable is associated significantly with the dependent variable. This represents path c in the mediation path analysis (see Figure 2). The next step in the mediation process is to determine whether or not the independent variable is associated with the mediator variable; this represents path a in the mediation path analysis. Analysis was then conducted to determine if the mediator and dependent variable were significantly related. Lastly, analysis is conducted to determine whether or not the mediator variable is associated significantly with the dependent variable when controlling for the independent variable. This analysis represents path c'.

To conduct the initial step and determine if the independent variable was associated with the dependent variable, the relationship between trauma symptom severity (measured using the Trauma Symptom Checklist-40) and psychological well-being (measured by three measures, the Scales of Psychological Well-Being, the Satisfaction with Life Scale, and the Zung Depression Scale) was then assessed. This comparison yielded three separate correlations given that three separate measures of psychological well-being were used. When looking at the childhood trauma group and using the Scales of Psychological Well-Being, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = -.55$) was significant, $t(62) = -5.09, p < .01$. When psychological well-being is measured by the Satisfaction with Life Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = -.56$) was significant, $t(62) = -5.19, p < .01$. When psychological well-being is measured by the Zung Depression Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = .69$) was significant, $t(62) = 7.54, p < .01$.

Analysis was also conducted on the no childhood maltreatment group. When looking at the no childhood trauma group and using the Scales of Psychological Well-Being, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = -.45$) was significant, $t(101) = -5.02, p < .01$. When psychological well-being is measured by the Satisfaction with Life Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = -.39$) was significant, $t(101) = -4.25, p < .01$. When psychological well-being is measured by the Zung Depression Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = .56$) was significant, $t(101) = 6.73, p < .01$.

To conduct the next step in the mediation model, analyses were conducted to determine whether or not the independent variable was associated with the mediator variable. The

independent variable in this study is trauma symptom severity (measured by the Trauma Symptom Checklist-40) and the dependent variable in this study is self-compassion (measured by the Self-Compassion Scale). When looking at the childhood maltreatment group, the beta weight for trauma symptom severity predicting self-compassion ($\beta = -.582$) was significant, $t(62) = -5.596$, $p < .01$. This analysis was also conducted within the no childhood maltreatment group; the beta weight for trauma symptom severity predicting self-compassion ($\beta = -.338$) was significant, $t(101) = -3.593$, $p < .05$.

Next, analysis was conducted to determine whether or not the mediator variable was associated significantly with the dependent variable. In this study the mediator variable was self-compassion (measured by the Self-Compassion Scale), and the dependent variable was psychological well-being (measured by three measures, the Scales of Psychological Well-Being, the Satisfaction with Life Scale, and the Zung Depression Scale). When looking at the childhood trauma group and using the Scales of Psychological Well-Being, the beta weight for self-compassion predicting psychological well-being ($\beta = -.243$) was significant, $t(62) = -2.12$, $p < .05$. When psychological well-being is measured by the Satisfaction with Life Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = -.298$) was significant, $t(62) = -2.491$, $p < .05$. When psychological well-being was measured by the Zung Depression Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = .424$) was significant, $t(62) = 4.357$, $p < .01$.

Analysis was also conducted for the no childhood maltreatment group. When looking at the no childhood trauma group and using the Scales of Psychological Well-Being, the beta weight for self-compassion predicting psychological well-being ($\beta = -.269$) was significant, $t(102) = -3.40$, $p < .01$. When psychological well-being was measured by the Satisfaction with

Life Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = -.250$) was significant, $t(102) = -2.811$, $p < .01$. When psychological well-being was measured by the Zung Depression Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = .384$) was significant, $t(102) = 5.343$, $p < .01$.

Lastly, an analysis was conducted to determine whether or not the mediator variable was associated significantly with the dependent variable when controlling for the independent variable. In this study, the mediator variable was self-compassion (measured using the Self-Compassion Scale), the dependent variable was psychological well-being (measured by the Scales of Psychological Well-Being, Satisfaction with Life Scale, and the Zung Depression Scale), and the independent variable was childhood trauma (measured by the Trauma Symptom Checklist-40). According to the Baron and Kenny model, the analysis of the relationship between the aforementioned variables represents path c'. When looking at the childhood maltreatment group and using the Scales of Psychological Well-Being as the measure of psychological well-being, the beta weight when examining whether self-compassion was associated with psychological well-being, while controlling for childhood maltreatment ($\beta = -.52$), was significant, $t(62) = 4.54$, $p < .01$. When psychological well-being was measured by the Satisfaction with Life Scale, the path c' remained significant ($\beta = .44$), $t(62) = 3.68$, $p < .01$. When psychological well-being was measured by the Zung Depression Scale, path c' remained significant ($\beta = -.47$), $t(62) = -4.78$, $p < .01$. When looking at the childhood maltreatment group and using the Scales of Psychological Well-Being as the measure of psychological well-being, the beta weight when examining whether or not self-compassion was associated significantly with psychological well-being, controlling for childhood maltreatment ($\beta = .53$) was significant, $t(101) = 6.71$, $p < .01$. When psychological well-being was measured by the Satisfaction with Life

Scale, the path c' remained significant ($\beta = .42$), $t(101) = 4.70$, $p < .01$. When psychological well-being was measured by the Zung Depression Scale, the path c' remained significant ($\beta = -.52$), $t(101) = -7.18$, $p < .01$.

Once paths a , b , c , and c' were computed, the mediation path analyses were completed for both the childhood maltreatment group (see Figures 3, 4, and 5) and the no childhood maltreatment group (see Figures 6, 7, and 8). Each of the analyses was completed using the three measures of psychological well-being: Scales of Psychological Well-Being, Satisfaction with Life Scale, and the Zung Depression Scale. Sobel tests were also conducted on the mediation models. Full mediation was not supported, however self-compassion served as a partial mediator between trauma symptom severity and psychological well-being. Sobel tests showed a significant drop in the relationship between trauma symptom severity and psychological well-being. Although this drop did occur, trauma symptom severity did remain the most significant predictor of well-being.

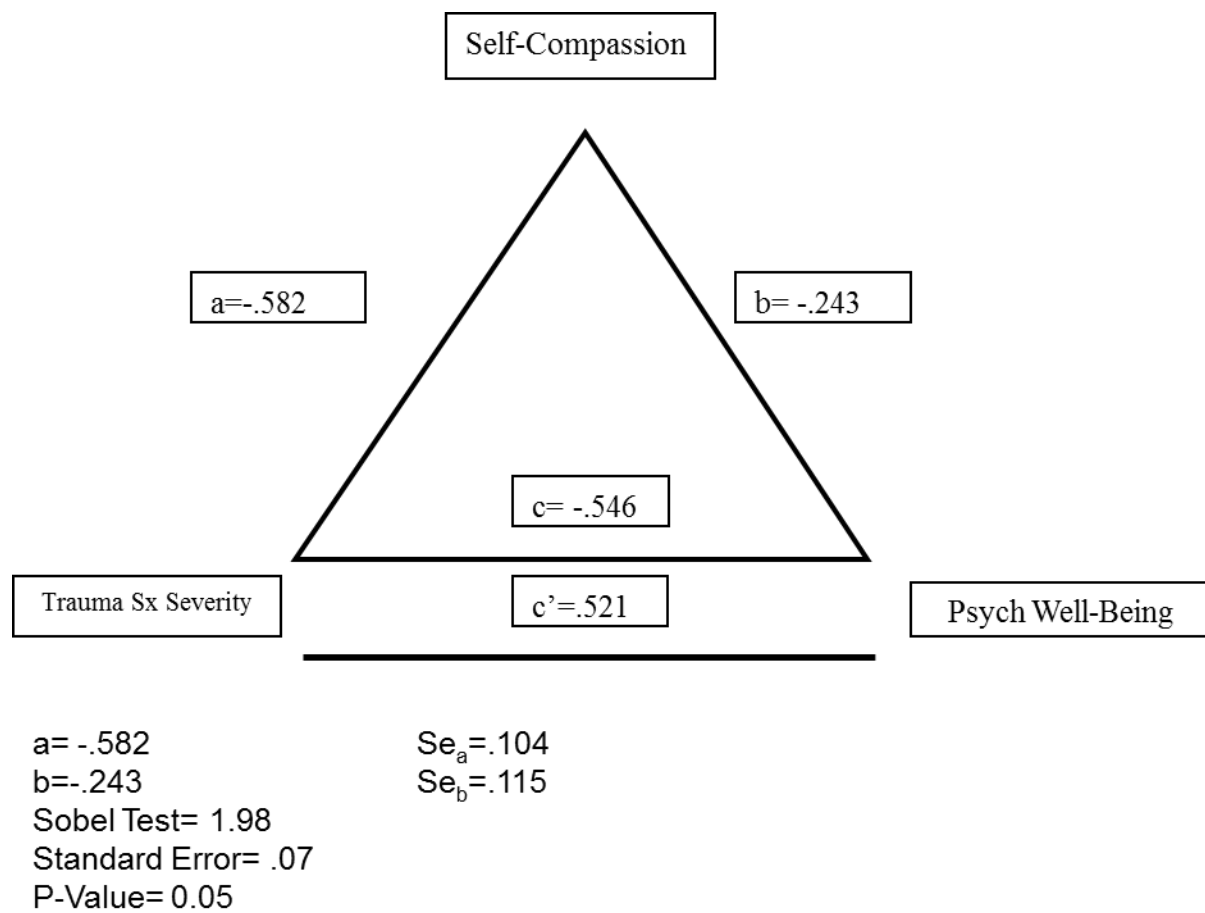


Figure 2: Childhood Maltreatment Group (Scales of Psychological Well-Being)

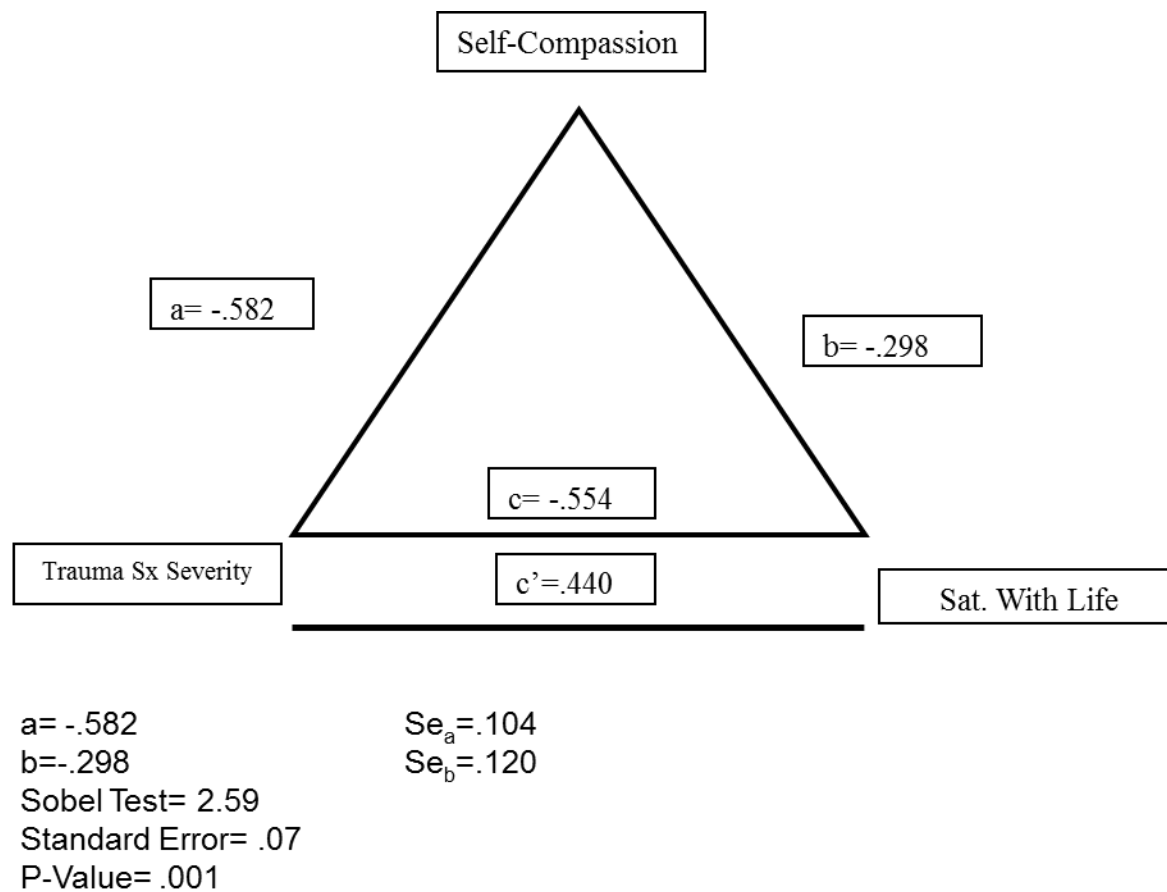


Figure 3: Childhood Maltreatment Group (Satisfaction with Life Scale)

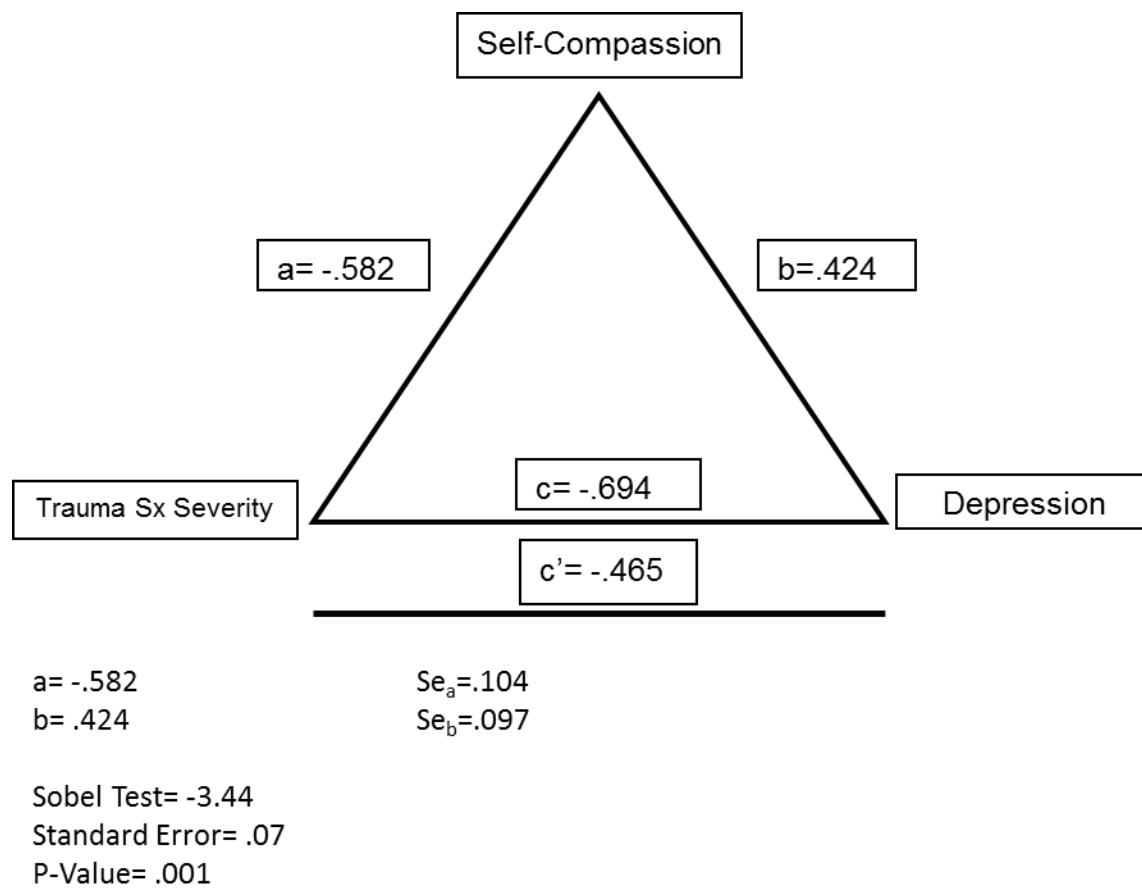


Figure 4: Childhood Maltreatment Group (Zung Depression Scale)

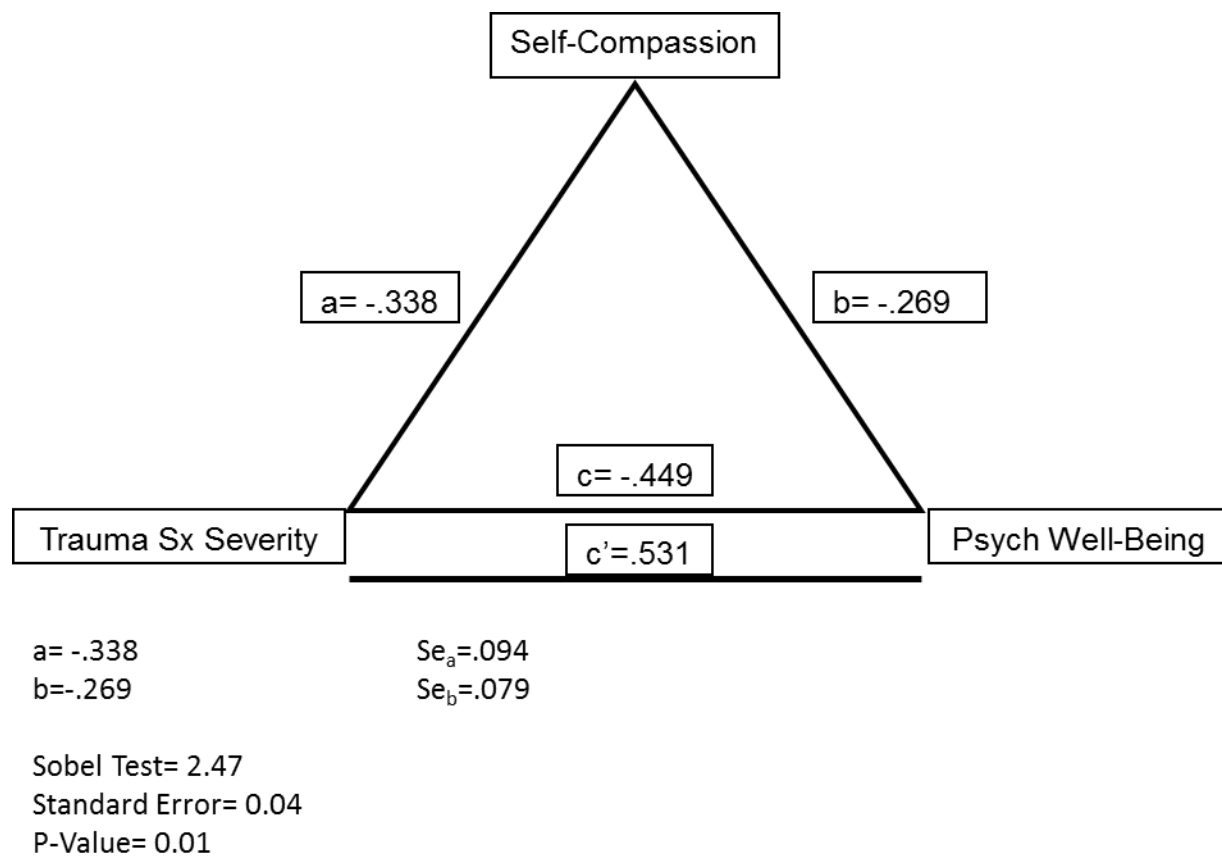
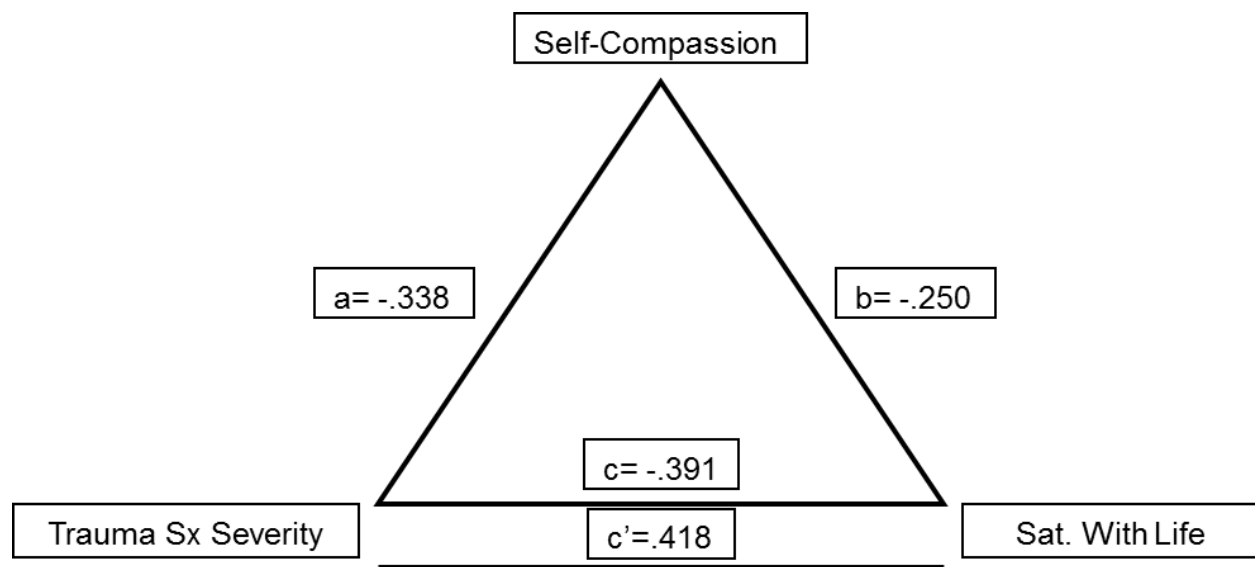


Figure 5: No Childhood Maltreatment Group (Scales of Psychological Well-Being)



a = -.338

b = -.250

Se_a = .094

Se_b = .0889

Sobel Test = 2.22

Standard Error = 0.04

P-Value = 0.03

Figure 6: No Childhood Maltreatment Group (Satisfaction with Life Scale)

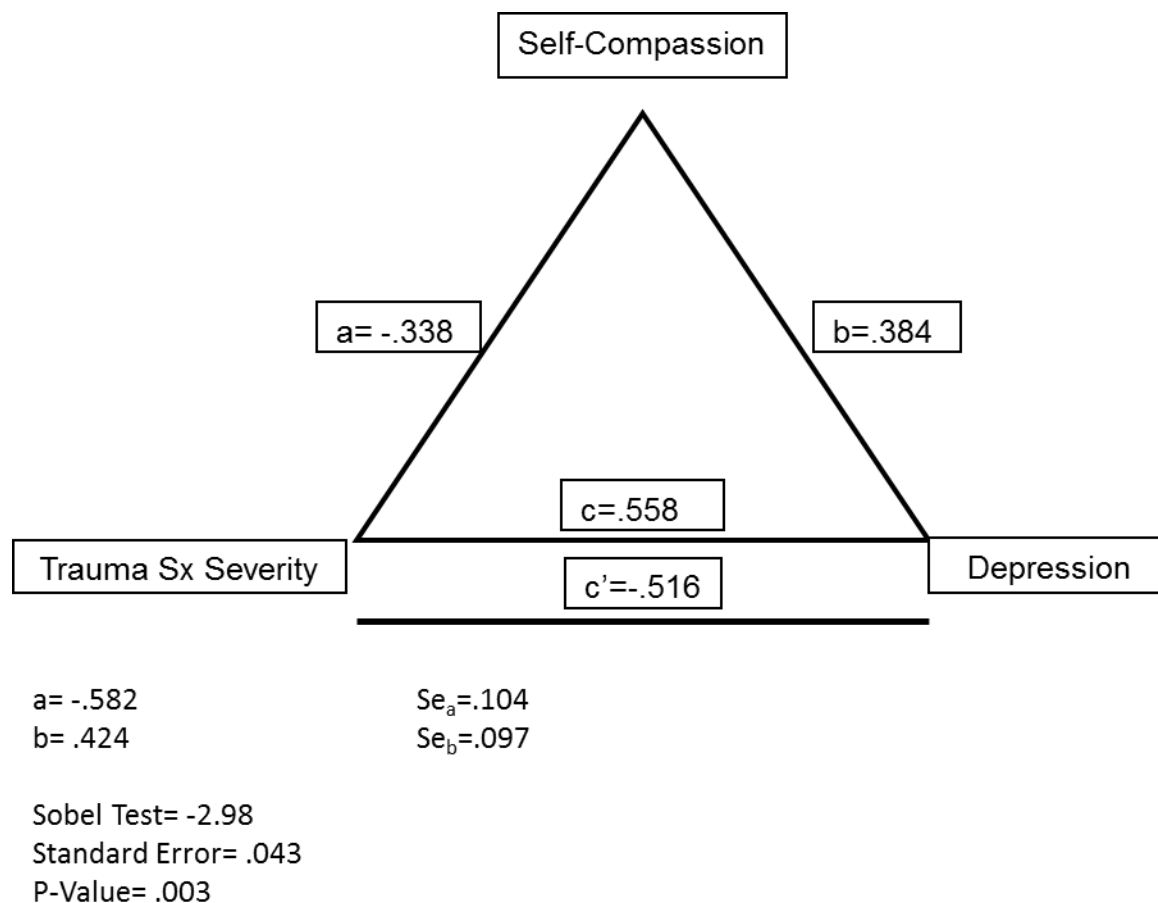


Figure 7: No Childhood Maltreatment Group (Zung Depression Scale)

Discussion

The focus of the current study was to explore the relationship between self-compassion, trauma symptom severity, and psychological well-being. Specifically, analyses were conducted to examine the mediating effect of self-compassion on trauma symptom severity and psychological well-being among males who have experienced childhood maltreatment. Current research has provided support for the negative impact of enduring childhood maltreatment. These negative impacts may be severe and can persist into adulthood. Kendall-Tackett (2002) asserts that these possible negative effects can be classified into four broad categories: (a) behavioral effects, (b) social effects, (c) cognitive effects, and (d) emotional effects (Kendall-Tackett). One of the possible negative consequences, and a focus of this research, is a possible

decrease in psychological well-being (Dhaliwal, Gauzus, & Ross, 1996). Literature also indicates that one's gender may serve to exacerbate negative symptoms following childhood maltreatment (Mejia, 2005).

Although literature has explored positive coping strategies, one variable that has recently been explored as a protective factor is self-compassion (Dervic, Grunebaum, Burke, Man, & Oquendo, 2006; Runtz & Schallow, 1997). Self-compassion has been found to have a positive relationship with psychological well-being (Gilbert, 2005). Although current literature asserts that there is likely a relationship between self-compassion and psychological well-being, this literature is limited (Gilbert, 2005; Neff, 2004, Tate, Adams, Allen, and Hancock, 2007). This research was conducted in an attempt to understand the relationship between self-compassion, trauma symptom severity, and psychological well-being among male survivors of childhood maltreatment.

This study explored self-compassion as a preventative factor for males who experienced childhood maltreatment. To explore the mediating effects of self-compassion, the researcher completed four analyses. Prior to completing the analyses the researcher conducted correlation analyses to examine the relationship between the variables. When looking specifically at the childhood maltreatment group, the relationships between the three variables (trauma symptom severity, psychological well-being, and self-compassion) were strong.

Results indicated that the mediator variable, self-compassion, partially mediated the relationships between trauma symptom severity and psychological well-being. It was found that the relationship between trauma symptom severity and psychological well-being was reduced when self-compassion was used as the mediating variable. The first step in this mediation consisted of determining whether or not the independent variable was associated significantly

with the dependent variable. In this study the independent variable was trauma symptom severity (measured by the Trauma Symptom Checklist-40) and the dependent variable was psychological well-being (measured by three separate measures: Scales of Psychological Well-Being, Zung Depression Scale, and Satisfaction with Life Scale). This comparison yielded three separate correlations given that three separate measures of psychological well-being were used. When using the Scales of Psychological Well-Being, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = -.55$) was significant, $t(62) = -5.09$, $p < .01$. When psychological well-being is measured by the Satisfaction with Life Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = -.56$) was significant, $t(62) = -5.19$, $p < .01$. When psychological well-being is measured by the Zung Depression Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = .69$) was significant, $t(62) = 7.54$, $p < .01$. Within this study regression equations were conducted to explore each step of the mediation equation. Regression is done to determine the strength of the relationships between two variables. The results of this regression equation indicate that the relationship between trauma symptom severity and psychological well-being is significant regardless of the measure used to assess psychological well-being.

When looking at trauma symptom severity and psychological well-being, the strongest relationship was observed when psychological well-being was assessed by the Zung Depression Scale and least strong when psychological well-being was assessed by the Scales of Psychological Well-Being. Literature provides strong support that an increase in depressive symptoms can result from childhood maltreatment (Brier & Elliot, 1994; Dhaliwal, Gauzus, & Ross, 1996). Additionally, literature also provides support for the relationship between trauma symptom severity and psychological well-being even when not assessed specifically by the Zung

Depression Scale. Current research indicates that many areas of functioning can be decreased following childhood maltreatment (Kendall-Tackett, 2002).

The next step in this mediation involved determining whether or not the independent variable was associated with the mediator variable. In this study the independent variable was trauma symptom severity (measured by the Trauma Symptom Checklist-40) and the mediator variable was self-compassion (measured by the Self-Compassion Scale). The beta weight for trauma symptom severity predicting self-compassion ($\beta = -.582$) was significant, $t(62) = -5.596$, $p < .01$. The results of this regression equation indicate that the relationship between trauma symptom severity and self-compassion is significant and the Beta weight indicates that the strength of this predictive relationship is strong. Previous psychological research provides support for the relationship between trauma symptom severity and self-compassion (Gilbert & Procter, 2006; Thompson & Waltz, 2008).

Next, the researcher conducted analyses to determine if the mediator and dependent variable were significantly related. In this study the mediator variable was self-compassion (measured by the Self-Compassion Scale), and the dependent variable was psychological well-being (measured by three measures, the Scales of Psychological Well-Being, the Satisfaction with Life Scale, and the Zung Depression Scale). When examining this relationship using the Scales of Psychological Well-Being, the beta weight for self-compassion predicting psychological well-being ($\beta = -.243$) was significant, $t(62) = -2.12$, $p < .05$. When psychological well-being is measured by the Satisfaction with Life Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = -.298$) was significant, $t(62) = -2.491$, $p < .05$. When psychological well-being was measured by the Zung Depression Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = .424$) was significant,

$t(62) = 4.357, p < .01$. These results indicate that the relationship between self-compassion and psychological well-being is a significant one. Psychological well-being was measured with three separate measures. In this study the strongest relationship was observed when psychological well-being was measured by the Zung Depression Scale. Previous research shows support for the relationship between self-compassion and psychological well-being (Gilbert, 2005; Neff, 2004; Wei, Liao, Ku, & Shaffer, 2011).

Lastly, analyses were conducted to determine whether or not the mediator variable was associated significantly with the dependent variable when controlling for the independent variable. In this study, the mediator variable was self-compassion (measured using the Self-Compassion Scale), the dependent variable was psychological well-being (measured by the Scales of Psychological Well-Being, Satisfaction with Life Scale, and the Zung Depression Scale), and the independent variable was childhood trauma (measured by the Trauma Symptom Checklist-40). When using the Scales of Psychological Well-Being as the measure of psychological well-being, the beta weight when examining whether self-compassion was associated with psychological well-being, while controlling for childhood maltreatment ($\beta = -.52$), was significant, $t(62) = 4.54, p < .01$. When psychological well-being was measured by the Satisfaction with Life Scale, the path c' remains significant ($\beta = .44$), $t(62) = 3.68, p < .01$. When psychological well-being was measured by the Zung Depression Scale, path c' remains significant ($\beta = -.47$), $t(62) = -4.78, p < .01$. These results indicate that self-compassion was significantly associated with psychological well-being even when controlling for trauma symptom severity. This finding indicates that there is a predictive relationship between self-compassion and psychological well-being even when trauma symptom severity is controlled for.

Research implications. Should further research be conducted to examine the effect of self-compassion on psychological well-being, factors that also contribute to psychological well-being should be explored. The results indicate that self-compassion is a partial mediator suggesting that while self-compassion affects this relationship, it is highly probable that additional variables contribute as well. Future research should examine variables that may contribute to the mediating effects of self-compassion within this sample. In addition to other variables that may contribute, research should also explore the mediating effect of self-compassion within a larger sample of males who have experienced childhood maltreatment. Should future research explore this relationship within a larger sample, the impact of self-compassion may differ significantly.

Being that self-compassion was shown to partially mediate the relationships between trauma symptom severity and psychological well-being among male survivors of childhood maltreatment, future research exploring how self-compassion can be increased and promoted among male survivors may be helpful. Literature has provided support for how gender may serve to enhance negative symptoms following trauma. The results of this study show preliminary support for self-compassion partially mediating the relationship between trauma symptom severity and psychological well-being. Future research to explore how self-compassion may be increased specifically among male survivors of childhood maltreatment would serve to provide practical applications of these findings.

Future researchers can improve on these findings by exploring a treatment modality that serves to increase self-compassion among male survivors of childhood maltreatment. This type of research would serve to explore how an increase of self-compassion may increase the psychological well-being for men who have experienced childhood maltreatment. As previous

studies have indicated, male survivors represent a unique population with protective and risk factors that are specific to these survivors. Studies that explore the implementation of interventions within this population would be beneficial to continue to expand the literature.

Practical applications. The results of this study provide preliminary support for the mediating effect of self-compassion on the relationship between psychological well-being and trauma symptom severity for male survivors of childhood maltreatment. These results may be applied in a clinical setting in several ways. The clinician may work with a male survivor to enhance self-compassion promoting well-being and more adaptive psychological functioning. Previous literature indicates that psychological well-being may be reduced among male survivors and may be seen across several areas of functioning. Should the clinician work to promote self-compassion, these negative symptoms and decreased sense of well-being may be reduced. Gilbert and Proctor (2006) explore the compassionate mind training for people with high shame and self-criticism. The results of this study indicate that individuals who participated in this training showed reductions in depression, anxiety, shame, and self-criticism. Clinicians working with male survivors of childhood maltreatment who report high negative symptoms and decreased psychological well-being would likely benefit from working to increase and enhance self-compassion.

Limitations. Although this study provided preliminary data to suggest that self-compassion does partially mediate the relationship between trauma symptom severity following childhood maltreatment and psychological well-being, there are limitations to this study. The most notable limitation of the study is the recruitment of the sample. Although the research survey was distributed widely online, the greatest percentage of respondents accessed the survey through SONA. The only individuals with access to this SONA site were college students at a

medium-sized university. Sixty-five percent of individuals who reported having experienced childhood maltreatment accessed the survey through SONA and 55% of individuals who did not report childhood maltreatment accessed the survey through SONA.

Another limitation of the study was the limited number of individuals who endorsed childhood maltreatment. Sixty-five individuals endorsed having experienced childhood maltreatment in this study. While the results indicate that self-compassion among this sample may serve to mediate the relationship between trauma symptom severity following childhood maltreatment and psychological well-being, it is important to consider that these results may differ among a larger sample size of individuals who experienced childhood maltreatment. While the findings in this study suggest that self-compassion partially mediates the relationships between psychological well-being and trauma symptom severity, a large sample may provide greater statistical support for this mediation.

The last notable limitation of this study is the sensitivity of the trauma symptom measure used among this sample of males. When looking at the sample of males who did not report having experienced childhood maltreatment, the mean score on this measure was significantly lower than for those who reported childhood maltreatment; however, it is important to note that individuals who have not experienced childhood maltreatment still endorsed, on average, negative symptoms. This may be the result of individuals who have not experienced childhood maltreatment having experienced trauma in adulthood, or having negative symptoms as a result of other life stressors. Additionally, when examining the responses of those who have experienced childhood maltreatment, the researchers did not measure social desirability. It may be possible that those who have experienced childhood maltreatment reported negative symptoms at a lower rate.

Conclusion

This study attempted to examine the mediating effect of self-compassion on trauma symptom severity and psychological well-being. The findings indicate that while self-compassion does not fully mediate this relationship, self-compassion does serve as a partial mediator. The current body of literature has provided research to explore various factors that may serve to promote well-being following a traumatic or difficult life event. This research has added to the body of literature by examining possible protective factors specific to male survivors. Research has previously indicated that males have unique experiences following trauma and difficult life events as a result of the gender socialization process. When exploring treatment options for specific populations it is imperative that research provide support for protective factors that have empirical support within the cultural group. This research offers support for a practical intervention for male survivors of childhood maltreatment. Research indicates that this group of survivors may have unique needs.

Research also indicates that there are several possible factors to reduce the negative impact of childhood maltreatment and increase psychological well-being—one of them being self-compassion. In a study conducted by Thompson and Waltz (2008), the relationship between self-compassion and post-traumatic symptoms was explored. In this study it was found that those who had lower levels of self-compassion were more likely to engage in avoidant behaviors in an attempt to avoid emotional triggers of past traumas. Such avoidance served to maintain negative emotional coping following the traumatic event. As a result of the findings it was posited that survivors of abuse and those that suffer from post-traumatic stress disorder may benefit from therapy that includes aspects of self-compassion. Self-compassion may serve to enhance an

individual's ability to approach, rather than avoid, the impact of their trauma and work to reduce the negative impact.

While not directly focused on post-traumatic stress disorder, a study by Gilbert and Procter (2006) examined the integration of self-compassion into therapy for individuals who have psychological disorders that occur as a result of shame and self-criticism. After having experienced the compassionate mind training, participants reported a significant reduction in anxiety and depression, and a reduction of self-criticism. Overall, it was reported that infusing treatment with elements of self-compassion resulted in decreased depression, anxiety, self-attacking, inferiority feelings, submissive behavior, and shame. Gilbert and Procter (2006) assert that self-compassion infused therapy can be helpful in treating individuals with traumatic histories. The current research provides support for self-compassion serving as a partial mediator between psychological well-being and trauma symptom severity within this population and provides empirical support for the implementation of interventions to enhance self-compassion.

References

- Afifi, T., & Macmillan, H. (2011). Resilience following child maltreatment: A review of protective factors. *Canadian Journal of Psychiatry, 56*(5), 266-272.
- Allgower, A., Wardle, J., & Steptoe, A. (2001). Depressive symptoms, social support, and personal health behaviors in young men and women. *Health Psychology, 20*, 223-227.
- Asberg, K., & Renk, K. (2012). Substance use coping as a mediator of the relationship between trauma symptoms and substance use consequences among incarcerated females with childhood sexual abuse histories. *Substance Use & Misuse, 47*(7), 799-808.
- Baer, R., Lynkins, E., & Peters, J. (2012). Mindfulness and self-compassion as predictors of psychological wellbeing in long-term meditators and matched nonmeditators. *The Journal of Positive Psychology, 7*(3), 230-238.
- Baron, R., & Kenny, D. (1986). The moderator-mediator variable distinction in social psychology research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 51*(6), 1173-1182.
- Bartholow, B.N., Doll, L.S., Joy, D., Douglas, J.M., Bolan, G., Harrison, J.S., Moss, P.M., & McKirnan, D. (1994). Emotional, behavioral, and HIV risks associated with sexual abuse among adult homosexual and bisexual men. *Child Abuse & Neglect, 18*, 747-761.
- Baumeister, R. F., Campbell, J. D., Krueger, J. I., & Vohs, K. D. (2003). Does high self-esteem cause better performance, interpersonal success, happiness, or healthier lifestyles? *Psychological Science in the Public Interest, 4*, 1-44.
- Beckner-Lausen, E., & Mallon-Kraft, S. (1997). Pandemic outcomes: The intimacy variable. In G.K. Kantor & J.S. Jasinski (Eds.), *Out of darkness: Current perspectives on family violence* (pp. 49-57). Newbury Park, CA: Sage.

- Bernstein, D. P., Fink, L., Handelsman, L., Foote, J., Lovejoy, M., Wenzel, K., Sapareto, E., & Ruggiero, J. (1994). Initial reliability and validity of a new retrospective measure of child abuse and neglect. *American Journal of Psychiatry*, *151*, 1132–1136.
- Brems, C, Johnson, M., & Freemon, M. (2004). Childhood abuse history and substance use among men and women receiving detoxification services. *American Journal of Drug and Alcohol Abuse*, *30*, 799-821.
- Briere, J.N., & Elliot, D.M. (1994). Immediate and long-term impacts of child sexual abuse. *The Future of Children*, *4*, 54-69.
- Briere, J., & Runtz, M. (1989). The Trauma Symptom Checklist (TSC-33) early data on a new scale. *Journal of Interpersonal Violence*, *4*(2), 151-163.
- Chandy J., Blum R., & Resnick M. (1996). Gender-specific outcomes for sexually abused adolescents. *Child Abuse & Neglect*, *20*, 1219–1231.
- Cook,E., Chaplin, T., Sinha, R., Tebes, J., & Mayes, L. (2012). The stress response and adolescents' adjustment: The impact of child maltreatment. *Journal of Youth and Adolescence*, *41*, 1067-1077.
- Dhaliwal, G., Gauzas, L., Antonowicz, D., & Ross, R. (1996). Adult male survivors of childhood sexual abuse: prevalence, sexual abuse characteristics, and long term effects. *Clinical Psychology Review*, *16*(7), 619-639.
- Dervic, K., Grunebaum, M., Burke, A., Mann, J., & Oquendo, M. (2006). Protective factors against suicidal behavior in depressed adults reporting childhood abuse. *Journal of Nervous & Mental Disease*, *194*(12), 971-974.
- Diener, E., Emmons, R.A., Larsen, R.J., & Griffin, S. (1985). The Satisfaction with Life Scale. *Journal of Personality Assessment*, *49*, 71–75.

- Drapalaski, A., Youman, K., Stuewig, J., & Tangney, J. (2009). Gender differences in jail inmates' symptoms of mental illness, treatment history and treatment seeking. *Criminal Behaviour and Mental Health, 19*, 193-206.
- Dube, S., Anda, R., Felitti, V., Chapman, D., Williamson, D., & Giles, W. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the lifespan. Findings from the adverse childhood experiences study. *The Journal of the American Medical Association, 286*(24), 3089-3096.
- Enoch, M. (2011). The role of early life stress as a predictor for alcohol and drug dependence. *Psychopharmacology, 214*, 17-31.
- Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., & Marks, J.S. (2001). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. In K. Franey, R. Geffner, & R. Falconer (Eds.), *The Cost of Child Trauma: Who Pays? We All Do* (pp.53-69). San Diego, CA: Family Violence and Sexual Assault Institute.
- Fergusson, D., Boden, J., & Horwood, L. (2008). Exposure to childhood sexual and physical abuse and adjustment in early adulthood. *Child Abuse & Neglect, 32*, 607-619.
- Fergusson, D., & Mullen, P. (1999). *Childhood sexual abuse—An evidence based perspective*. Sage, CA: Thousand Oaks.
- Fleming, J., Mullen, P.E., Sibthorpe, B., & Bammer, G. (1999). The long-term impact of childhood sexual abuse in Australian women. *Child Abuse & Neglect, 23*, 145-159.
- Femina, D., Yeager, C., & Lewis, D. (1990). Child abuse: Adolescent records vs. adult recall. *Child abuse & neglect, 14*(2), 227-231.

- Fisher, P. A., Gunnar, M. R., Chamberlain, P., & Reid, J.B. (2000). Preventive intervention for maltreated preschool children: Impact on children's behavior, neuroendocrine activity, and foster parent functioning. *Journal of American Academy of Child Adolescence and Psychiatry*, 39, 1356-1364.
- Ford, J. D. (2005). Treatment implications of altered neurobiology, affect regulation and information processing following child maltreatment. *Psychiatric Annals*, 35, 410-419.
- Gauthier, L., Stollak, G., Messe, L., & Aronoff, J. (1996). Recall of childhood neglect and physical abuse as differential predictors of current psychological functioning. *Child Abuse & Neglect*, 20, 549-559.
- Gilbert, P. (2005). Compassion and cruelty: a biopsychosocial approach. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 9–74). London: Routledge.
- Gilbert, P. & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism; Overview and pilot study of a group therapy approach. *Clinical Psychology and Psychotherapy*, 13, 353-379.
- Higgins, D., & McCabe, M. (2003). Maltreatment and family dysfunction in childhood and the subsequent adjustment of children and adults. *Journal of Family Violence*, 18(2), 107-120.
- Kendall-Tackett, K. (2002). The health effects of childhood abuse: four pathways by which abuse can influence health. *Child Abuse and Neglect*, 6 (7), 715- 730.
- Kendall- Tackett, K.A., Marshall, R., & Ness, K.E. (2000). Victimization, healthcare use, and health maintenance. *Family Violence & Sexual Assault Bulletin*, 16, 18-21.

- Leary, M., Tate, E., Adams, C., Allen, A., & Hancock, J. (2007). Self-compassion and reactions to unpleasant self-relevant events: The implications of treating oneself kindly. *Journal of Personality and Social Psychology*, 92(5), 887-904.
- Lee, R., & Robbins, S. (1995). Measuring belongingness: The social connectedness and social assurance Scales. *Journal of Counseling Psychology*, 42, 232-241.
- Levant, R. (1996). The new psychology of men. *Professional Psychology: Research and Practice*, 27(3), 259-265.
- Liu, W. (2005). The study of men and masculinity as an important multicultural competency consideration. *Journal of Clinical Psychology*, 61(6), 685-697.
- MacKinnon, D. P., Fairchild, A. J., & Fritz, M. S. (2007). Mediation analysis. *Annual review of psychology*, 58, 593.
- Mejia, X.E. (2005). Gender matters: Working with adult male survivors of trauma. *Journal of Counseling & Development*, 83, 29-40.
- Mikulincer, M., Shaver, P. R., & Pereg, D. (2003). Attachment theory and affect regulation: The dynamic development and cognitive consequences of attachment-related strategies. *Motivation and Emotion*, 27, 77-102.
- Murphy, J.M., Nierenberg, A.A., Monson, R.R., Laird, N.M., Sobol, A.M., & Leighton, A.H. (2002). Self disparagement as a feature and forerunner of depression: Findings from the Stirling County study. *Comprehensive Psychiatry*, 43, 13-21.
- Neely, M., Schallert, D., Mohammed, S., Roberts, R., & Chen, Y. (2009). Self-kindness when facing stress: The role of self-compassion, goal regulation, and support in college students' well-being. *Motivation Emotion*, 3, 88-97.

- Neff, K. D. (2003a). Development and validation of a scale to measure self-compassion. *Self and Identity*, 2, 223–250.
- Neff, K. D. (2003b). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity*, 2, 85–102.
- Neff, K. D. (2004). Self-compassion and psychological well-being. *Constructivism in the Human Sciences*, 9(2), 27–37.
- Neff, K.D. (2009). The role of self-compassion in development: A healthier way to relate to oneself. *Human Development*, 52, 211–214.
- Neff, K.D. (2011). Self-compassion, self-esteem, and well-being. *Social and personality psychology compass*, 5(1), 1–12.
- Neff, K.D., Rude, S.S., & Kirkpatrick, K.L. (2007). An examination of self-compassion in relation to positive psychological functioning and personality traits. *Journal of research in personality*, 41, 908–916.
- Neff K., Leary M., & Hoyle R. (2009). Handbook of individual differences in social behavior. New York: Guilford Press; Self-Compassion; pp. 561–573.
- Neff, K. D., & McGehee, P. (2010). Self-compassion and psychological resilience among adolescents and young adults. *Self and Identity*, 9, 225–240.
- Pitzer, L., Fingerman, K. (2010). Psychosocial resources and associations between childhood physical abuse and adult well-being. *Journal of Gerontology: Psychological Sciences*, 65B(4), 425–433.
- Runtz, M., Schallow, J. (1997). Social support and coping strategies as mediators of adult adjustment following childhood maltreatment. *Child Abuse & Neglect*, 21(2), 211–226.

- Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry*, 57(3), 316-331.
- Ryff, C., & Heidrich, S. (1997). Experience and well-being: Explorations on domains of life and how they matter. *International Journal of Behavioral Development*, 20, 193-206.
- Ryff, C., & Keyes, C. (1995). The structure of psychological well-being revisited. *Journal of personality and social psychology*, 69(4), 719-727.
- Ryff, C., & Singer, B. (2008). Know thyself and become what you are: A eudaimonic approach to psychological well-being. *Journal of happiness studies*, 9, 13-39.
- Schraufnagel, T., Davis, K., George, W., & Norris, J. (2010). Childhood sexual abuse in males and subsequent risky behavior: A potential alcohol use pathway. *Child Abuse & Neglect*, 34(5), 369-378.
- Shand, F. L., Degenhardt, L., Slade, T., & Nelson, E. C. (2011). Sex differences amongst dependent heroin users: Histories, clinical characteristics and predictors of other substance dependence. *Addictive Behaviors*, 36(1/2), 27-36.
- Sobel, M. (1982). Asymptotic confidence intervals for indirect effects in structural equations models. In S. Leinhardt (Ed.), *Sociological methodology 1982* (pp.290-312). San Francisco: Jossey-Bass.
- Tanaka, M., Werkerle, C., Schmuck, M., & Paglia-Boak, A. (2011). The linkages among childhood trauma, adolescent mental health, and self-compassion in child welfare adolescents. *Child abuse and neglect*, 35, 887- 898.
- Thompson, B.L., & Waltz, J. (2008). Self-Compassion and PTSD symptom severity. *Journal of Traumatic Stress*, 21(6) 556- 558.

- U.S. Census Bureau, *2010 Census Redistricting Data (Public Law 94-171) Summary File*, Tables P1 and P2.
- Van Dam, N., Sheppard, S., Forsyth, J., & Erileywine, M. (2011). Self-Compassion is a better predictor than mindfulness of symptom severity and quality of life in mixed anxiety and depression. *Journal of Anxiety Disorders*, *25*, 123-130.
- Vettese, L., Dyer, C., Li, W., & Wekerle, C. (2011). Does self-compassion mitigate the association between childhood abuse and later emotion regulation difficulties? A preliminary investigation. *International journal of mental health addiction*, *1*, 1-12.
- Vitaliano, P.P., Scanlan, J.M., Zhang, J., Savage, M., Brummett, B., Barefoot, J., & Siegler, I.C. (2001). Are the salutogenic effects of social supports modified by income? A test of an “added value hypothesis.” *Health Psychology*, *20*, 155-165.
- Waldrop, A. E., Santa Ana, E. J., Saladin, M. E., McRae, M. L., & Brady, K. T. (2007). Differences in early onset alcohol use and heavy drinking among persons with childhood and adulthood trauma. *The American Journal on Addictions*, *16*, 439-442.
- Wei, M., Liao, K., Ku, T., & Shaffer, P. (2011). Attachment, self-compassion, empathy, and subjective well-being among college students and community adults. *Journal of Personality*, *79*(1), 191- 221.
- Wilsnack S., Vogeltanz N., Klassen A., & Harris T. (1997). Childhood sexual abuse and women's substance abuse: National survey findings. *Journal of Studies on Alcohol*, *58*, 264–271.
- Wood, A., & Joseph, S. (2010). The absence of positive psychological (eudemonic) well-being as a risk factor for depression: A ten year cohort study. *Journal of Affective Disorders*, *122*, 213-217.

- Young-Wolf, K., Kendler, K., & Prescott, C. (2012). Interactive effects of childhood maltreatment and recent stressful life events on alcohol consumption in adulthood. *Journal of Studies on Alcohol and Drugs*, 73(4), 559-569.
- Zanarini, M.C., Frankenburg, F.R., Bradford Reich, D., Marino, M.F., Haynes, M.C., & Gunderson, J.G. (1999). Violence in the lives of adult borderline patients. *Journal of Nervous and Mental Disease*, 187, 65-71.
- Zung W. (1965). A self-rating depression scale. *Archives of General Psychiatry*, 12, 63-70.
- Zuroff, D.C., Koestner, R., & Powers, T.A. (1994). Self-criticism at age 12: A longitudinal study of adjustment. *Cognitive Therapy and Research*, 18, 367-385.

Chapter 2: Literature Review

Prevalence rates of childhood abuse, neglect and maltreatment vary. According to recent data from a childhood maltreatment study (including both abuse and neglect), the National Child Abuse and Neglect Data System (NCANDS) reported a national estimate of between 695,000 and 754,000 children having endured maltreatment in 2010. Using the United States Census Bureau's *Current Population Reports*, the national estimate indicates that approximately 10% of children in the United States experience childhood maltreatment. Although there are data to report the prevalence rates of maltreatment, findings regarding the impact of childhood maltreatment are rather inconsistent. One body of literature points to long-term and pervasive consequences for adults including increased anxiety and depression, increased substance abuse, and increased risk of suicidal ideation or behavior. Kendall-Tackett (2002) proposes that the consequences of childhood maltreatment can be divided into four domains: behavioral, social, cognitive, and emotional. The impact of childhood maltreatment on perceptions of well-being (a negative cognitive outcome) is particularly salient as decreased well-being has been associated with negative affect, increased negative self-appraisals, and increased maladaptive coping strategies (Kendall-Tackett).

In contrast to the body of literature that suggests negative outcomes, another body of literature suggests that there are few to no negative outcomes as a result of maltreatment (Afifi & MacMillan, 2011). Additionally, researchers are exploring what may help individuals recover from challenging experiences such as childhood maltreatment. Self-compassion, or the act of being gentle with oneself, has been found to be an important therapeutic intervention in helping individuals to recover from challenging events like the endurance of abuse or neglect (Neff, 2003).

Current research suggests several reasons for the inconsistency in the literature concerning the effects of having endured childhood maltreatment. Although these potential factors are varied, there is a possible factor that has not been extensively explored in the literature. Mejia (2002) notes that one possible contributing factor to the difference in symptoms following childhood maltreatment may be gender. Mejia asserts that men may have a profoundly difference experience in processing and managing childhood maltreatment given gender role socialization. With male survivors of childhood maltreatment being somewhat less represented in the literature than female survivors, and with the possible influence of gender on recovery from such maltreatment, it is essential that male survivors of childhood maltreatment be researched more extensively.

In an attempt to understand the relationship between childhood maltreatment and outcomes, the following chapter outlines the available research. This chapter begins with an overview of the relevant constructs related to this study by providing an operational definition and a brief description of how these constructs may differ from similar psychological constructs. Next is the current research relevant to how these constructs fit together and how these findings inform understandings of how self-compassion may serve to improve psychological well-being among male survivors of childhood maltreatment. Finally, the chapter concludes with the research questions posed by this study.

The next section provides definitions and a brief overview of the constructs being explored in this study. More in-depth research on these constructs and literature addressing how these constructs fit together follows.

Operational Definitions

Childhood maltreatment, psychological well-being, and self-compassion are the primary terms being explored in this chapter. The definitions of these terms are based on current literature.

Childhood maltreatment. For the purpose of this study, the definition of childhood maltreatment used is consistent with that of previous research (Bernstein et al., 1994, Cook, Chaplin, Sinha, Tebes, & Mayes, 2012). Childhood maltreatment refers to the occurrence of one or multiple incidences of childhood physical and/or emotional abuse or neglect, and/or sexual abuse occurring prior to the age of 18 and perpetrated by a parent or other caregiver of the individual who endured the maltreatment.

Research provides distinctions between abuse and neglect. Abuse is defined as active harm perpetrated against the child while neglect reflects a caregiver's failure to provide developmentally appropriate and supportive environments (Tanaka, Wekerle, Schmuck, & Paglia-Boak, 2011). As a result of this definition of childhood maltreatment, multiple forms of childhood abuse and neglect can be examined allowing for self-compassion and psychological well-being to be studied within the context of having survived childhood maltreatment as a whole—not as a result of a specific form of abuse or neglect.

Previous research indicates that examining one type of abuse or neglect in isolation from other forms of abuse or neglect may not provide a full understanding on the influence of childhood maltreatment as a whole. In a study conducted by Felitti and colleagues (2001), 9,367 women and 7,970 were assessed for childhood sexual abuse. Childhood sexual abuse was then compared to the incident of other adverse childhood events (ACES), including emotional abuse, physical abuse, having seen one's mother battered, household substance abuse, household mental illness, parental separation/ divorce, criminal household member, emotional neglect, and

physical neglect. Felitti and colleagues found that having experienced childhood sexual abuse significantly increased the likelihood that children had experienced one or more ACES in addition to the childhood sexual abuse. Felitti and colleagues assert that it is not likely that one form of childhood abuse or neglect occurs in isolation of all others. For the most comprehensive understanding of the effect of childhood abuse and neglect, this study will examine childhood maltreatment which captures various forms of abuse and neglect. Furthermore, having survived maltreatment is primary to this research; the type of maltreatment having been survived is secondary.

Psychological well-being. Psychological well-being is a broad construct that is defined differently by different theorists. In general, psychological well-being focuses on existential concerns and how individuals feel about the world around them (Wood & Joseph, 2010). For the purpose of this study the conceptualization used by Ryff and Keyes (1995) was used. Ryff and Keyes (1995) essentially assert that psychological well-being refers to the intrapsychic, interpersonal, and actualization needs, goals, and strivings of an individual. Ryff and Keyes posit that psychological well-being can be best captured through the examination of six distinct dimensions of wellness: (a) autonomy, (b) environmental mastery, (c) personal growth, (d) positive relations with others, (e) purpose in life, and (f) self-acceptance. Together these concepts represent an overall theme of psychological well-being. The level to which an individual endorsed success in each area of well-being was considered together as a representation of the individual's overall feeling of well-being.

- *Autonomy* refers to one's ability to be self-determined, independent, and able to regulate one's own behaviors (Ryff & Singer, 2008).

- *Environmental mastery* refers to the ability to either create or seek out an environment that corresponds with one's needs and abilities (Ryff & Singer, 2008).
- *Personal growth* denotes the ability and desire to develop and strive toward one's potential (Ryff & Singer, 2008).
- *Positive relations* with others is understood to be one's ability to connect with others through close identifications or deep and meaningful friendships that foster feelings of love, empathy, warmth, and affection (Ryff & Singer, 2008).
- *Purpose in life* is described as one's ability to create meaning and direction in one's life while self-acceptance refers to individuals' ability to be aware and accepting of their strengths as well as their weakness (Ryff & Singer, 2008).

Self-compassion. Neff (2003a) defined self-compassion as “being kind and understanding toward oneself in instances of pain or failure rather than being harshly self-critical; perceiving one's experiences as part of the larger human experience rather than seeing them as isolating; and holding painful thoughts and feelings in mindful awareness rather than over-identifying with them (pg. 223).” Neff provides three key components when conceptualizing self-compassion: (a) self-kindness, (b) common humanity, and (c) mindfulness (Neff, 2009). When exploring the three concepts, Neff (2009) presents them in opposing terms to provide context.

- *Self-kindness* essentially reflects the notion that one should be caring, gentle, and understanding with oneself. This entails not treating oneself critically, harshly, or in a judgmental fashion. One must have the understanding that even when enduring difficult or troubling situations it is more beneficial to be soothing and gentle to oneself than to be

harsh, critical, or cold. Self-kindness is seen as being in direct opposition with self-judgment (Neff, 2009).

- *Common humanity* serves to help the individual remain aware that all humans make mistakes and encounter failures and that this is a commonly experienced flawed condition, not one that reflects personal shortcomings or flaws (Neff, 2009). Common humanity is seen as being in direct opposition with feelings or beliefs of isolation. One has the understanding that suffering or discomfort is a common occurrence that all humans must endure.
- *Mindfulness* involves one's ability to be present in the moment. Attending to what is happening in a particular moment in time is an attempt to reduce the likelihood of ruminating on negative thoughts. Mindfulness is conceptualized as being in direct opposition with over-identification (Neff, 2009).

Having operationally defined the terms that are explored in this study, it is also imperative that current research regarding these constructs be explored. It is also necessary that research that provides insight into how these constructs fit together be explored. The upcoming section will first discuss literature relevant to the experience of childhood maltreatment. Literature discussing how negative symptoms may impact ones' psychological well-being will then be discussed. Lastly, literature on self-compassion was reviewed and research about how self-compassion may mediate the relationship between maltreatment-related symptoms and psychological well-being will then be discussed.

Responses to Childhood Maltreatment

Current literature suggests that the consequences resulting from having endured childhood maltreatment (abuse or neglect) range from no symptom expression to the taking of

one's own life through suicide (Vettese, Dryer, Li, & Wekerle, 2011). The first body of literature states that the effects of childhood maltreatment may be long lasting and impact various areas of the adults' life (Kendall-Tackett, 2002).

The second body of literature suggests that the effects of having experienced childhood maltreatment may not always be as enduring and widespread as previously assumed, leaving the survivor not nearly as psychologically compromised as one might expect. This body of research asserts that there may be protective factors, like personality traits or resilience, that reduce the impact of negative symptoms experienced following childhood maltreatment (Afifi & Macmillan, 2011). This body of literature provides a rationale for the importance of exploring the ways by which individuals' reactions to negative life events can be lessened or mitigated. Both of the aforementioned bodies of literature are important to the proposed study and both were reviewed, beginning with the body of literature that discusses the negative maltreatment-related symptoms and followed by the literature that asserts that survivors may not be as psychologically distressed following childhood maltreatment as previously assumed.

Negative consequences of childhood maltreatment. Literature on the negative maltreatment-related symptoms present after experiencing neglect or abuse in childhood is extensive and longstanding. Much of the previously accepted research confirms the notion that exposure to adverse environmental experiences early in life can contribute to increased difficulty later in life. Possible negative consequences are varied and range in intensity, including consequences such as increased risk of developing post-traumatic stress disorder (Kendall-Tackett, 2002), affective disorders and increased negative affective symptoms (Brier & Elliott, 1994; Vettese, Dryer, Li, & Wekerle, 2011), disorders of addiction (Bartholow et al., 1994; Dhaliwal, Gauzas, & Ross, 1996; Felitti et al., 2001, Kendall-Tackett et al., 2000), and suicidal

ideation and para-suicidal behaviors (Dube, Anda, Felitti, Chapman, Williamson, & Giles, 2001). There is also an increased chance of revictimization later in life, health problems (e.g. diabetes, heart disease, and immune disorders), and even economic consequences such as lower levels of education, lower employment earnings, and the acquisition of fewer assets as an adult (Currie & Wisdom, 2010; Ford, 2005).

Literature provides evidence that the negative effects of enduring childhood maltreatment can leave the survivor with difficulties that can be classified into four main domains: (a) behavioral effects, (b) social effects, (c) cognitive effects, and (d) emotional effects (Kendall-Tackett, 2002). In general, available research has explored these domains using samples that include both male and female respondents. Sex differences were emphasized in the findings when applicable, but most studies focused on the impact of childhood maltreatment in a mixed sample of males and females as opposed to samples with only male or only female respondents. Much of the literature that will be reviewed for the current study focuses on studies conducted with samples that include both male and female respondents. Based on the researcher's review of the literature, studies conducted using all male participants are quite limited. These findings of the relevant literature will be reviewed in the context of the previously mentioned domains: behavioral effects, social effects, cognitive effects, and emotional effects.

Behavioral effects. One of the most commonly identified maladaptive behavior after having experienced childhood maltreatment is the abuse or misuse of substances. Research indicates that individuals who have endured negative childhood events are more likely to use drugs, including psychoactive drugs, intravenously administered drugs, and alcohol, than those who have not endured childhood maltreatment (Bartholow et al., 1994; Felitti et al., 2001, Kendall-Tackett et al., 2000). Exposure to childhood abuse or maltreatment has been linked to

substance abuse and has been found to contribute to an earlier onset of drug and alcohol use when comparing those who have experienced childhood maltreatment with those who have not (Ford, 2005). Fisher and colleagues found that those individuals who experienced childhood maltreatment began drinking alcohol on average seven years earlier than those who did not experienced maltreatment as a child. Research also suggests that those individuals who experienced childhood maltreatment were heavier drinkers when compared to individuals who experienced maltreatment in adulthood (Fisher, Gunnar, Chamberlain, & Reid, 2000; Waldrop et al., 2007).

In a study with 1,513 heroin dependent individuals, predictors for substance dependence diagnoses for both male and female respondents included childhood sexual abuse. Results indicated that males were more likely than females to have prevalent lifetime substance dependence diagnoses. While the precipitating traumatic event was not identified, post-traumatic stress disorder was a significant predictor for substance misuse for males but not females (Shand, Degenhart, Slade, & Nelson, 2011).

Other researchers have found a relationship between childhood maltreatment and substance abuse and misuse, with those individuals who have experienced childhood maltreatment being more likely to have symptoms of substance misuse and abuse. Similar results have been found by Young-Wolf, Kendler, and Prescott (2012), Asberg and Renk (2012), Enoch (2011), Brems, Johnson, and Freeman (2004), and Drapalaski, Youngman, Stuewig, and Tangney (2009). Additional research discusses the utility of substance use. Dhaliwal, Gauzas, and Ross (1996) assert that the use of substances by male survivors of childhood abuse may be used in an effort to help repress memories of the abuse and to cope with negative emotions such as powerlessness, lowered self-esteem, loss of self-identity, and reduced social skills.

Suicidal ideation and para-suicidal behaviors. In addition to substance abuse, the incidences of suicidal ideation or para-suicidal behaviors have been reported as another negative behavioral outcome associated with the experience of childhood maltreatment. In a study examining the relationship between suicide attempts and adverse childhood experiences, in a sample of 17,337 adult men and women, the lifetime prevalence of having at least one suicide attempt was 3.8%. Participants who endorsed adverse childhood experiences were associated with an increased risk of attempted suicide, two to five times the base rate. It was concluded from this study that a significant and powerful relationship between adverse childhood experiences and the risk of attempted suicide existed (Dube, Anda, Felitti, Chapman, Williamson, & Giles, 2001). Similar findings from Dhaliwah, Gauzas and Ross (1996) support the conclusions of Dube et al. (2001). Dhaliwah, Gauzas, and Ross (1996) conducted a critical literature review of research relevant to male survivors of childhood sexual abuse. The literature reviewed indicated that male survivors of childhood abuse had higher levels of depression than their non-victimized counterparts and were more likely to attempt suicide (Dhaliwah, Gauzas, & Ross, 1996).

Risky sexual behavior. Another problematic behavioral outcome of childhood abuse is engagement in higher risk sexual behavior. Childhood sexual abuse in particular has been linked to an increase in risky sexual practices, including high numbers of sexual partners and unprotected sexual intercourse (Schraufnagel, Davis, George, & Norris, 2010) among both adolescent and adult male survivors. Male survivors of childhood sexual abuse have been found to engage in earlier consensual sexual initiation than their female counterparts who have also experienced maltreatment (Wilsnack, Vogeltanz, Klassen, & Harris, 1997; Chandy, Blum &

Resnick, 1996). In addition to behavioral effects, there are also social effects that have been identified as a result of childhood maltreatment.

Social effects. Childhood abuse not only affects survivors' behavioral coping, it also has implications for social aspects of the survivor's life. Literature indicates that the formation of social relationships and the ability to get along with others is essential to psychological well-being. Moreover, without good social support, individuals are likely to have negative outcomes, including exploitive or victimizing relationships, dissatisfaction with current relationships, and even compromised health (Allgower, Wardle, & Steptoe, 2001; Fleming et al., 1999; Vitaliano et al., 2001).

The ability to advocate for oneself and to build nurturing relationships with individuals who will not exploit you is necessary for sustaining successful interpersonal relationships. The ability to create and sustain positive, mutually beneficial social connections with others requires many social skills that those who have experienced past abuse may have difficulty with (Kendall-Tackett, 2002). These skills include not only the ability to build positive interpersonal relationships and assert oneself in these relationships, but also the ability to accurately read social cues. These interpersonal skills and others may be significantly compromised for survivors of childhood trauma. Adult survivors may have limited social abilities and may reduce their interactions with others and have fewer relationships (Kendall-Tackett). Adult survivors of childhood maltreatment are often engaged in relationships that are exploitive or victimizing (Fleming et al., 1999), have higher rates of divorce (Felitti, 1991), and their general satisfaction with present relationships is likely to be lower than those who have not experienced childhood maltreatment (Fleming).

Relationship and interpersonal dysfunctions. Relationship and interpersonal dysfunctions have also been identified as negative social effects of childhood abuse (Beckner-Lausen & Mallon- Kraft, 1997). Beckner-Lausen and Mallon-Kraft (1997) conducted a study that examined the relationship between child maltreatment and maladaptive interpersonal relationship outcomes. It was found that survivors of childhood abuse who had interpersonal difficulties adapted either an avoidant or intrusive interpersonal style. Individuals who had an avoidant style tended to be less interdependent on others, had low self-disclosure, and little warmth. Those individuals were likely to have few interpersonal connections and friends. In contrast, the intrusive style was characterized as an extreme need for closeness with others, excessive self-disclosure, and overly warm relationships. Both styles were characterized as dysfunctional and were likely to result in loneliness (Beckner-Lausen & Mallon- Kraft, 1997).

Compromised social connectedness. Compromised social connectedness as a result of abuse may also be linked to later revictimization. Revictimization has been found to increase with certain types of childhood abuse and can be understood partly as a failure of social connections. In a study conducted by Zanarini et al. (1999), 362 individuals with borderline personality disorder were assessed. Zanarini et al. identified five types of abuse that occurred during childhood that predicted later victimization: physical neglect by a caretaker, emotional withdrawal by a caretaker, a caretaker's failure to provide needed protection, sexual abuse by a non-caretaker, and sexual abuse. Findings by Kendall-Tackett (2002) indicate that revictimization increases negative outcomes such as injury, death, increase in stress and substance abuse, eating disorders, or smoking as a result of chronic stress. In addition to negative social effects, childhood abuse may also increase the likelihood of certain cognitive effects.

Cognitive effects. Cognitive effects refer to the beliefs and attitudes that influence one's perceptions and interpretations of situations that occur during daily existence. Essentially this is an individual's internal mental framework involved in interpreting interactions with others and one's own life events. One's cognitive appraisals can directly influence an individual's perception of psychological well-being and may relate to mood states such as depression, self-efficacy, and even perceptions of physical health. Research indicates that individuals who are mistreated as children may develop internal interpretations of the world as overly dangerous and adversarial (Kendall-Tackett, 2002).

Sexual dysfunction. One cognitive effect of enduring childhood maltreatment seen among male survivors is sexual dysfunction. Findings have suggested that male survivors of childhood sexual abuse have higher levels of sexual dysfunction than their non-abused counterparts. Problems of sexual dysfunction include many cognitive components, including sexual identity concerns or confusion, lower sexual self-esteem, and fear of negative emotions after having acceptable sexual experiences (Dhaliwal, Gauzas, & Ross, 1996).

Reduced self-efficacy. Adult survivors of maltreatment are likely to underestimate their sense of self-efficacy or self-worth when dealing with real or perceived danger, which in turn may increase perceptions of helplessness, powerlessness, and danger (Briere & Elliot, 1994). Gauthier, Stollak, Messe, and Aronoff (1996) conducted a study that included 236 male and 276 female undergraduate students to assess the relationship between physical abuse and neglect and later dysfunctional attachment styles. The results of this study indicated that individuals who experienced childhood abuse were more likely to be distrusting of themselves and others and had increased levels of anxiety, paranoia, and hostility. These enduring and lasting patterns of negative thinking can have detrimental effects on the survivor's health and sense of well-being

(Kendall-Tackett, 2002). As a result of these cognitive distortions, lowered self-esteem may also be seen in adult survivors of childhood maltreatment. Survivors of childhood abuse may be more likely to see themselves as flawed and have a sense of shame regarding the maltreatment that they have endured (Dhaliwal, Gauzas, & Ross, 1996).

Increased self-criticism and rumination. Self-criticism and rumination are two important cognitive processes to consider when conceptualizing survivors of childhood abuse (Zuroff, Koestner, & Powers, 1994). Zuroff, Koestner, and Powers (1994) found that rumination was a contributor to self-criticism and that both self-criticism and rumination served as strong predictors of later maladjustment. While self-criticism is a cognitive process that may result from other negative cognitive processes such as rumination, negative cognitive processes may also be linked to negative mood states.

Murphy, Nierenberg, Monson, Laird, Sobol, and Leighton (2002) found that self-criticism was associated with a lifetime risk of depression. Self-criticism has also been found to be linked with lowered self-esteem which can influence an individual's ability to be able to improve their mood following a setback in life (Heimpel, Wood, Marshall, & Brown, 2002). Individuals who had endured childhood maltreatment were more likely to experience negative cognitive processes—including rumination, self-criticism, and lowered self-esteem. Heimpel, Wood, Marshall, and Brown posited that individuals with such cognitive processes experience greater loss of energy to a mood lowering setback and may struggle with far more self-criticism than others.

These compromised cognitive processes can be the result of shame (Cheung, Gilbert, & Irons, 2004). The interaction between shame and negative cognitions may be occurring in a cycle in which a decrease in mood triggers self-criticism, which further lowers mood. This cycle of

shame, self-criticism, lowered self-esteem, and decreased mood severely impacts the individual's coping skills and may serve to impact overall psychological well-being. Since negative cognitive processes can have such notable influence on mood and emotional states, it is also important to explore the emotional effects of childhood maltreatment on the survivor.

Emotional effects. Emotional dysregulation, or difficulty in controlling or stabilizing one's mood, is a commonly identified consequence of childhood maltreatment. Emotional regulation difficulties can be seen as a decreased awareness and understanding of one's emotions, a decreased acceptance of emotions, and an inappropriate use of coping skills with impulsive emotionally motivated behaviors. Emotional consequences have been documented in relationships with the self and others and may present as self-dislike, shame, criticism of others, dissociation, feelings of isolation from others, psychopathology, substance abuse, and inflexibility in responding to the demands of the environment (Vettese, Dryer, Li, & Wekerle, 2011).

Another noted consequence of having endured childhood maltreatment is a compromised ability to self-regulate. This is likely to result from damage to the individual's self-regulation pathways and may contribute to numerous negative outcomes for a survivor of childhood maltreatment (Ford, 2005). Neurobiological studies have documented dysregulation in the hypothalamic-pituitary-adrenal axis (HPA) stress response systems as well as other neurotransmitters and neuropeptides among adults who have experienced childhood maltreatment. When conducting neuroimaging studies specifically for female survivors, it was suggested that survivors of childhood maltreatment may have altered brain structures and that brain functioning may actually be impaired (Ford).

Existing research also indicates that children raised in stressful conditions often have challenges forming secure attachments and may become emotionally dysregulated (Ford, 2005). This emotional dysregulation is likely to occur as a result of abuse or neglect exposure in early years. Research indicates that disturbances in self-regulatory pathways are more likely to occur in children, since the key components of the system (the amygdala and the prefrontal cortex) associated with self-regulation are still in formative stages during childhood (Ford).

Depressive symptoms. In addition to emotional consequences, Brier and Elliot (1994) examined literature examining male and female survivors of childhood maltreatment and assert that depression is the most commonly occurring sequela of childhood abuse. Depressive symptoms among survivors are likely to include sleep disturbances, fatigue, despondency, and crying episodes. Survivors of childhood maltreatment are also at an increased risk for developing symptoms associated with post-traumatic stress disorder (Kendall-Tackett, 2002). In some studies up to 80% of research participants reported some symptoms associated with post-traumatic stress disorder (Briere and Elliot, 1994). These symptoms included hypervigilance, intrusive thoughts, and intrusive flashbacks and were often coupled with negative mood states.

Decreased well-being and greater emotional distress. When looking specifically at male survivors of childhood maltreatment, Dhaliwal, Gauzus, and Ross (1996) found that male survivors had significantly lower levels of well-being and greater emotional adjustment concerns than non-victims. In fact, male survivors were found on average to have higher scores on Minnesota Multiphasic Personality Inventory (MMPI) subscales measuring hypochondriasis, hysteria, psychopathic deviate, paranoia, psychasthenia, and schizophrenia (Dhaliwal, Gauzus, & Ross, 1996). It was also found that survivors of childhood maltreatment scored significantly higher than those who had not experienced childhood maltreatment on scales measuring

maladjustment within all the subscales of the Abuse Symptom Checklist (TSG33). These subscales measure dissociation, anxiety, depression, anger, and sleep disturbances (Briere et al., 1988). Populations of survivors of childhood maltreatment also reported more symptoms consistent with phobia, panic disorder, and obsessive compulsive disorder.

Anger. Another well-documented emotional response among survivors of childhood maltreatment is anger. Anger, whether directed at the self or others, has been found to be a coping strategy for individuals who have experienced childhood maltreatment. When directed at the self, it may be the resultant feelings of frustration with oneself for “allowing” the abuse to take place or for not protecting oneself. Anger may also result from feeling isolated or feeling a loss of power. When directed at others, anger will likely be directed at the perpetrator for violating the survivor, or at those who should have stopped the abuse from occurring or protected the survivor (Kendall- Tackett, 2002).

While the negative effects of childhood maltreatment can be seen in many areas of the survivors’ social, cognitive, behavioral, and emotional functioning, literature also suggests that the effects may not be as severe as the previously reviewed literature suggests. Current literature asserts that research findings on the effects of childhood maltreatment may be inconsistent as a result of how these studies were conducted. It is also suggested that individuals may not experience these negative effects universally and may cope with childhood maltreatment more successfully than is often believed.

Opposing literature on the effects of childhood maltreatment. The other body of literature asserts that research findings on the effects of childhood maltreatment may be inconsistent as a result of these studies being conducted with specialized populations, such as those who are self-referred for counseling, psychiatric patients, and prisoners (Fergusson, Boden,

& Horwood, 2008). Ferguson, Boden, and Horwood (2008) state that the extent to which findings from specialized populations can be generalized to an entire population is not yet clear.

Retrospective data. The accuracy of retrospective accounts of childhood maltreatment remains somewhat controversial (Della & Femina, 1990; Fergusson, 2000). Retrospective accounts of childhood maltreatment have been said to be somewhat inaccurate at adequately capturing the events that happened in childhood. This effect is known as recall bias and refers to the events that individuals who have psychiatric disorder may be more likely to report such as childhood sexual abuse or childhood physical abuse. This bias calls into question the accuracy of the report in that there is a possibility of observing a false relationship between childhood physical or sexual abuse and later adjustment being that individuals may be more willing to recall or report these events (Fergusson & Mullen, 1999). It was asserted that those with associations between childhood physical abuse and later adjustment using retrospective studies may actually be a product of a reporting bias, as those with adjustment problems may be more prone to recall or disclose abuse (Widom, Phahael, & DuMont, 2004).

Confounding variables. Fergusson and Lynskey (1997) found that while childhood maltreatment was associated with negative mental health outcomes like depression and anxiety, this correlation becomes statistically non-significant when controlling for confounding variables related to social and contextual factors such as social and demographic background, including family type, maternal education, maternal age, and socioeconomic status.

Other studies suggest that aside from simply having endured maltreatment as a child, there may be other factors that better explain the observable negative effects that have been cited in the literature. Higgins and McCabe (2003) conducted three studies examining maltreatment and family dysfunction in childhood and the subsequent adjustment of children and adults. The

findings of these studies suggested that while childhood maltreatment scores predicted later maladjustment and psychopathology, childhood family variables such as family structure and family support were better predictors of later adjustment.

Pitzer and Fingerman (2010) conducted a study to explore the psychosocial resources that may explain variability in well-being for adults who experienced childhood physical abuse by their parents. This study aimed to understand whether psychosocial resources, such as emotional support, explained variability in well-being for adults who experienced childhood physical abuse by their parents. This study included 2,711 adults with ages ranging from 25-74 years. The results of this study indicated that “very severe” parental abuse in childhood does not always lead to poor health and well-being outcomes. While this study focused specifically on the influence of personal control as a buffer against detrimental effects of childhood physical abuse, the results suggest that the negative effects of childhood abuse may be buffered. These studies demonstrate not only that enduring childhood abuse does not always result in lowered psychological well-being but that there may be additional contributors to a decrease in psychological well-being following the endurance of childhood abuse. This finding validates the belief that there must then also be additional contributors that can protect against these negative effects of childhood maltreatment and as a result may serve to lower negative effects.

The importance of protective factors. Research on protective factors associated with recovery from childhood maltreatment provides insight into the possibility that the endurance of childhood maltreatment is not exclusively predictive of negative outcomes. Negative outcomes of having endured childhood abuse may actually be buffered by protective factors such as resilience. In studies conducted by Roy, Carli, and Sarchiapone (2011), the effect of resilience on suicidal behavior (an established outcome of having experienced childhood maltreatment) was

assessed in a sample of individuals who experienced childhood abuse. Participants in these studies were given the Childhood Trauma Questionnaire (Bernstein et al., 1994) and the Connor-Davidson Resilience Scale (Connor & Davidson, 2003). The Childhood Trauma Questionnaire was given to measure childhood physical abuse, emotional abuse, physical neglect, emotional neglect, and sexual abuse. The Connor-Davidson Resilience Scale was given to measure resilience. When scores on these measures were compared, it was found that participants who had never attempted suicide had significantly higher scores on the Connor-Davidson Resilience Scale. The findings suggest that resilience was a protective factor against the negative effects of childhood maltreatment.

Although the literature does present somewhat contrasting views about the effects of childhood maltreatment on the survivors of the abuse, the potential negative effects are severe enough to warrant extensive research. For this study, it is also important to consider the influence of sex on possible maltreatment-related responses.

Male survivors of childhood maltreatment. Literature indicates that male survivors of childhood maltreatment may respond differently to the event(s) for a number of reasons. One noted contributor to this difference is the effect of gender socialization (Mejia, 2005) on male survivors.

Gender socialization. Current research findings assert that gender socialization may be a key component for the differences between how males respond to childhood maltreatment and how female survivors respond to maltreatment. Mejia (2005) states that young boys experience ongoing socialization in order to become what is considered “acceptable male” within a given society. Boys may grow up adhering to these social constructions in an attempt to become and remain “ideally masculine.”

Research indicates that male babies from birth to several months of age are actually more emotionally expressive than their female counterparts but by the time male children are five to six years of age they are far less likely to express hurt or distress (Mejia, 2005). At some point between birth and five to six years of age, male children are exposed to various factors that begin to shape their perceptions of what it means to be male—this is gender socialization. The experience of such a process is likely to contribute to how a male survivor processes and copes with childhood maltreatment (Mejia, 2005).

Shame. The male socialization process involves the use of shame to “toughen-up” the male child and instill in the child that expressing emotions such as pain or hurt conveys weakness. This process is called the “shame-hardening process” whereby shame is used as a punishment for not meeting the societal standards of masculinity (Mejia, 2005). The male being socialized is to become “stoic, stable, independent, and never show weakness” and as a result, healthy coping strategies for dealing with negative emotions and trauma are diminished and curtailed (Mejia, 2005). This is likely to account for some degree of variability in the responses of males and females to childhood maltreatment. Such a process contributes greatly to restricted emotional responses, relationship difficulties, and an inability to express and communicate feelings. Overall, childhood maltreatment can lead to negative consequences; when the survivor is male, negative maltreatment-related symptoms may be exacerbated. These negative symptoms have been proven to have a relationship with a decrease in psychological well-being for survivors. Next, relevant literature on psychological well-being will be reviewed.

Psychological Well-Being

Throughout the development of the construct of psychological well-being, there have been three components that have been central to the conceptualization. Well-being was once

seen primarily as increased positive affective states, decreased negative affective states, and high satisfaction with life (Diener, 1984). When positive affect occurred more frequently than negative affect this was viewed as happiness. Happiness was then perceived as evidence of psychological well-being with happiness and well-being used nearly synonymously (Ryff & Keyes, 1995). Aside from these general conceptualizations of well-being, well-being was also often confused with a somewhat similar concept known as satisfaction with life.

Psychological well-being vs. satisfaction with life. Psychological well-being and satisfaction with life, while seemingly similar are indeed different constructs. Satisfaction with life addresses individuals' general sense of how fulfilled they are with their life as a whole (Diener, Emmons, Larsen, & Griffin, 1985). Life satisfaction reflects an evaluative judgment or cognitive evaluation of one's life. The specific processes that underlie such judgments are unclear and life satisfaction judgments have often been criticized as having limited reliability and validity when measured (Pavot & Diener, 2008). Psychological well-being, however, addresses aspects of the psychological self that extend beyond one's own cognitive appraisal of how satisfied one is with life. With the inconsistent definitions of psychological well-being in the literature and the possible confusion of this construct with satisfaction with life, Ryff and Keyes (1995) presented a more comprehensive and empirically supported definition of psychological well-being.

Expanded notion of psychological well-being. Ryff and Keyes (1995) expounded on the previously stated notion of psychological well-being and developed a multifaceted conceptualization of what it means to be psychologically well. As stated in the "operational definitions" section of this chapter, Ryff and Keyes (1995) suggest that psychological well-being is comprised of six domains of functioning. The domains are (a) autonomy, (b) environmental

mastery, (c) personal growth, (d) positive relations with others, (e) purpose in life, and (7) self-acceptance. To assess an individual's level of each of these areas, a psychological well-being scale, Scales of Psychological Well-Being, was developed (Ryff & Keyes).

Autonomy refers to a collection of qualities that involves self-determination, independence, and self-regulation of behaviors. Ryff and Keyes (1995) indicated that higher scores on the autonomy subscale are likely to indicate higher levels of self-determination and independence while lower scores are likely to indicate increased concerns with evaluations of others. *Environmental mastery* refers to an individual's ability to find or create an environment that suits personal needs and capacities (Ryff & Singer, 2008). Higher scores on this subscale likely indicate an increased sense of competence and mastery in managing one's environment and an increased ability to make appropriate use of one's surroundings in order to meet one's needs. Lower scores likely indicate difficulty managing everyday affairs and a lack of a sense of control over one's external world (Ryff & Keyes, 1995).

Personal growth places emphasis on continuous development of one's potential and on being open to experiences that afford the individual the opportunity to develop instead of achieving a fixed state of being (Ryff & Singer, 2008). Higher scores on the personal growth subscale are likely to indicate a personal interest in growing and expanding, openness to new experiences, and possession of a good degree of self-knowledge and effectiveness. Lower scores likely indicate a sense of personal stagnation and even boredom or disinterest in life (Ryff & Keyes, 1995). Another key aspect of psychological well-being is *positive relationships with others*. Positive relationships with others is essential and implies that feelings of love, empathy, warmth, and affection contributes to the deep friendships and close identification with others that help to promote an overall sense of connectedness that aids in a sense of well-being (Ryff &

Singer, 2008). Higher scores are likely to indicate a perception of warm, satisfying, and trusting relationships with others while lower scores indicate increased probability of having few close and trusting relationships and a difficulty being warm and open with others (Ryff & Keyes, 1995).

Ryff and Singer (2008) also discuss *purpose in life* which refers primarily to the ability to create meaning and direction in life. Higher scores are likely to indicate an overall interest in goals in life and a sense of direction, feelings that past and present experiences have meaning, and that life has purpose. Lower scores likely indicate a lack of a sense of meaning in life and fewer goals or aims (Ryff & Keyes, 1995). *Self-acceptance* is defined as a long-term self-evaluation that involves being both aware and accepting of one's personal strengths and weaknesses (Ryff and Singer, 2008). Higher scores on this subscale likely indicate a positive attitude about who one is and an acceptance of the multiple aspects of oneself, both good and bad. Lower scores likely indicate dissatisfaction with who one is (Ryff & Keyes, 1995). In addition to the effect of childhood maltreatment and psychological well-being, literature on self-compassion must also be explored.

Self-Compassion

Self-compassion involves a personal desire to improve one's health and well-being and is associated with a greater personal initiative to make needed or necessary life changes (Neff, 2009). The central theme of self-compassion is that one must experience one's suffering without avoiding or disconnecting from the suffering. Experiencing suffering is accomplished by the adherence to the three basic components of self-compassion: (a) self-kindness versus self-judgment, (b) a sense of common humanity versus isolation, and (c) mindfulness versus over-identification (Neff, 2003). In keeping with these components, one has a desire to reduce or

minimize emotional suffering and to heal oneself with kindness and non-judgmental understanding. Rather than seeing oneself as inherently flawed or of poor character, the individual understands that suffering and flaws are a part of the greater human experience.

Components of self-compassion. Self-kindness refers to the tendency to be caring and understanding with oneself rather than being harshly critical or judgmental (Neff, 2009). In life, suffering is unavoidable. During a time of suffering, self-kindness assists the individual in not judging him/herself harshly. Self-kindness encourages acting in a soothing and comforting manner to one's self. In keeping with self-kindness, self-compassionate individuals do not berate themselves when they do not succeed and as a result may be more likely and able to admit mistakes and modify unproductive behaviors (Neff, Hseih, & Dejittthirat, 2005).

Common humanity involves experiencing one's negative emotions or emotional discomfort as part of the human experience as opposed to an isolated occurrence that only the individual experiences. Common humanity involves understanding and accepting that all human beings are imperfect and must endure the consequences of their shortcomings and mistakes. The notion of common humanity serves to connect one's own imperfect state to the commonly shared flawed condition of others in order to promote a greater perspective (Neff, 2009).

Mindfulness, the final component of self-compassion, promotes the concept of being aware and present in the moment. By being purposefully aware of the present moment as opposed to operating on "autopilot," it is proposed that the life circumstances can be more clearly experienced and processed in a balanced way (Neff, 2009). This purposeful awareness is understood as mindfulness.

Through the components of self-compassion, understanding, kindness, and acceptance towards one's self can be given, rather than self-pity or exaggeration. Regardless of the source

of emotional distress, self-compassion can be applied in any life circumstance in which an individual is in need of care and gentleness. It is important to make the distinction between self-compassion and a related construct called self-esteem.

Self-compassion versus self-esteem. Self-esteem is understood to be a personal evaluation of one's worthiness as an individual as well as a perception of being good and valuable that results from our perceived competence in domains of importance. Essentially, self-esteem stems from the thought that one is good at things that are deemed personally important and the assurance that others' perceptions are appropriate and positive. However, self-esteem is often more impacted by the evaluations of others than by personal evaluations of oneself (Harter, 1999). Self-esteem is also highly resistant to change and is the result of doing well, not the cause of doing well (Baumeister et al., 2003; Swann, 1996).

Although the concept of self-esteem has been studied extensively and the benefits of higher levels of self-esteem have been extensively researched, recent studies suggest that there are great potential costs as a result of the pursuit of high self-esteem (Crocker & Park, 2004). These potential costs may come in the form of narcissism, distorted self-perception, prejudice, or even violence toward those who threaten the individual's ego (Neff, Kirkpatrick, & Rude, 2007). The desire to have high self-esteem is associated with self-enhancement bias, meaning that people see themselves in a more positive manner than is accurate and true. While arguments have suggested that positive illusions such as this enhance psychological well-being, such illusions can obscure one's judgment and make needed areas of improvement difficult to see. The need to feel superior to others in order to feel good about oneself means that the pursuit of high self-esteem may involve an over-inflation of the self and a devaluing of others (Neff, 2011).

Current research, however, indicates that self-compassion is different from self-esteem. While self-compassion and self-esteem are moderately correlated with one another, self-compassion has proven to be a more unique and empirically stronger predictor for many phenomena associated with self-esteem such as self-consciousness, self-rumination, contingent self-worth, and unstable self-worth (Neff, Hseih, & Dejitthirat, 2005). Research indicates that people who lack self-compassion are likely to have lowered feelings of self-worth because they are likely to be judgmental and hard on themselves. Inversely, those with high levels of self-compassion are likely to have increased feelings of self-worth because they are kinder, gentler, and more accepting of themselves (Neff, 2011). Self-compassion goes beyond self-esteem in that it predicts a unique variance in anxiety and depression when controlling for global self-esteem levels. This finding suggests that even when controlling for self-esteem, levels of self-compassion are able to predict varying levels of anxiety and depression above and beyond what self-esteem is able to predict. Self-compassion is also a significant predictor of happiness, optimism, and positive affect when controlling for self-esteem (Neff & Vonk, 2009).

Research also indicates that self-compassion offers mental health benefits that self-esteem does not, without some of the negative outcomes associated with high self-esteem (Neff, 2011). Self-compassion, unlike self-esteem, is not significantly correlated with narcissism. (Neff, Hseih, & Dejitthirat, 2005) Further, the positive affect and strong sense of self that result from self-compassion are not based on performance evaluations of the self or comparisons with others as is the case with self-esteem (Neff, Kirkpatrick, & Rude, 2007). That is to say that individuals are able to experience positive affect and have positive feelings about themselves that are not contingent upon how well they perform on tasks or how they compare to others. This,

unfortunately, is not the case with self-esteem, as it is directed related to how well one does on tasks of importance and on how well one compares to others.

Self-compassion promotes a feeling of connectedness with others and acceptance of oneself. As a result, individuals are more likely to feel as though they are cared for, interpersonally connected, and emotionally calm and regulated (Gilbert, 2005). Self-esteem, however, focuses on an evaluation of superiority and inferiority that gives rise to a social ranking system in which the individual must establish and sustain an appropriate rank (Gilbert & Irons, 2005). In a study conducted by Leary, Tate, Adams, and Allen (2005) it was found that individuals with higher reported levels of self-compassion were more likely to demonstrate emotional balance when faced with potentially humiliating situations, receiving unflattering feedback from others, and remembering past negative life events than those with high reported levels of self-esteem.

Neff and Vonk (2009) found that when compared to levels of self-esteem, levels of self-compassion were associated with more non-contingent and stable feelings of self-worth over time, while also offering stronger protection against social comparison, self-consciousness, and self-rumination. Research also indicates that self-compassion has been associated with reduced anxiety after thinking about one's greatest weakness. Self-esteem, however, did not have this protective quality (Neff, Kirkpatrick, & Rude, 2007).

Gilbert and Irons (2005) asserted that these observable differences between self-esteem and self-compassion may result, at least in part, from the different psychological systems that each activate. Self-esteem is thought to result from an evaluation of inferiority and superiority that serves to establish social ranks and is associated with alerting and energizing impulses and dopamine activation (Neff, 2011). Self-compassion however, is thought to deactivate the threat

system (associated with feelings of insecurity, defensiveness, and activation of the limbic system) and activate the self-soothing system which is associated with feelings of security, attachment, and safety.

Overall, research indicates that self-compassion promotes greater emotional resilience and stability than self-esteem. Self-compassion also involves far less self-evaluation, self-enhancement, or ego-defensiveness than self-esteem (Neff, 2011). Rather than comparing the self to others in a social ranking order, self-compassion moves the ego to the background and allows the individual to experience greater interconnectedness with others and a shared human experience. In this way, self-compassionate individuals do not have to feel superior to others to have positive emotions and evaluations of themselves (Neff, 2011). With self-compassion, a stable and enduring foundation of positive self-regard is established, rather than the fleeting and unstable feelings of esteem that come in comparison to others (Neff, 2011). Neff (2003b) also found that self-compassion was negatively related to emotional regulation difficulties, rumination, dissociation, negative affect, and indicators of psychopathology. Studies have found that self-compassion can serve to promote psychological well-being and be a powerful predictor of positive mental health functioning (Neff, 2003a).

Self-Compassion and Psychological Well-Being

Gilbert (2005) asserted that given the theoretical constructs, a positive association between self-compassion and well-being is to be expected. It is suggested that self-compassion promotes well-being through helping an individual feel cared for, connected to others, and emotionally calm. Self-compassion can be viewed as an emotional regulation strategy in which negative emotions are not avoided but met with awareness and treated as a sense of shared common humanity. As a result, self-compassion reduces negative feelings and transforms then

into positive feelings (Gilbert). For this reason, Neff (2004) asserts that self-compassion may help individuals cultivate well-being, happiness, positive affect, and social connectedness (Wei, Liao, Ku, & Shaffer, 2011).

Neff, Leary, and Hoyle (2009) asserted that the three components of self-compassion, self-kindness, common humanity, and mindfulness, in combination give rise to a self-compassionate frame of mind which has been associated with an increased sense of psychological well-being (Neff, Leary, & Hoyle, 2009). Specifically, Neff, Leary, and Hoyle examined self-compassion in comparison and individual personality differences. The data gathered suggest that one's ability to be compassionate is linked to greater emotional resilience and psychological well-being.

Individuals with higher levels of self-compassion have been found to have lower levels of both depression and anxiety (Neff, 2003). These individuals are also likely to have better emotional coping skill, are less frightened by potential failure, and tend to be more intrinsically motivated to learn new things and expand their way of being in the world. Self-compassion can have an effect on an individual's mood and affect, which can ultimately influence one's sense of psychological well-being. Self-compassion has also been found to be negatively associated with negative mood states such as depression, and anxiety, as well as contributors to negative mood states, including self-criticism, rumination, thought suppression, and neurotic perfectionism (Neff, 2003a). Individuals with higher levels of self-compassion have also been found to be more socially and interpersonally connected with others (Neff, Leary, & Hoyle, 2009). The correlation between these factors and self-compassion are likely contributing to the relationship between self-compassion and increased psychological well-being.

Research provides strong support for the assertion that self-compassion does more than just ameliorate psychopathology and negative mental health symptoms; self-compassion also predicts positive psychological strengths and enhances well-being (Neff, Rude, & Kirkpatrick, 2007). Higher reported levels of self-compassion have also been found to predict enhanced psychological health and may also reduce one's overall level of stress (Neff, 2011). Neff, Rude, and Kirkpatrick (2007) found that more self-compassionate individuals experience significantly more positive and less negative mood states. Self-compassion has also been associated with higher levels of brain activation in the left prefrontal cortex, a region of the brain that is associated with joy and optimism (Lutz, Greischar, Rawlings, Richard, & Davidson, 2004).

In addition to promoting positive affect, self-compassion has been shown to moderate reactions to distressing situations involving failure, rejection, embarrassment, and other negative events (Neff, Kirkpatrick, & Rude 2007). Neff, Kirkpatrick, and Rude conducted two studies to examine the relationship between self-compassion and psychological health. In study 1, the researchers found that self-compassion served to buffer against anxiety when participants were faced with an "ego-threat" in the laboratory setting. In study 2 researchers found that increases in self-compassion were associated with increases in psychological well-being when tested over a one month period.

Self-compassion has also been associated with lower negative emotions when faced with real, remembered, and imagined events and with an improvement in patterns of thoughts that generally facilitate people's ability to cope with negative events (Neff, Rude, and Kirkpatrick, 2007). Individuals who are highly self-compassionate are aware of negative events in a way that reduces their impact. Observing negative events in a non-judgmental way and as part of the

common human experience may help those with high levels of self-compassion to have a broader perspective than those with lower levels of self-compassion.

Neff and McGehee (2010) conducted a study to examine self-compassion in a sample of adolescents. In this study it was found that self-compassion was strongly associated with one's sense of psychological well-being. Self-compassion was also found to partially mediate the interaction between family/cognitive factors and psychological well-being. Findings suggest that self-compassion may influence the relationship between negative family and cognitive factors and one's sense of psychological well-being. This study demonstrates that even in the presence of a difficult family situation, adolescents higher in levels of self-compassion were found to have increased senses of psychological well-being. Based on these findings, Neff and McGehee (2012) suggest that self-compassion may be an effective intervention for individuals suffering from negative self-views as a result of difficult life circumstances. As previously discussed, literature asserts that those who have experienced childhood maltreatment are likely to experience negative consequences such as negative cognitions about self or others.

Leary, Tate, Adams, Allen, and Hancock (2007) also conducted a study to examine the connection between self-compassion and psychological well-being. Leary et al. (2007) conducted five studies investigating the processes by which self-compassion helps individuals better manage unpleasant life events. To do this Leary and colleagues wanted to examine the degree to which students' well-being was associated with their emotional responses to stress and challenge.

In study 1, Leary et al. (2007) found that self-compassion predicted both emotional and cognitive reactions to negative life events when looking specifically at everyday life events. This means that when individuals encounter daily stressors that are often present in everyday life,

those who reported higher levels of self-compassion were able to approach these stressors in a cognitive and emotional fashion that was more adaptive than those who were lower in reported levels of self-compassion.

The second study provided results that assert that self-compassion serves to buffer against negative feelings directed at the self when imagining distressing life events. This means that when individuals imagined distressing life events, those with higher reported levels of self-compassion were better able to manage or reduce the amount of negative emotions directed at themselves than those who reported lower levels of self-compassion. This makes sense given the self-kindness and decreased self-criticism that is associated with higher levels of self-compassion.

The third study found that when students were given ambivalent feedback, self-compassion moderated negative emotions especially for those who were low in measures of self-esteem. This means that on average, when presented with feedback that could be taken in either a negative or positive way, those with higher levels of self-compassion experienced less negative emotions than those who reported having lower levels of self-compassion.

Study 4 showed that when viewing videotapes of their performances, students who reported lower levels of self-compassion undervalued their performances in comparison to observers. This means that when observing their own performance, individuals were more likely to undervalue, or perceive themselves as doing worse than those who observed them, if their level of self-compassion was lower as opposed to higher. Being that self-compassion relates directly to how individuals view themselves and how compassionate and gentle they are with themselves, it makes sense that those who report lower levels of self-compassion view themselves more harshly or critically than those in the world around them may view them.

Lastly, the fifth study experimentally induced a self-compassionate perspective and found that self-compassion resulted in participants' ability to acknowledge their roles in negative events without becoming overwhelmed by negative feelings. Specific to students, these findings suggest that self-compassion may help students increase levels of well-being. In general, however, Leary et al. (2007) use these findings to assert that self-compassion attenuates individual's responses to negative events.

Other studies have been conducted to explore the relationship between self-compassion and psychological well-being as well. Neely et al. (2009) conducted two studies to explore this relationship. The first study focused on the degree to which students' abilities to manage their goals predicted their sense of well-being. This study looked specifically at the students' ability to disengage from unattainable goals and reengage in alternative goals. Additionally, this study explored the contributions of self-compassion to the students' sense of well-being above what was accounted for by the experience of stressful life events. The results of the first study indicated that self-compassion predicted reactions to negative events in daily life.

Study 2 was designed to test the conclusions of the first study and to better understand how self-compassion influenced well-being by comparing self-compassion to two other predictors (the need for social support, and the availability of social support). Results indicated that adding measures of stress, social support, and self-compassion increased the amount of variance accounted for on the well-being index. Self-compassion was found to be a reliable correlate of students' well-being (Neely et al., 2009).

Overall, these findings suggest that one's level of self-compassion may predict how one is likely to respond when faced with negative life events. Additionally, self-compassion may also predict how well-being may be affected after a negative life event. This is to say, individuals

who are higher in self-compassion are likely to respond in a way that is more adaptive than those who are lower in levels of self-compassion. The need and availability of social support was then examined as a predictor for how one might respond to negative and stressful life events. Together social support and self-compassion were found to account for differing levels of psychological well-being. These findings indicate that self-compassion is a reliable predictor of psychological well-being.

Tate, Adams, Allen, and Hancock (2007) asserted that psychological well-being can be directly influenced by self-compassion. One way in which self-compassion can influence psychological well-being is by influencing the way that one views oneself. Those who are high in reports of self-compassionate are far less likely to judge themselves in a harsh or critical way. In contrast, those who are lower in reported levels of self-compassion are more likely to view themselves in a way that is judgmental and unkind. One's cognitions or perceptions of oneself will have a direct impact on one's overall sense of well-being (Tate, Adams, Allen, & Hancock). Individuals who are self-compassionate are more accurate in their self-evaluations because their self-judgments are less influenced by catastrophizing self-criticism or defensive self-enhancement (Tate, Adams, Allen, & Hancock).

Self-Compassion and Maltreatment-Related Symptoms

Self-compassion has also been documented to be a helpful concept for those recovering from traumatic experiences. In a study by Gilbert and Procter (2006), the integration of self-compassion into therapy for individuals who have psychological disorders that occur as a result of shame and self-criticism was conducted. After having experienced the compassionate mind training, participants reported a significant reduction in anxiety and depression, and a reduction of self-criticism. Overall, it was reported that infusing treatment with elements of self-

compassion resulted in decreased depression, anxiety, self-attacking, inferiority feelings, submissive behavior, and shame. Gilbert and Procter (2006) assert that self-compassion infused therapy can be helpful in treating individuals with traumatic histories.

In another study conducted by Thompson and Waltz (2008), the relationship between self-compassion and post-traumatic symptoms was explored. In this study it was found that those who had lower levels of self-compassion were more likely to engage in avoidant behaviors in an attempt to avoid emotional triggers of past traumas. As a result, it was posited that survivors of abuse and those that suffer from post-traumatic stress disorder may benefit from therapy that includes aspects of self-compassion.

Given that self-compassionate individuals are less likely to be self-critical, it is likely that individuals who practice self-compassion will be more willing to acknowledge areas of weakness that need to be changed (Neff, 2003). Individuals who practice self-compassion do not focus exclusively on pleasure or self-indulgences which may serve to decrease well-being. For example, much of the time spent giving oneself pleasure may involve things such as drugs, over-eating, watching too much television, and may actually promote self-harm. Self-compassionate individuals are more likely to do things to promote their health that may involve a certain amount of displeasure, such as exercising or eating properly. Although such things may be less pleasurable, they may also serve to increase well-being (Neff, Rude, and Kirkpatrick, 2007). While current literature asserts that there is likely a relationship between self-compassion and psychological well-being, this literature is limited (Gilbert, 2005; Neff, 2004, Tate, Adams, Allen, and Hancock, 2007). Literature is even more limited when considering the relationship between self-compassion and psychological well-being among individuals who have experienced childhood maltreatment and even more so when the relationship between self-compassion and

psychological well-being is considered among a traditionally understudied sample population like males.

Psychological Well-Being, Self-Compassion, and Childhood Maltreatment

While research relating specifically to self-compassion, childhood maltreatment, and psychological well-being is limited, current literature does provide some insight into how these constructs may intersect. While the focus of current literature is not exclusively on male survivors, much of the research does include male participants.

Childhood maltreatment decreases self-compassion and psychological well-being.

Findings from Neff and McGehee (2010) asserted that family experiences, such as parental support, may play a significant role in the development of self-compassion. Individuals are likely to learn how to treat themselves by modeling their parent's behavior. In a time of suffering or failure, children may learn to relate to themselves the way that their parents relate to them. If caregivers are supportive and nurturing, children may learn to treat themselves in the same manner; if, however, the parents are neglectful or abusive to the child, the child may learn to be harsh, self-critical, and even self-loathing (Neff & McGehee, 2010).

Inconsistent, neglectful, or abusive parenting may result in the child having a compromised or negative view of self which will likely impede the development of self-compassion (Wei, Laio, Ku, & Shaffer, 2011). An increase in self-criticism may increase an individual's need for validation outside of the self. This validation is often found in others and when individuals rely heavily on external sources of validation they are less likely to cultivate and develop the internal resources that generate self-compassion (Neff & McGehee, 2010). When an individual possesses a considerable amount of self-criticism they are also more likely to exaggerate their own distress, becoming consumed by painful thoughts and feelings as a result of

feeling as though their negative experiences are happening to them alone (Mikulincer et al., 2003).

Individuals who have experienced childhood abuse are more likely to exhibit problematic attachment styles that may result in the previously mentioned negative consequences. Neff and McGehee (2010) found that problematic attachment styles were negatively correlated with self-compassion and that individuals who lack the capacity for self-compassion are less likely to feel a sense of well-being. Individuals who do not have the skills to connect appropriately with others in early life may also have difficulty achieving this later in life which would serve to influence positive relations with others. In addition to relating to others, these individuals may also have a difficult time managing themselves, particularly their emotional states.

One core cluster of negative symptom expression following childhood maltreatment is an inability to regulate one's emotions, or emotional dysregulation (Vettese, Dryer, Li, & Wekerle, 2011). Childhood abuse and emotional dysregulation are strongly correlated together but research indicates that when studying individuals who experienced childhood trauma, as self-compassion increased the severity of emotional dysregulation decreased. Self-compassion was also found to mediate the relationship between childhood abuse and later emotional dysregulation (Vettese, Dryer, Li, & Wekerle, 2011). Not only might managing emotional states be difficult, but one's view of the self as a whole may also be compromised.

Childhood maltreatment survivors and increased self-compassion. Previously reviewed literature supports the understanding that the endurance of childhood maltreatment can have a negative impact on psychological well-being (Kendall-Tackett, 2002). Vettese, Dryer, Li, and Wekerle (2011) conducted a study to examine whether self-compassion mitigated the association between childhood maltreatment and later emotional regulation difficulties. Vettese

and colleagues found that as self-compassion increased, emotional regulation difficulties associated with childhood maltreatment decreased.

Thompson and Waltz (2008) asserted that survivors of maltreatment, particularly those with post-traumatic stress disorder, may benefit from incorporating the concepts of self-compassion into treatment to minimize the negative symptoms, such as self-criticism and rumination, that result from the endurance of a traumatic event. Self-criticism and rumination may impede an individual's ability to feel autonomous and self-accepting. There may also be a decrease in perceived environmental mastery as the highly critical individual may not feel competent or efficacious. Self-compassion may help to decrease some of the cognitive consequences of childhood maltreatment and serve to promote or increase psychological well-being (Thompson & Waltz). Inversely, a lack of self-compassion may not serve to reduce or buffer the cognitive effects that may arise as a result of childhood maltreatment; this may result in a decrease in psychological well-being.

Another aspect of psychological well-being that may be influenced by the experience of childhood maltreatment is positive relations with others (Thompson & Waltz, 2008). Intuitively, it is understandable that an individual who has been mistreated early in life may have a more difficult time connecting with others. While not all childhood maltreatment is perpetrated by parents, Neff and McGhee (2010) looked at parent-child attachment to provide insight into the attachment concerns that can arise as a result of childhood trauma. In this study subjects were recruited from a subject pool and given course participation credit. These subjects then completed the Self-Compassion Scale (Neff, 2003a), the Beck Depression Inventory (Beck & Steer, 1987), the Spielberger State-Trait Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1970), the Social Connectedness Scale (Lee & Robbins, 1995), the Maternal Subscale of the

Family Messages Measure, the Index of Family Relations, the Relationship Questionnaire, and the Personal Uniqueness Subscale of the New Personal Fable Scale (Lapsley, FitzGerald, Rice, & Jackson, 1989). Results of this study indicate that self-compassion and well-being are strongly linked when examined among a sample of adults and adolescents. Family relationship factors, such as the severity and magnitude of problems between family members' relationships with one another, as well as individual cognitive patterns, were found to be predictive scores for self-compassion. Essentially, the interactions one has with one's family and the thoughts or beliefs one has about oneself were shown to be predictive of scores on measures of self-compassion. Additionally, self-compassion was found to partially mediate the relationship between such family/cognitive factors and psychological well-being. This means that the results of this study indicate that family and cognitive factors influence self-compassion scores, and that self-compassion can serve to partially mediate the negative impact of family and cognitive factors on psychological well-being.

Baer, Lynkins, and Peters (2012) conducted a study to examine the relationship between psychological health, mindfulness, and self-compassion. The study tested three hypotheses. The first hypothesis postulated that mindfulness and self-compassion would be significantly correlated with each other and that mindfulness and self-compassion would be significantly correlated to psychological well-being and meditation experience. The second hypothesis asserted that mindfulness and self-compassion would account for independent variance in psychological well-being. In other words, even when examined separately, both mindfulness and self-compassion were likely to have an influence on psychological well-being. Even in the absence of mindfulness, self-compassion would be likely to explain varying levels of psychological well-being.

The third hypothesis posited that a significant relationship between meditation experience and psychological well-being could be accounted for by mindfulness and self-compassion. This means that the relationship between meditation and psychological well-being could be at least partially explained by mindfulness and self-compassion. Each of these hypotheses looks at some aspect of the relationship between psychological well-being, self-compassion, and mindfulness.

In this study, participants included 77 adults who engaged in mindfulness meditation at least one or two times weekly, and 75 adults who had never meditated regularly but may have tried to do so on just a few occasions. Participants were given measures to assess for mindfulness, self-compassion, and psychological well-being using the Five Facet Mindfulness Questionnaire (Baer, Smith, Hopkins, Krietemeyer, & Tony, 2006), the Self-Compassion Scale (Neff, 2003), and the Scale of Psychological Well-being (Ryff & Keyes, 1995). Results of this study suggest that both mindfulness and self-compassion were important in predicting psychological well-being. When comparing total scores on the Self-Compassion Scale and the Five Facet Mindfulness Questionnaire, Baer, Lynkins, and Peters (2012) concluded that self-compassion was a stronger predictor of psychological well-being than mindfulness. Results also indicated that the significant association between meditation and increased psychological well-being was completely accounted for by a combination of mindfulness and self-compassion scores. Overall, these results indicate that self-compassion can greatly enhance psychological well-being.

Consistent with these findings, Van Dam, Sheppard, Forsyth, and Earleywine (2010) conducted a study to examine the relationship between self-compassion and psychological well-being. In this study, the researchers compared the ability of the Self-Compassion Scale and the Mindful Attention Awareness Scale to predict various components of psychological well-being.

For this study, researchers used measures of anxiety, depression, worry, and quality of life to conceptualize psychological well-being. Measures of self-compassion, mindfulness, depression, anxiety, worry, and quality of life were given to 504 participants. Using multiple regression and correlation analyses, statistical analyses were conducted to explore the predictive validity of mindfulness and self-compassion in relation to symptom severity and quality of life in individuals with mixed anxiety and depression. Findings from this study suggest that self-compassion is a more robust predictor of psychological well-being (using measures of anxiety, depression, and quality of life) than mindfulness.

Other researchers have also found that self-compassion is uniquely associated with well-being above what can be accounted for by other constructs. In a study conducted by Neely, Schallert, Mohammed, Roberts, and Chen (2009), it was found that self-compassion predicted variations in self-reported levels of psychological well-being above the variation predicted by goal regulation, stress, and degree and availability of social support. Overall, the literature provides evidence that enduring childhood maltreatment may serve to decrease psychological well-being, that psychological well-being may be increased with increases in self-compassion, and that increases in self-compassion may serve to promote high levels of psychological well-being as well as decrease the impact of negative maltreatment-related symptoms (Neff, 2009; Neff, Leary, & Hoyle, 2009; Neff & McGhee, 2010).

Although research has been conducted to examine the relationship between self-compassion and psychological well-being, this relationship has not been thoroughly explored in the context of having endured childhood maltreatment. With the understanding that being male may serve to exacerbate the negative symptoms following childhood maltreatment and result in a compromised sense of psychological well-being (Mejia, 2005), it is important to explore this

relationship specifically in a male sample. To date there are no studies that examine the relationship between self-compassion and psychological well-being among a sample of male survivors of childhood maltreatment.

Hypotheses

The previously discussed literature asserts that just by virtue of being male, survivors of childhood abuse may deal with increase in shame and a compromised sense of self (Cheung, Gilbert, & Irons, 2004; Mejia, 2005). Current literature on the effects of childhood abuse suggests that the negative effects of childhood abuse may be exhibited within behavioral, social, cognitive, and emotional aspects of the survivor's functioning (Kendall-Tackett, 2002). Additionally, male survivors may also experience higher rates of shame and inferiority than males who have not experienced maltreatment. These increased feelings of guilt and shame may contribute to negative self-schemas (Cheung, Gilbert, & Irons, 2004; Mejia, 2005).

Previously discussed literature asserts that shame-proneness, interpersonal vulnerabilities, lowered self-esteem, and increased substance abuse are possible consequences of having endured childhood maltreatment. Literature also asserts that being male may exacerbate negative symptoms associated with surviving childhood maltreatment (Heimpel, Wood, Marshall, & Brown, 2002; Gilbert & Procter, 2006). As negative consequences increase for male survivors of childhood maltreatment, it is likely that this will coincide with a decrease in perceived psychological well-being among these male survivors.

Although psychological well-being may be compromised, self-compassion, or the ability to be kind with oneself, has been found to ameliorate some of the negative outcomes of childhood abuse when looking at the behavioral, social, cognitive, and emotional aspects of the survivor (Neff, 2009, & Neff, 2003). Self-compassion has been shown to be associated with

greater resilience (Neff and McGehee 2010), an increase in the appropriate use of internal and external resources, and increased ability to navigate situations involving significant threat (Masten and Wright 2009). Self-compassion has also been associated with an increase in well-being (Neff, 2009) and is a significant predictor of happiness, optimism, and positive affect when controlling for self-esteem (Neff & Vonk, 2009).

Although current research is beginning to explore the relationship between self-compassion and psychological well-being (Baer, Lynkins, & Peters, 2012; Neely et al., 2009; Van Dam et al., 2010), there is little understanding of the relationship between self-compassion and psychological well-being for male survivors of childhood maltreatment. Thus, the examination of the relationship between self-compassion and psychological well-being for male survivors of childhood abuse is needed to supplement existing literature.

Given the void in the literature surrounding self-compassion and psychological well-being among male survivors of childhood trauma, the following research questions and hypotheses are proposed:

1. Is there a relationship between trauma symptom severity following childhood trauma and self-compassion? It is hypothesized that there will be a negative correlation between trauma symptom severity following childhood trauma and self-compassion.
2. Is there a relationship between trauma symptom severity and psychological well-being? It is hypothesized that there will be a negative correlation between trauma symptom severity and psychological well-being.
3. Is there a relationship between self-compassion and psychological well-being? It is hypothesized that there will be a positive correlation between self-compassion and psychological well-being.

4. Does self-compassion influence the relationship between trauma symptom severity and psychological well-being? It is hypothesized that self-compassion will mediate the relationship between trauma symptom severity and psychological well-being.

Chapter 3: Methods

Existent literature on recovery from childhood trauma is extensive and varied. Current research has provided numerous considerations for the treatment of the negative consequences that may occur. Of the possible negative consequences, one is a decreased sense of psychological well-being. Self-compassion, a relatively new construct, has been associated with several psychological benefits including increased psychological well-being (Neff, 2010).

Although there is an understanding of the relationship between self-compassion and psychological well-being for those who have experienced traumatic events, there is limited research that has been conducted to evaluate this relationship. Research is even more limited when exploring the relationship between self-compassion and psychological well-being for male survivors of childhood trauma. Thus, the current study is proposed to supplement existing literature and examine the relationship between self-compassion and psychological well-being for male survivors.

This chapter begins by outlining the criteria needing to be met for participation in this study. Then, an overview of the measures that were used as well as applicable psychometric properties of these measures will be reported. Finally, statistical techniques for analyzing the data are reviewed.

Participants

Participants were males, 18 years of age or older. This study compared males who have experienced childhood sexual maltreatment with males who have not experienced childhood maltreatment. Therefore, males who were 18 years of age or older were eligible to participate in this study regardless of past childhood maltreatment.

For this study, childhood maltreatment was limited to the experience of physical abuse, physical neglect, emotional abuse, emotional neglect, and sexual abuse. Participants were able to indicate the experience of one or several of these forms of maltreatment. These incidences of abuse or neglect must have occurred prior to the age of 18 and been perpetrated by a parent or other trusted caretaker.

Sample recruitment. The sample was recruited using a variety of techniques. List servers that are geared to reaching male survivors of childhood maltreatment were accessed. In addition to list servers, announcements were made on online websites. These websites included SONA, which provided researchers with access to Radford University undergraduate males. Snowball sampling was also utilized. Snowball sampling refers to a sampling technique that is used by researchers to identify potential research participants particularly when members of the research sample are difficult to identify or locate (Castillo, 2009). This type of sampling works much like a chain of referrals. Once organizations or individuals have been identified, they were asked to forward the research information to other individuals or organizations that they feel may be interested in participating. Snowball sampling offers many advantages, such as assisting the researcher in accessing populations that are difficult to reach using other sampling methods, and the process is relatively simple (Castillo). Refer to Appendix A for the research announcement.

Sample selection. Individuals were selected to participate in the study if they endorsed two basic criteria. The participants must have indicated that they are male and that they are over the age of 18. If participants endorsed these criteria, they were provided access to the survey. During the survey it was assessed whether or not the individuals have experienced childhood maltreatment, the type of maltreatment endured, approximate length of maltreatment, and symptom severity related to the maltreatment.

Measures

Respondents completed six measures when participating in this study. These measures included: Demographic Questionnaire (Appendix C), Self-Compassion Scale Short Form (Appendix D), Zung Self-Rating Depression Scale (Appendix E), Satisfaction with Life scale (Appendix F), Scales of Psychological Well-Being (Appendix G), and the Trauma Symptom Checklist-40 (Appendix H).

Demographic information form. The first measure administered was the Demographic Questionnaire. This is a five-item form that assesses the participant's sex, ethnicity, age, type of maltreatment experienced, and approximate duration of the maltreatment experienced. The aim of this research is to explore self-compassion and psychological well-being following childhood maltreatment in a male sample. For this reason the question of sex was asked. It was also important to determine the participant's year of birth. This allowed for certainty that the individual was over the age of 18.

The type of maltreatment endured was assessed so that participants could be placed in the appropriate group (those who have endured childhood maltreatment, or those who have not endured childhood maltreatment). The approximate length of time that the maltreatment endured was assessed to inform findings about symptom severity. Childhood maltreatment-related symptoms were assessed in order to better understand the mediating role that self-compassion may have when looking at psychological well-being later in life. It is therefore important to have an understanding of not only the symptoms that resulted after having experienced childhood maltreatment, but also the approximate amount of time and self-perceived intensity of the maltreatment.

Self-compassion scale. Respondents then completed the Self-Compassion Scale Short Form (Appendix D) which is a psychometrically and theoretically sound measure that is composed of 12 items and yields scores on six subscales (Neff, 2003a). This scale has been used by Raes, Pommier, Neff, and Van Gucht (2011) and has been found to demonstrate adequate internal consistency with $\alpha \geq 0.86$ and a near perfect correlation with the long form ($r \geq 0.97$). Confirmatory factor analysis on the short form supported the same six-factor structure as the long form for the Self-Compassion Scale. Raes, Pommier, Neff, and Van Gucht (2011) assert that the short form is a reliable and valid alternative to the long form for the Self-Compassion Scale (Neff, 2003).

Subscales examined for the Self-Compassion Scale Short-Form include self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification. Items are answered using a five-point scale with a score of 1 corresponding to “Almost Never” and a score of 5 corresponding to “Almost Always.” Items that compose the self-judgment, isolation, and over-identification subscales are reversed scored. To compute the total self-compassion score, the mean of each subscale is calculated. Each subscale mean is then added and averaged to yield a total self-compassion score.

Scales of Psychological Well-Being. The Scales of Psychological Well-Being (see Appendix G) are composed of 54 items from a total of six domains. These domains are autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance. Items on this measure are answered using a six-point scale ranging from 1 (strongly disagree) to 6 (strongly agree).

This scale has been examined many researchers, including Abbot, Ploubidis, Huppert, Wadsworth, and Croudace (2006); Akin (2008); Ryff and Heidrich (1997); and Ryff and Keyes,

(1995) to determine the scale's validity and reliability among various samples. Overall this scale has been reported to be psychometrically sound and have good reliability and validity. Internal consistency and correlation with 20-item parent scales are reported for each of the six domains assessed by the Psychological Scales of Well-Being. The "autonomy" scale was reported to have an internal consistency of $\alpha=.83$ and a correlation with the 20-item parent scale of $r=.97$. The environmental mastery scale was reported to have an internal consistency of $\alpha=.86$ and a correlation with the 20-item parent scale of $r=.98$. The personal growth scale was reported to have an internal consistency of $\alpha=.85$ and a correlation with the 20-item parent scale of $r=.97$. The positive relations with others scale was reported to have an internal consistency of $\alpha=.88$ and a correlation with the 20-item parent scale of $r=.98$. The purpose in life scale was reported to have an internal consistency of $\alpha=.88$ with a correlation with the 20-item parent scale of $r=.98$. The self-acceptance scale was reported to have an internal consistency of $\alpha=.91$ and a correlation with the 20-item parent scale of $r=.99$ (Ryff, 1989). Although there is scale of psychological well-being that has a three-item-per-scale assessment as opposed to the fourteen-item- or nine-item-per-scale assessment, the three-item measure is not recommended for use. The psychometric properties of the three-item scales have low internal consistency and are reported to be poor for high quality assessment of well-being (Ryff & Keyes, 1995).

There are no specific scores or cutoff points for assigning a high or low level of well-being. Distinctions between high or low levels of well-being are determined based on distributional information from the sample that is being assessed. High levels of well-being can be defined as scores that are in the top 25% of the distribution and low levels are in the bottom 25% of the distribution.

In order to adequately measure psychological well-being, two additional measures of well-being were used: Zung Self-Rating Depression Scale, and Satisfaction with Life Scale. These measures will provide some information on negative affective experiences of respondents as well as their overall satisfaction with their lives.

Zung Self- Rating Depression Scale. The Zung Self-Rating Depression Scale is a measure that is used to quantify the depression status of a client. The scale has 20 items that are used to rate four common symptoms of depression. These symptoms, which are considered characteristic of depression, include the pervasive effect, the physiological equivalents, other disturbances, and psycho motor activities. Each item on the scale is scored on a 1 – 4 scale with responses ranging from a little of the time to most of the time (Zung, 1965). An overall score is yielded and corresponds with a range of depression (normal range, mildly depressed, moderately depressed, severely depressed).

The Zung Self-Rating Depression Scale has been found to be psychometrically sound and exhibits good reliability and validity. In a community survey of 1,173 subjects, $\alpha=0.79$ (Knight et al., 1983). When considering the validity of this measure, there was correlation between scores of the Zung Self-Rating Depression Scale and the Minnesota Multiphasic Personality Inventory Depression Scale ($r=0.65$).

Satisfaction with Life Scale. The satisfaction with life scale is a five-item measure used to assess an individual's satisfaction with life as a whole. This scale is designed not to assess satisfaction with specific domains in life like the Ryff Scales of Psychological Well-Being. This scale allows respondents to weight the domains of their life as they see fit in whatever way they choose to. Respondents indicate their agreement or disagreement using a seven-point scale ranging from strongly disagree to strongly agree. This scale has been found to be

psychometrically sound with good reliability and validity. Diener et al. (1985) reported a reliability coefficient of $\alpha=0.87$. When considering validity, the Satisfaction with Life Scale has been shown to be negatively correlated with other measures of distress. The Satisfaction with Life Scale has been shown to be strongly negatively correlated with the Beck Depression Inventory with $r=-0.72$ (Pavot & Diener, 1993). This measure has been used by other researchers to explore the relationship between psychological well-being and childhood maltreatment (Chaudhury, Murthy, Banerjee, Kumari, & Alreja, 2011; Galea, 2012).

Trauma Symptom Checklist-40. The Trauma Symptom Checklist- 40 (see Appendix H) is a 40-item measure to assess symptom severity following a childhood or adult traumatic event. Items are answered using a four-point scale. Each symptom is rated according to its frequency of occurrence over the past two months. This measure provides scores on six subscales: anxiety, depression, dissociation, sexual abuse trauma index (SATI), sexual problems, and sleep disturbances. A total score is also provided. This is a psychometrically sound measure with studies indicating reliability typically ranging from $\alpha=.66$ to $\alpha=.77$ for subscales and reliability for the full scale averaging between $\alpha=.89$ and $\alpha=.91$. A number of prior studies that look specifically at male survivors of childhood maltreatment use this checklist for measuring symptom severity, including Bagley, Wood, and Young (1994) and Briere, Evans, Runtz, and Wall (1988).

Overall, self-compassion was assessed using the Self-Compassion Short Form. Childhood maltreatment-related symptom severity was assessed using the Trauma Symptom Checklist-40. Psychological well-being was assessed using several assessments. The Scales of Psychological Well-Being, the Zung Self-Rating Depression Scale, and the Satisfaction with Life Scale were used to assess psychological well-being.

Procedure

Approval for this study was obtained from Radford University's Institutional Review Board (IRB). Once approval was obtained, recruitment began. Internet-based recruiting methods included list serve announcements, recruitment through websites serving male survivors of childhood trauma, and email correspondence via chain sampling (see Appendix A). Snowball or chain sampling is a sampling technique that has been identified as a valid means for gaining access to populations that may be difficult to access (Patton, 2002). This process entailed identifying organizations, list servers, or websites and asking these organizations to forward this information to others who may be interested in taking the survey.

Potential participants received the electronic announcement of the study as well as a link that could be used to access the study. Once participants accessed the link, they were taken to a webpage that provided information about the survey. If they chose to participate, participants were taken to the complete survey including: Demographic Questionnaire (Appendix C), Self-Compassion Scale Short Form (Appendix D), Zung Self-Rating Depression Scale (Appendix E), Satisfaction with Life Scale (Appendix F), Scales of Psychological Well-Being (Appendix G), and the Trauma Symptom Checklist-40 (Appendix H).

If participants did not endorse the previously mentioned statement, they were taken to another webpage that said the following: "Based on your previous response you are not eligible to complete this survey. Thank you so much for your time and your interest in this study." The survey then ended for these participants. Participants that endorsed the question completed all other measures. A total number of 136 items were included in this survey.

Data Analysis and Hypotheses

Scores on the Self-Compassion Scale, Scales of Psychological Well-Being, Trauma Symptom Checklist-40, Zung Self-Rating Depression Scale, and the Satisfaction with Life scale were calculated. The Self-Compassion scale required that appropriate items be reverse scored prior to the mean score of the subscales being calculated. Subscales on the Self-Compassion Scale and the Scales of Psychological Well-Being were also calculated. Statistical analysis was conducted to explore a mediator relationship, with self-compassion mediating the relationship between maltreatment-related symptom severity and psychological well-being.

The model of mediation used asserts that a construct intervenes between stimulus and response. There are several general analytic considerations that must be made. The variable (self-compassion) was seen to serve as a mediator when it meets the following conditions: “(a) variations in levels of the independent variable significantly accounts for variations in the presumed mediator (path a), (b) variations in the mediator significantly account for variations in the dependent variable (path b), and (c) when paths a and b are controlled, a previously significant relation between the independent and dependent variables is no longer significant, with the strongest demonstration of mediation occurring when path c is zero” (Barron & Kenny, 1986).

To verify this relationship, several steps were taken. First, the relationship between trauma symptom severity and psychological well-being was explored. There must be a significant correlation between these two scores. Then the relationship between maltreatment-related symptom severity and self-compassion was explored. There must be a significant correlation between these two scores. The relationship between self-compassion and psychological well-being was explored and must yield a significant correlation. Finally, the

initial relationship between trauma symptom severity and psychological well-being was re-evaluated including the influence of self-compassion.

If the previously stated hypotheses are correct, the relationship between trauma symptom severity and psychological well-being were influenced by self-compassion. More specifically, if self-compassion serves as a mediator between trauma symptom severity and psychological well-being, then as self-compassion increases or decreases, the relationship between trauma symptom severity and psychological well-being will also change. It is hypothesized that higher levels of maltreatment-related symptom severity will correlate with lower levels of psychological well-being. Alternatively, lowers levels of trauma symptom severity will correlate with higher levels of psychological well-being. Should self-compassion serve as a mediator, the previously mentioned levels of maltreatment-related symptom severity and psychological well-being will fluctuate based on levels of self-compassion.

Testing mediation. To establish mediation, there are several conditions that must hold true. The first condition is that the independent variable must affect the mediator in the first equation. The second condition is that the independent variable must be shown to affect the dependent variable. The third condition is that the mediator must affect the dependent variable in the third equation (Baron & Kenny, 1986). Mediation is a causal chain of hypothesis testing. In mediation, one variable affects a second variable. The second variable then affects a third variable. With this link between the variables, the second variable serves to mediate the relationship between a predictor variable and an outcome variable. For the purposes of this study, childhood maltreatment-related symptom severity is the first variable that affects the second variable which is self-compassion. Self-compassion in turn affects the third variable which is psychological well-being. Therefore, in accordance with the model of mediation, self-

compassion serves to mediate the relationship between childhood maltreatment-related symptom severity and psychological well-being. When all the regression equations were completed, the significances of multiple pathways of prediction between the variables were observed.

Testing mediation requires conducting four regression equations. The first equation is a regression analysis with the first variable predicting the third variable. For this study this regression equation examines the predictive ability of childhood maltreatment-related symptom severity for predicting psychological well-being. This regression analysis establishes a relationship between the severity of symptoms following childhood maltreatment and psychological well-being later in life. This equation represents path c in the mediation model (see Figure 1).

The second regression equation involves conducting a simple regression analysis with the first variable predicting the second variable. For the purposes of this study, this equation will examine the relationship between childhood maltreatment-related symptom severity and self-compassion. This equation will establish a predictive relationship between childhood maltreatment-related symptom severity and self-compassion. This equation represents path a in the regression model (Figure 2).

The third equation involves conducting a simple regression analysis with the second variable predicting the third variable. This equation will involve conducting a regression analysis with self-compassion predicting psychological well-being. This equation represents path b in the regression model.

The first three regression equations are conducted to establish that zero-order relationship among the variables exists (MacKinnon, Fairchild, & Fritz, 2007). If the relationship between these variables is found to be significant using regression, the fourth equation must be conducted.

The fourth equation conducts a multiple regression analysis with the first variable predicting the second variable. This equation will conduct a multiple regression analysis with childhood maltreatment-related symptom severity predicting self-compassion. A form of mediation (full or partial) will be supported if the effect of path b is still significant once childhood maltreatment-related symptoms are controlled for.

Sobel (1982) provided an approximate significant test for effects of the mediator variable on the independent and dependent variables. This must be done so that the investigator can examine the absolute effect size in addition to the level of significance in the regressions. This relationship was explored in both sample groups (males who have endured childhood maltreatment and males who have not endured childhood maltreatment).

Overall, participants' calculated scores on the Self-Compassion Scale Short Form, Zung Self-Rating Depression Scale, Satisfaction with Life Scale, Scales of Psychological Well-Being, and the Trauma Symptom Checklist-40 were determined using directions specific to each measure to obtain the score on that measure. These scores were then used in multiple regression equations to determine the mediating effect of self-compassion on maltreatment-related symptoms and psychological well-being among male survivors of childhood maltreatment.

Chapter 4: Results

The National Child Abuse and Neglect Data System (NCANDS) asserts that between 695,000 and 754,000 children experience abuse or neglect prior to the age of 18. The United States Census Bureau's *Current Population Reports* indicates that in the year 2010 there were approximately 74 million children in the United States (Census Bureau, 2010). While prevalence rates are likely to vary, these statistics suggest that approximately 10% of children in the United States experience maltreatment prior to the age of 18. Maltreatment is understood to be one or more incidents of neglect or abuse whether physical, sexual, or emotional (Bernstein et al., 1994; Cook, Chaplain, Sinha, Tebes & Mayes, 2012).

Childhood maltreatment can negatively impact various areas of functioning for the survivor well into adulthood; these effects can be seen when looking at four broad categories of functioning: behavior, social, cognitive, and emotional (Kendall-Tackett, 2002). Difficulties in one or more areas of functioning can serve to decrease one's perceived psychological well-being (Kendall-Tackett). While the impacts of childhood maltreatment alone can have adverse impacts on the survivor, research asserts that the impact of sex/gender may serve to further exacerbate such impacts. Mejia (2005) stated that young boys experience ongoing socialization in order to become what is considered to be "acceptably male" within a given society. In the United States this socialization process of males contributes greatly to several responses that may serve to further decrease psychological well-being, including restricted emotional responses, relationship difficulties, and an inability to express and communicate feelings.

Although perceived psychological well-being can be significantly reduced following a traumatic experience and further impacted by virtue of being male, psychological well-being may be increased by a number of factors. Of these factors, self-compassion is currently being

researched as a contributor to psychological well-being following trauma exposure (Neff, 2003a; Neff, Leary, & Hoyle, 2009; Neff, Rude, & Kirkpatrick, 2007). Current research is beginning to explore the relationship between self-compassion and psychological well-being but more research is needed (Baer, Lynkins, & Peters, 2012; Neely et al., 2009; Van Dam et al., 2010). Although there is a current understanding that sex/gender can exacerbate symptoms following trauma exposure, no research to date has explored the relationship between self-compassion and psychological well-being for male survivors of childhood maltreatment. Given the void in current literature, the following research question was proposed: does self-compassion influence the relationship between trauma symptom severity and psychological well-being when examined within a sample of male survivors of childhood maltreatment.

In this chapter a review of the hypotheses that were tested in the study is provided. Additionally, descriptive statistics about the sample of individuals who participated in this study are provided. Finally, statistical analyses that were conducted to confirm or disconfirm the hypotheses are outlined.

Hypotheses

Based on the available literature, four hypotheses were proposed. Hypothesis 1: It was hypothesized that there would be a negative correlation between trauma symptom severity following childhood trauma and self-compassion. Hypothesis 2: It was hypothesized that there would be a negative correlation between trauma symptom severity and psychological well-being. Hypothesis 3: It was hypothesized that there would be a positive correlation between self-compassion and psychological well-being. Hypothesis 4: It was hypothesized that self-compassion would mediate the relationship between trauma symptom severity and psychological well-being.

A number of measures were included to assess the variable of interest: self-compassion, trauma or maltreatment, well-being, and life satisfaction. As was noted in chapters two and three, self-compassion is identified as the ability for one to be kind to oneself, to recognize suffering as a human experience, and to be mindful and balanced in one's approach to life (neither amplifying nor subduing one's negative emotions that may be experienced). The Self-Compassion Scale short form (SCS) is a 12-item measure that was used to assess self-compassion, being that this form has fewer items than the original measure but yields valid and reliable measures of self-compassion (Raes, Pommier, Neff, & Van Gucht, 2011). In the current study the Trauma Symptom Checklist-40 (TSC) was used to assess trauma symptom severity. The Trauma Symptom Checklist is a 40-item measure that yields an overall trauma symptom severity score and provides six subscales: anxiety, depression, dissociation, sexual abuse trauma index, sexual problems, and sleep disturbances (Brier & Runtz, 1989). In order to assess well-being, three measures were used: the Scales of Psychological Well-Being, the Satisfaction with Life Scale, and the Zung Depression Scale. The Scales of Psychological Well-Being (PWB) is a 54-item measure that assesses six facets of well-being: autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance (Ryff & Keyes, 1995). Additionally, Satisfaction with Life Scale (SWL) is a five-item measure that assesses one's subjective satisfaction with life (Diener, Emmons, Larsen, & Griffin, 1985). Lastly, the Zung Depression Scale (ZDS), a 20-item self-report scale, was used to assess depressive symptoms.

To test this mediating relationship, correlations to examine the relationship between self-compassion, trauma symptom severity, and psychological well-being were conducted. It was hypothesized that among the sample of males who had experienced childhood maltreatment,

there would be a negative correlation between trauma symptom severity and psychological well-being. This suggests that males who experienced childhood maltreatment and had higher levels of trauma symptom severity would also have lower levels of psychological well-being. It was also hypothesized that among this sample of men there would be a positive correlation between self-compassion and psychological well-being. This means that males who experienced childhood maltreatment but had higher levels of self-compassion would also report higher levels of psychological well-being. Lastly, it was hypothesized that there would be a negative correlation between trauma symptom severity and self-compassion. This hypothesis suggests that males who experienced childhood trauma and reported higher levels of trauma symptom severity would also likely report lower levels of self-compassion. Once a relationship between the variables (self-compassion, trauma symptom severity, and psychological well-being) was established, the mediating effect of self-compassion on the relationship between trauma symptom severity and psychological well-being was examined.

Reliability. In addition to an examination of the correlation between measures, the internal consistency of each measure was also assessed to determine the reliability of each psychometric measure within the research sample ($n=165$). When examining the internal consistency of the Trauma Symptom Checklist it was found that internal consistency was excellent ($\alpha=.939$). The internal consistency of the Satisfaction with Life Scale ($\alpha=.894$), the Self-Compassion Scale ($\alpha=.802$), and the Scales of Psychological Well-Being ($\alpha=.782$) were found to be good. The internal consistency of the Zung Depression Inventory was found to be poor ($\alpha=.534$).

Overview of mediation. In order to determine whether self-compassion mediated the relationship between trauma symptom severity and psychological well-being, it was necessary to

conduct a number of steps. The first step consisted of a simple regression analysis with childhood maltreatment-related symptom severity predicting psychological well-being. The second regression analysis consisted of a simple regression analysis with childhood maltreatment-related symptom severity predicting self-compassion. Next, a simple regression analysis was conducted with self-compassion predicting psychological well-being. The first three regression equations were conducted in order to establish a zero-order relationship among the variables. Since significance was found, the fourth and final analysis was conducted. A multiple regression analysis was conducted with childhood maltreatment-related symptom severity predicting self-compassion.

Descriptive Statistics

Three-hundred and ninety-nine individuals completed the online survey that was available for an 8-week period. Prior to performing data analysis, respondents who did not self-identify as male, did not identify as over 18 years of age, and/or did not complete the entire survey were removed (234 participants), resulting in a sample of 165 participants. For the 165 participants who self-identified as male and were 18 years of age or older, the mean age was 26.75 years ($SD= 11.16$). Males who reported having experienced childhood maltreatment ($n=63$) were slightly older on average ($M= 28.00$, $SD= 11.86$) than those who did not report having experienced ($n=102$) childhood maltreatment ($M= 26.00$, $SD= 10.71$). The racial/ethnic diversity of this sample was representative of the current racial/ethnic diversity observed in the United States of America according to the 2010 United States Census Bureau (U.S. Census Bureau, 2010).

The racial/ethnic percentages remained comparable when examining respondents who reported having endured childhood maltreatment and respondents who reported having

experienced no childhood maltreatment (Table 4). When examining respondents who reported having experienced childhood maltreatment, the largest percentage of respondents identified as Caucasian/White (81%). Respondents who identified as African American/Black represented the next highest racial/ethnic group (10%). This trend was consistent when examining respondents who reported no childhood maltreatment, with Caucasian/White representing the highest percentage of respondents (72%) and African American/Black representing the next highest percentage of respondents (16%).

In addition to age and ethnic/racial identity of male respondents, data was also collected to better understand how the respondents became aware of the survey, being that the survey was a widely distributed web-based survey—the survey was distributed through a variety of web-based forums including e-mail, SONA (an online research informational site provided through the University), list servers, social networking sites such as Facebook, and websites for survivors of trauma. Over half of the respondents, 65%, reported having accessed the survey through SONA with smaller percentages of respondents reporting accessing the survey through “other” online resources (15%), Facebook (13%), emails from various organizations (7%), or list servers (1%). When examining respondents who reported experiencing childhood maltreatment with respondents who did not report childhood maltreatment it was observed that the greatest percentage of respondents reported accessing the survey through SONA (55% and 71% respectively), followed by accessing the survey through “other” online resources (19% and 12% respectively). The average response time to complete the study was 18 minutes and 50 seconds.

Within this research sample, 38% of the respondents endorsed having experienced childhood maltreatment (n=63). For the purpose of this research, a positive endorsement of childhood maltreatment include one or more instances of physical abuse, physical neglect,

emotional abuse, emotional neglect, and/or sexual abuse occurring before the age of 18. Of the 38% of respondents that endorsed childhood maltreatment, 22% reported physical abuse, 7% reported physical neglect, 22% reported emotional abuse, 21% reported emotional neglect, and 8% reported sexual abuse. Respondents were able to endorse as many instances of maltreatment as they had experienced. While 62% of the sample ($n=102$) endorsed no instance of maltreatment, of the 38% who experienced maltreatment ($n=63$), the majority of respondents reported more than one type of abuse or neglect experienced prior to the age of 18. Table 5 identifies the frequency with which respondents endorsed various types of childhood maltreatment. Respondents who endorsed having experienced no childhood maltreatment were placed in the “0” category, respondents who reported one form of maltreatment were placed in the “1” category, respondents who endorsed two types of maltreatment were placed in the “2” category, and so forth.

Descriptive Analyses

Respondents in this study were asked to complete five measures. These measures were the Self-Compassion Scale (SCS), Zung Depression Scale (ZDS), Satisfaction with Life Scale (SWL), Trauma Symptom Checklist (TSC), and the Scales of Psychological Well-Being (PWB). Each scale yields a total score which allows respondents’ scores to be compared to one another and allows for calculation of the mean scores for a given measure.

Self-Compassion Scale. Scores for the Self-Compassion Scale range from 1 to 5, with 1 indicating a low level of self-compassion and 5 indicating a higher level of self-compassion. Scores for the Self-Compassion Scale for the childhood maltreatment group ($M=2.83$, $SD= 0.63$) were lower than self-compassion scale scores for the no childhood maltreatment group ($M=3.40$, $SD= 0.63$). An independent-samples t test was conducted to evaluate the difference between

these two groups on levels of self-compassion. The test was significant, $t(163) = -5.68, p = .00$. Respondents in the childhood maltreatment group on average reported lower levels of self-compassion than those in the no childhood maltreatment group.

Zung Depression Scale. When examining scores for depression using the Zung Depression Scale the highest possible score is 80 with most individuals scoring between 50 and 69. The higher the score on this measure, the higher the respondent's level of depression. Scores for the Zung Depression scale for the childhood maltreatment group ($M=42.75, SD= 9.35$) were higher than the depression scale scores for the no childhood maltreatment group ($M=34.50, SD= 7.65$). An independent-samples t test was conducted to evaluate the difference between these two groups on levels of depression. The test was significant, $t(163) = 6.17, p = .00$. Respondents in the childhood maltreatment group, on average, reported higher levels of depression than those in the no childhood maltreatment group.

Satisfaction with Life Scale. The Satisfaction with Life Scale yields scores that indicate low, moderate, or high life satisfaction. Scores from 5-17 indicate a low level of life satisfaction, scores from 18-29 indicate a moderate level of life satisfaction, and scores 30-35 indicate high levels of life satisfaction. Scores for the Satisfaction with Life scale for the childhood maltreatment group ($M=20.44, SD= 6.77$) were lower than the satisfaction with life scores for the no childhood maltreatment group ($M=25.97, SD= 6.18$).

An independent-samples t test was conducted to evaluate the difference between these two groups on levels of satisfaction with life. The test was significant, $t(163) = -5.38, p = .00$. Respondents in the childhood maltreatment group, on average, reported lower levels of depression than those in the no childhood maltreatment group.

Trauma Symptom Checklist-40. The Trauma Symptom Checklist yields scores that indicate trauma symptom severity with higher scores indicating higher symptom severity. Scores for the trauma symptom checklist for the childhood maltreatment group ($M=76.67$, $SD= 23.29$) were higher than the trauma symptom severity scores for the no childhood maltreatment group ($M=60.06$, $SD=16.59$).

An independent-samples t test was conducted to evaluate the difference between these two groups on levels of symptom severity. The test was significant, $t(163) = 5.34$, $p = .00$. Respondents in the childhood maltreatment group, on average, reported higher levels of trauma symptom severity than those in the no childhood maltreatment group.

Although the childhood maltreatment group on average reported higher levels of trauma symptom severity, it is important to note that the no maltreatment group on average did report a mean score of 60.6. This score may be accounted for by the type of measure used to assess symptom severity. The Trauma Symptom Checklist assesses six subscales: anxiety, depression, dissociation, sexual abuse trauma index, sexual problems, and sleep disturbances (Brier & Runtz, 1989). Although an individual may not have experienced trauma during childhood, it is possible that an individual experienced traumatic experiences during adulthood that may account for an increase in symptoms. Additionally, it is possible that respondents may have concerns with any given subscale without having endured maltreatment in childhood.

Scales of Psychological Well-Being. Lastly, the Scales of Psychological Well-Being yield scores that indicate psychological well-being with higher scores indicating higher well-being. Scores for the Scales of Psychological Well-Being for the childhood maltreatment group ($M=35.79$, $SD= 6.23$) were lower than the psychological well-being scores for the no childhood maltreatment group ($M= 40.56$, $SD= 6.340$). An independent-samples t test was conducted to

evaluate the difference between these two groups on levels of psychological well-being. The test was significant, $t(163) = -4.70, p = .00$. Respondents in the childhood maltreatment group, on average, reported lower levels of psychological well-being than those in the no childhood maltreatment group.

Correlations

Prior to the mediation analyses being conducted on the two groups (childhood maltreatment and no childhood maltreatment), several correlations were conducted. The aim of conducting these analyses was to ensure that there was a relationship between the variables to be mediated. According to the mediation hypothesis two variables are correlated and this relationship occurs through one variable's relationship to another (Barry & Kenny, 1986). It is therefore imperative to examine whether or not a relationship exists between the variables. First, the relationship between trauma symptom severity and psychological well-being was examined. Three measures were used to measure psychological well-being (Scales of Psychological Well-Being, Satisfaction with Life Scale, and Zung Depression Scale).

Within the childhood maltreatment group, the correlation between trauma symptom severity and psychological well-being was strong when psychological well-being was measured by the Scales of Psychological Well-Being, $r(63) = -.55, p < .01$; strong when psychological well-being was measured with the Satisfaction with Life Scale, $r(63) = -.55, p < .01$; and strong when measured with the Zung Depression Scale, $r(63) = .69, p < .01$. Within the no childhood maltreatment group, the correlation between trauma symptom severity and psychological well-being was strong when psychological well-being was measured by the Scales of Psychological Well-Being, $r(102) = -.45, p < .01$; weak when psychological well-being was measured with the

Satisfaction with Life Scale, $r(102) = -.39, p < .01$; and strong when measured with the Zung Depression Scale, $r(102) = .56, p < .01$ (see Table 1).

Next, the relationship between trauma symptom severity and self-compassion was examined. Within the childhood maltreatment group, the correlation between trauma symptom severity and self-compassion was strong, $r(63) = -.58, p < .01$. Within the no childhood maltreatment group, the correlation between trauma symptom severity and self-compassion was weak, $r(102) = -.34, p < .01$.

Lastly, the relationship between psychological well-being and self-compassion was examined (Table 2). Three measures were used to measure psychological well-being (Scales of Psychological Well-Being, Satisfaction with Life Scale, and Zung Depression Scale). Within the childhood maltreatment group, the correlation between self-compassion and psychological well-being was strong when psychological well-being was measured by the Scales of Psychological Well-Being, $r(63) = .66, p < .01$; strong when psychological well-being was measured with the Satisfaction with Life Scale, $r(63) = .62, p < .01$; and strong when measured with the Zung Depression Scale, $r(63) = -.71, p < .01$. Within the no childhood maltreatment group, the correlation between self-compassion and psychological well-being was strong when psychological well-being was measured by the Scales of Psychological Well-Being, $r(102) = .62, p < .01$; strong when psychological well-being was measured with the Satisfaction with Life Scale, $r(102) = .50, p < .01$ and; strong when measured with the Zung Depression Scale, $r(102) = -.65, p < .01$.

Mediation Analyses

Mediation was conducted using the four steps proposed by Baron and Kenny. This mediation model proposes four paths to mapping mediation (see Figure 2). The mediation

hypothesis used to guide this research states that two variables are correlated through one or more mediating variables. This mediation hypothesis asserts that two variables are correlated (for example variable A is correlated with variable B) and that this correlation is because variable A is related to variable B through one or more additional variables known as the mediating variables (Baron & Kenny, 1986). Mediation was conducted in this study to examine the relationship between trauma symptom severity and psychological well-being and how this relationship may be occurring through a third mediating variable, self-compassion.

According to the mediation model, the initial step is to determine whether or not the independent variable is associated significantly with the dependent variable. This represents path c in the mediation path analysis (Figure 2). The next step in the mediation process is to determine whether or not the independent variable is associated with the mediator variable. This represents path a in the mediation path analysis. Analysis was then conducted to determine if the mediator and dependent variable were significantly related. Lastly, analysis was conducted to determine whether or not the mediator variable is associated significantly with the dependent variable when controlling for the independent variable. This analysis represents path c'.

To conduct the initial step and determine if the independent variable was associated with the dependent variable, the relationship between trauma symptom severity (measured using the Trauma Symptom Checklist-40) and psychological well-being (measured by three measures, the Scales of Psychological Well-Being, the Satisfaction with Life Scale, and the Zung Depression Scale) was assessed. This comparison yielded three separate correlations given that three separate measures of psychological well-being were used. When looking at the childhood trauma group and using the Scales of Psychological Well-Being, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = -.55$) was significant, $t(62) = -5.09$, $p < .01$.

When psychological well-being is measured by the Satisfaction with Life Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = -.56$) was significant, $t(62) = -5.19$, $p < .01$. When psychological well-being is measured by the Zung Depression Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = .69$) was significant, $t(62) = 7.54$, $p < .01$.

Analysis was also conducted on the no childhood maltreatment group. When looking at the no childhood trauma group and using the Scales of Psychological Well-Being, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = -.45$) was significant, $t(101) = -5.02$, $p < .01$. When psychological well-being was measured by the Satisfaction with Life Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = -.39$) was significant, $t(101) = -4.25$, $p < .01$. When psychological well-being was measured by the Zung Depression Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = .56$) was significant, $t(101) = 6.73$, $p < .01$.

To conduct the next step in the mediation model, analyses were conducted to determine whether or not the independent variable was associated with the mediator variable. The independent variable in this study is trauma symptom severity (measured by the Trauma Symptom Checklist-40) and the dependent variable in this study is self-compassion (measured by the Self-Compassion Scale). When looking at the childhood maltreatment group, the beta weight for trauma symptom severity predicting self-compassion ($\beta = -.582$) was significant, $t(62) = -5.596$, $p < .01$. This analysis was also conducted within the no childhood maltreatment group, in which the beta weight for trauma symptom severity predicting self-compassion ($\beta = -.338$) was significant, $t(101) = -3.593$, $p < .05$.

Next, analysis was conducted to determine whether or not the mediator variable was associated significantly with the dependent variable. In this study the mediator variable was self-compassion (measured by the Self-Compassion Scale), and the dependent variable was psychological well-being (measured by three measures, the Scales of Psychological Well-Being, the Satisfaction with Life Scale, and the Zung Depression Scale). When looking at the childhood trauma group and using the Scales of Psychological Well-Being, the beta weight for self-compassion predicting psychological well-being ($\beta = -.243$) was significant, $t(62) = -2.12$, $p < .05$. When psychological well-being was measured by the Satisfaction with Life Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = -.298$) was significant, $t(62) = -2.491$, $p < .05$. When psychological well-being was measured by the Zung Depression Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = .424$) was significant, $t(62) = 4.357$, $p < .01$.

Analysis was also conducted for the no childhood maltreatment group. When looking at the no childhood trauma group and using the Scales of Psychological Well-Being, the beta weight for self-compassion predicting psychological well-being ($\beta = -.269$) was significant, $t(102) = -3.40$, $p < .01$. When psychological well-being was measured by the Satisfaction with Life Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = -.250$) was significant, $t(102) = -2.811$, $p < .01$. When psychological well-being was measured by the Zung Depression Scale, the beta weight for trauma symptom severity predicting psychological well-being ($\beta = .384$) was significant, $t(102) = 5.343$, $p < .01$.

Lastly, analysis was conducted to determine whether or not the mediator variable was associated significantly with the dependent variable when controlling for the independent variable. In this study, the mediator variable was self-compassion (measured using the Self-

Compassion Scale), the dependent variable was psychological well-being (measured by the Scales of Psychological Well-Being, Satisfaction with Life Scale, and the Zung Depression Scale), and the independent variable was childhood trauma (measured by the Trauma Symptom Checklist-40). According to the Baron and Kenny model, the analysis of the relationship between the aforementioned variables represents path c'. When looking at the childhood maltreatment group and using the Scales of Psychological Well-Being as the measure of psychological well-being, the beta weight when examining whether self-compassion was associated with psychological well-being, while controlling for childhood maltreatment ($\beta = -.52$), was significant, $t(62) = 4.54, p < .01$. When psychological well-being was measured by the Satisfaction with Life Scale, the path c' remains significant ($\beta = .44$), $t(62) = 3.68, p < .01$. When psychological well-being was measured by the Zung Depression Scale, path c' remains significant ($\beta = -.47$), $t(62) = -4.78, p < .01$. When looking at the childhood maltreatment group and using the Scales of Psychological Well-Being as the measure of psychological well-being, the beta weight when examining whether or not self-compassion was associated significantly with psychological well-being, controlling for childhood maltreatment ($\beta = .53$) was significant, $t(101) = 6.71, p < .01$. When psychological well-being was measured by the Satisfaction with Life Scale, the path c' remained significant ($\beta = .42$), $t(101) = 4.70, p < .01$. When psychological well-being was measured by the Zung Depression Scale, the path c' remained significant ($\beta = -.52$), $t(101) = -7.18, p < .01$.

Once paths a, b, c, and c' were computed, the mediation path analyses were completed for both the childhood maltreatment group (see Figures 3, 4, and 5) and the no childhood maltreatment group (see Figures 6, 7, and 8). Each of the analyses was completed using the three measures of psychological well-being: Scales of Psychological Well-Being, Satisfaction with

Life Scale, and the Zung Depression Scale. Sobel tests were also conducted on the mediation models. Full mediation was not supported; however, self-compassion served as a partial mediator between trauma symptom severity and psychological well-being. Sobel tests showed a significant drop in the relationship between trauma symptom severity and psychological well-being. Although this drop did occur, trauma symptom severity did remain the most significant predictor of well-being.

Summary of Findings

Overall, it was found that the mediator variable, self-compassion, partially mediated the relationship between trauma symptom severity and psychological well-being. Several analyses were conducted to confirm this mediation. Initially correlation analyses between the variables within this sample were conducted to ensure that a mediation analysis could be conducted. When examining the relationship between the trauma symptom severity and psychological well-being among a sample of males who experienced childhood maltreatment, it was found that there was a significant relationship between these variables. It was also found that there was a relationship between trauma symptom severity and self-compassion, as well as self-compassion and psychological well-being. Three measures of psychological well-being, the Scales of Psychological Well-Being, the Zung Depression Scale, and the Satisfaction with Life Scale were used. Next, the mediation analyses were conducted. When conducting the analysis partial mediation was determined. It was found that the relationship between trauma symptom severity and psychological well-being was reduced when self-compassion was used as a mediating variable. According to the mediation model, the relationship between the initial variables (trauma symptom severity and psychological well-being in this research) is reduced if the mediator variable accounts for part or all of the initial relationship between the variables. Findings from

the analysis indicated that self-compassion did not fully mediate the relationships; however, a partial mediation was found.

Chapter 5: Discussion

The focus of the current study was to understand the relationship between self-compassion, trauma symptom severity, and psychological well-being. More specifically, analysis was conducted to examine the mediating effect of self-compassion on trauma symptom severity and psychological well-being for males who experienced childhood maltreatment.

Current research has asserted that the negative impacts of having endured childhood maltreatment can be severe and persist into adulthood. Kendall-Tackett (2002) argues that the possible negative effects can be classified into four broad categories of consequence: (a) behavioral effects, (b) social effects, (c) cognitive effects, and (d) emotional effects (Kendall-Tackett). One of the possible negative consequences, literature asserts, is that a decrease in psychological well-being can be observed (Dhaliwal, Gauzus, & Ross, 1996). Literature also indicates that one's gender may serve to exacerbate negative symptoms following childhood maltreatment (Mejia, 2005).

Although literature has explored social support, positive coping strategies, and religious beliefs as protective factors following difficult life events, one variable that holds promise as a protective factor is self-compassion (Dervic, Grunebaum, Burke, Man, & Oquendo, 2006; Runtz & Schallow, 1997). Self-compassion has been found to have a positive relationship with psychological well-being (Gilbert, 2005). Thompson and Waltz (2008) explored the relationship between self-compassion and post-traumatic symptoms. Thompson and Waltz found that those who had lower levels of self-compassion were more likely to engage in avoidant behaviors in an attempt to avoid emotional triggers of past traumas. As a result, it was suggested that abuse survivors and those who suffer from post-traumatic stress disorder may benefit from therapy that includes aspects of self-compassion. Although current literature asserts that there is likely a

relationship between self-compassion and psychological well-being, this literature is limited (Gilbert, 2005; Neff, 2004, Tate, Adams, Allen, and Hancock, 2007). Self-compassion has been identified in the literature as an area for future study when attempting to reduce the impact of negative life events. Self-compassion has been identified as a possible preventive factor for those who have experienced negative life events (Neff, 2003). In an attempt to understand the relationship between self-compassion, trauma symptom severity, and psychological well-being among male survivors of childhood maltreatment, the following hypotheses were proposed:

1. Is there a relationship between trauma symptom severity following childhood trauma and self-compassion? It is hypothesized that there will be a negative correlation between trauma symptom severity following childhood trauma and self-compassion.
2. Is there a relationship between trauma symptom severity and psychological well-being? It is hypothesized that there will be a negative correlation between trauma symptom severity and psychological well-being.
3. Is there a relationship between self-compassion and psychological well-being? It is hypothesized that there will be a positive correlation between self-compassion and psychological well-being.
4. Does self-compassion influence the relationship between trauma symptom severity and psychological well-being? It is hypothesized that self-compassion will moderate the relationship between trauma symptom severity and psychological well-being.

Findings

This study explored self-compassion as a preventative factor for males who experienced childhood maltreatment. To explore the mediating effects of self-compassion, the researcher completed four analyses. Prior to completing the analyses the researcher conducted correlation

analyses to examine the relationship between the variables. When looking specifically at the childhood maltreatment group, the relationships between the three variables (trauma symptom severity, psychological well-being, and self-compassion) were strong. This indicates that there is a strong relationship between these variables within this all-male sample to be explored through mediation.

Results indicate that the mediator variable, self-compassion, partially mediated the relationships between trauma symptom severity and psychological well-being. It was found that the relationship between trauma symptom severity and psychological well-being was reduced when self-compassion was used as mediating variable. According to the mediation model the relationship between the initial variables (trauma symptom severity and psychological well-being in this research) is reduced if the mediator variable accounts for part or all of the initial relationship between the variables. Findings from the analysis indicated that self-compassion did not fully mediate the relationships, however, a partial mediation was found.

The first step in this mediation consisted of determining whether or not trauma symptom severity was associated significantly with psychological well-being (measured by three separate measures: Scales of Psychological Well-Being, Zung Depression Scale, and Satisfaction with Life Scale). When examining the relationship between the variables with each of the measures, all were found to yield a significant relationship. Literature provides strong support that an increase in depressive symptoms can result from childhood maltreatment (Brier & Elliot, 1994; Dhaliwal, Gauzus, & Ross, 1996). Additionally, literature also provides support for the relationship between trauma symptom severity and psychological well-being even when not assessed specifically by the Zung Depression Scale. Current research indicates that many areas of functioning can be decreased following childhood maltreatment (Kendall-Tackett, 2002).

The next step in this mediation involved determining whether or not trauma symptom severity was associated with self-compassion. The results of this regression equation indicate that the relationship between trauma symptom severity and self-compassion is significant. Previous psychological research provides support for the relationship between trauma symptom severity and self-compassion (Gilbert & Procter, 2006; Thompson & Waltz, 2008).

Next, the researcher conducted analyses to determine if self-compassion and psychological well-being (measured by three separate measures: Scales of Psychological Well-Being, Zung Depression Scale, and Satisfaction with Life Scale) were significantly related. When examining the relationship between the variables with each of the measures, all were found to yield a significant relationship. Previous research shows support for the relationship between self-compassion and psychological well-being (Gilbert, 2005; Neff, 2004; Wei, Liao, Ku, & Shaffer, 2011).

Lastly, analyses were conducted to determine whether or not self-compassion was associated significantly with psychological well-being when controlling for trauma symptom severity. Results indicate that self-compassion was significantly associated with psychological well-being even when controlling for trauma symptom severity. This finding indicates that there is a predictive relationship between self-compassion and psychological well-being even when trauma symptom severity is controlled for.

Research Implications

Should further research be conducted to examine the effect of self-compassion on psychological well-being, factors that contribute to psychological well-being should be explored. The results indicate that self-compassion is a partial mediator, suggesting that while self-compassion affects this relationship, it is highly probable that additional variables contribute as

well. When examining the relationship between trauma symptom severity and psychological well-being, previous research has found that other factors serve as protective factors following childhood maltreatment including social support, religion/spirituality, and mindfulness (Allgower, Wardle, & Steptoe, 2001; Baer, Lynkins, & Peters, 2012; Dervic, Grunebaum, Burke, Mann, & Oquendo, 2006). Due to the complexity of reactions following the endurance of trauma, and the wealth of risk and protective factors, it stands to reason that one factor will not fully account for the relationship between trauma symptom severity and psychological well-being. Future research should examine variables that may contribute to the mediating effects of self-compassion within this sample.

Being that self-compassion was shown to partially mediate the relationships between trauma symptom severity and psychological well-being among male survivors of childhood maltreatment, future research exploring how self-compassion can be increased and promoted among male survivors may be helpful. Literature has provided support for the effects of gender and how being male may serve to enhance negative symptoms following trauma (Mejia, 2005). The results of this study show preliminary support for self-compassion partially mediating the relationship between trauma symptom severity and psychological well-being. Future research to explore how self-compassion may be increased specifically among male survivors of childhood maltreatment would serve to provide practical applications of these findings.

Future researchers can improve on these findings by exploring a treatment modality that serves to increase self-compassion among male survivors of childhood maltreatment. This type of research would serve to explore how an increase of self-compassion may increase the psychological well-being for men who have experienced childhood maltreatment. As previous studies have indicated, male survivors represent a unique population with protective and risk

factors that are specific to these survivors. Studies that explore the implementation of interventions within this population would be beneficial to continue to expand the literature. Gilbert and Proctor (2006) has previously conducted studies to examine the impact of self-compassion training for individuals with high levels of shame and self-criticism. Findings of this study showed that overall participants showed reductions in depression, anxiety, shame, and self-criticism. Future research may implement this self-compassion training within an all-male sample of subjects who have experienced childhood maltreatment to explore if the previous findings hold true within this population.

Practical Applications

The results of this study provide preliminary support for the mediating effect of self-compassion on the relationship between psychological well-being and trauma symptom severity for male survivors of childhood maltreatment. These results may be applied in a clinical setting in several ways. The clinician may work with a male survivor to increased self-compassion to promote well-being and more adaptive psychological functioning. Previous literature indicates that psychological well-being may be reduced among male survivors and may be seen across several areas of functioning (Kendall-Tackett, 2002; Mejia, 2005). Should the clinician work to promote self-compassion, these negative symptoms and decreased sense of well-being may be reduced. Gilbert and Proctor (2006) explore the compassionate mind training for people with high shame and self-criticism. The results of this study indicate that individuals who participated in this training showed reductions in depression, anxiety, shame, and self-criticism. Clinicians working with male survivors of childhood maltreatment who report high negative symptoms and decreased psychological well-being would likely benefit from working to increase and enhance self-compassion.

Additionally, this research can provide insight into the protective factors that may be more or less beneficial for male survivors. Research shows that there are protective factors that serve to promote psychological well-being following childhood maltreatment. This research provides insight into how one protective factor in particular can help male survivors. When considering clinical applications, this research may serve as a reminder for those practicing that there may be protective factors that are more or less beneficial to promote within a male population of childhood survivors.

Limitations

Although this study provided preliminary data to suggest that self-compassion does partially mediate the relationship between trauma symptom severity following childhood maltreatment and psychological well-being, there are limitations to this study. The most notable limitation is the recruitment of the sample. Although the research survey was distributed widely online, the greatest percentage of respondents accessed the survey through SONA. The only individuals with access to this SONA site were college students at a medium-sized university. Sixty-five percent of individuals who reported having experienced childhood maltreatment accessed the survey through SONA and 55% of individuals who did not report childhood maltreatment accessed the survey through SONA. The mean age of the sample was 26.75 years ($SD= 11.16$). Respondents in this sample who reported having experienced childhood maltreatment ($n=63$) were slightly older on average ($M= 28.00$, $SD= 11.86$) than those who did not report having experienced ($n=102$) childhood maltreatment ($M= 26.00$, $SD= 10.71$). While the sample was recruited by diverse means, it is important to consider that the survey results may have differed had the majority of respondents not been university students. It is possible that individuals in later stages of development may have a different response to their childhood

maltreatment. It is possible that the negative impact may be reduced after an extended period of time, or the symptoms could be exacerbated as a result of lack of treatment for many years.

Individuals at earlier or later stages of their lives may also have developed different coping styles and skills which may directly impact their levels of adaptive functioning and self-compassion.

Another limitation of the study was the limited number of individuals having endorsed childhood maltreatment. Sixty-five individuals endorsed having experienced childhood maltreatment in this study (thirty-nine percent of the full sample). While the results indicate that self-compassion among this sample may serve to mediate the relationship between trauma symptom severity following childhood maltreatment and psychological well-being, it is important to consider that these results may differ among a larger sample size of individuals who experienced childhood maltreatment. While the findings in this study suggest that self-compassion partially mediates the relationships between psychological well-being and trauma symptom severity, a large sample may provide greater statistical support for this mediation.

The last notable limitation of this study is the sensitivity of the trauma symptom measure used among this sample of males. When looking at the sample of males who did not report having experienced childhood maltreatment, the mean score on this measure was ($M=60.06$, $SD=16.59$). While this was still significantly less than those who reported childhood maltreatment ($M=76.67$, $SD=23.29$), it is important to note that individuals who have not experienced childhood maltreatment still endorsed, on average, negative symptoms. This may be the result of individuals who have not experienced childhood maltreatment having experienced trauma in adulthood, or having negative symptoms as a result of other life stressors. Additionally, when examining the responses of those who have experienced childhood

maltreatment, the researchers did not measure social desirability. It may be possible that those who have experienced childhood maltreatment reported negative symptoms at a lower rate.

Conclusion

This study attempted to examine the mediating effect of self-compassion on trauma symptom severity and psychological well-being. The findings indicate that while self-compassion does not fully mediate this relationship, self-compassion does serve as a partial mediator. The current body of literature has provided research to explore various factors that may serve to promote well-being following a traumatic or difficult life event. This research has added to the body of literature by examining a possible protective factor specific to male survivors.

These preliminary findings that provide support for self-compassion as a mediator between symptom severity and psychological well-being for males who have experienced childhood maltreatment provide empirical support for practical therapeutic interventions. Clinicians working with male clients who have experienced childhood maltreatment and have decreased overall psychological well-being can work to promote self-compassion. Increasing self-compassion (one's ability to be gentle with oneself) would serve as a protective factor, promoting more adaptive functioning, and increasing overall psychological well-being.

References

- Abbott, R., Ploubidis, G., Huppert, F., Kuh, D., Wadsworth, M., & Croudace, T. (2006). Psychometric evaluation and predictive validity of Ryff's psychological well-being items in a UK birth cohort sample of women. *Health & Quality of Life Outcomes*, 4, 76-16.
- Afifi, T., Macmillan, H. (2011). Resilience following child maltreatment: A review of protective factors. *Canadian Journal of Psychiatry*, 56(5), 266-272.
- Akin, A. (2008). The scales of psychological well-being: A study of validity and reliability. *Kuram ve Uygulamada Eğitim Bilimleri*, 8(3), 741-750.
- Allgower, A., Wardle, J., & Steptoe, A. (2001). Depressive symptoms, social support, and personal health behaviors in young men and women. *Health Psychology*, 20, 223-227.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (Revised 4th ed.). Washington, DC: Author.
- Asberg, K., & Renk, K. (2012). Substance use coping as a mediator of the relationship between trauma symptoms and substance use consequences among incarcerated females with childhood sexual abuse histories. *Substance Use & Misuse*, 47(7), 799-808.
- Baer, R., Lynkins, E., & Peters, J. (2012). Mindfulness and self-compassion as predictors of psychological well-being in long-term mediators and matched nonmediators. *The Journal of Positive Psychology*, 7(3), 230-238.
- Bagley, C., Wood, M., & Young, L. (1994). Victim to abuser: mental health and behavioral sequels of child sexual abuse in a community survey of young adult males. *Child Abuse and Neglect*, 18, 683-697.
- Baron, R., & Kenny, D. (1986). The moderator-mediator variable distinction in social

- psychology research: Conceptual, strategic, and statistical considerations. *Journal of Personality and social Psychology*, 51(6), 1173-1182.
- Bartholow, B.N., Doll, L.S., Joy, D., Douglas, J.M., Bolan, G., Harrison, J.S., Moss, P.M., & McKirnan, D. (1994). Emotional, behavioral, and HIV risks associated with sexual abuse among adult homosexual and bisexual men. *Child Abuse & Neglect*, 18, 747-761.
- Baumeister, R. F., Campbell, J. D., Krueger, J. I., & Vohs, K. D. (2003). Does high self-esteem cause better performance, interpersonal success, happiness, or healthier lifestyles? *Psychological Science in the Public Interest*, 4, 1–44.
- Beck , A., &Steer , R. (1987). Manual for the revised Beck Depression Inventory. San Antonio, TX: Psychological Corporation.
- Becker-Lausen, E., & Mallon-Kraft, S. (1997). Pandemic outcomes: The intimacy variable. In G.K. Kantor & J.S. Jasinski (Eds.), *Out of darkness: Current perspectives on family violence* (pp. 49-57). Newbury Park, CA: Sage.
- Bernstein, D. P., Fink, L., Handelsman, L., Foote, J., Lovejoy, M., Wenzel, K., Sapareto, E., & Ruggiero, J. (1994). Initial reliability and validity of a new retrospective measure of child abuse and neglect. *American Journal of Psychiatry*, 151, 1132–1136.
- Brems, C, Johnson, M., & Freemon, M. (2004). Childhood abuse history and substance use among men and women receiving detoxification services. *American Journal of Drug and Alcohol Abuse*, 30, 799-821.
- Briere, J.N., & Elliot, D.M. (1994). Immediate and long-term impacts of child sexual abuse. *The Future of Children*, 4, 54-69.
- Briere, J., & Elliott, D. (2003). Prevalence and psychological sequelae of self-reported

- childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse & Neglect*, 27, 1205–1222.
- Briere, J., Evans, D., Runtz, M., & Wall, T. (1988). Symptomatology in men who were molested as children: A comparison study. *American Journal of Orthopsychiatry*, 58, 457-461.
- Briere, J., Runtz, M. (1989). The Trauma Symptom Checklist (TSC-33) Early data on a new scale. *Journal of Interpersonal Violence*, 4(2), 151-163.
- Joan Joseph Castillo (2009). Snowball Sampling. Retrieved 15 Sep. 2012 from Experiment Resources: <http://www.experiment-resources.com/snowball-sampling.html>.
- Chandy J., Blum R., & Resnick M. (1996). Gender-specific outcomes for sexually abused adolescents. *Child Abuse & Neglect*, 20, 1219–1231
- Chaudhury, S., Murthy, P. S., Banerjee, A., Kumari, D., & Alreja, S. (2011). Poly-trauma Survivors: Assessment using Rating Scales and SIS - II. *SIS Journal of Projective Psychology & Mental Health*, 18(1), 39-49.
- Cheung, M.S.P., Gilbert, P., & Irons, C. (2004). An exploration of shame, social rank and rumination in relation to depression. *Personality and Individual Differences*, 36, 1143–1153.
- Connor, K., & Davidson, J. (2003). Development of a new resilience scale: the Connor-Davidson Resilience Scale (CD-RISC). *Depression and Anxiety*, 18(2), 76–82.
- Cook, E., Chaplin, T., Sinha, R., Tebes, J., & Mayes, L. (2012). The stress response and adolescents' adjustment: The impact of child maltreatment. *Journal of Youth and Adolescence*, 41, 1067-1077.
- Crocker, J., & Park, L. E. (2004). The costly pursuit of self-esteem. *Psychological Bulletin*, 130, 392–414.

- Currie, J., & Widom, C. (2010). Long-term consequences of child abuse and neglect on adult economic well-being. *Child Maltreat*, 15(2), 111-120.
- Dhaliwal, G., Gauzas, L., Antonowicz, D., & Ross, R. (1996). Adult male survivors of childhood sexual abuse: prevalence, sexual abuse characteristics, and long term effects. *Clinical Psychology Review*, 16(7), 619-639.
- Dervic, K., Grunebaum, M., Burke, A., Mann, J., & Oquendo, M. (2006). Protective factors against suicidal behavior in depressed adults reporting childhood abuse. *Journal of Nervous & Mental Disease*, 194(12), 971-974
- Diener, E. (1984). Subjective well-being. *Psychological Bulletin*, 95, 542-575.
- Diener, E., Emmons, R.A., Larsen, R.J., & Griffin, S. (1985). The Satisfaction with Life Scale. *Journal of Personality Assessment*, 49, 71–75.
- Diener, E., Suh, E.M., Lucas, R.E., & Smith, H.L. (1999). Subjective well-being: Three decades of progress. *Psychological Bulletin*, 125, 276–302.
- Draper, B., Pfaff, J., Pirkis, J., Snowdon, J., Lautenschlager, N., & Wilson, I., Almeida, O. (2008). Long-Term effects of childhood abuse on the quality of life and health of older people: Results from the depression and early prevention of suicide in general practice project. *Journal of American Geriatrics Society*, 6(2), 262- 271.
- Drapalaski, A., Youman, K., Stuewig, J., & Tangney, J. (2009). Gender differences in jail inmates' symptoms of mental illness, treatment history and treatment seeking. *Criminal Behaviour and Mental Health*, 19, 193-206.
- Dube, S., Anda, R., Felitti, V., Chapman, D., Williamson, D., & Giles, W. (2001). Childhood

- abuse, household dysfunction, and the risk of attempted suicide throughout the lifespan. Findings from the adverse childhood experiences study. *The Journal of the American Medical Association*, 286(24), 3089-3096.
- Dunkley, D., Zuroff, D., & Blankstein, K. (2003). Self-critical perfectionism and daily affect: Dispositional and situational influences on stress and coping. *Journal of Personality and Social Psychology*, 84(1), 234-252.
- Edwards, V.J., Holden, G.W., Felitti, V.J., & Anda, R.F. (2003). Relationship between multiple forms of childhood abuse and adult mental health in community respondents: results from the adverse childhood experiences study. *American Journal of Psychiatry*, 160, 1453-1460.
- Enoch, M. (2011). The role of early life stress as a predictor for alcohol and drug dependence. *Psychopharmacology*, 214, 17-31.
- Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., & Marks, J.S. (2001). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. In K. Franey, R. Geffner, & R. Falconer (Eds.), *The Cost of Child Trauma: Who Pays? We All Do* (pp.53-69). San Diego, CA: Family Violence and Sexual Assault Institute.
- Femina, D. D., Yeager, C. A., & Lewis, D. O. (1990). Child abuse: Adolescent records vs. adult recall. *Child abuse & neglect*, 14(2), 227-231.
- Fergusson, D., Boden, J., & Horwood, L. (2008). Exposure to childhood sexual and physical abuse and adjustment in early adulthood. *Child Abuse & Neglect*, 32, 607–619.
- Fergusson, D. M., & Lynskey, M. T. (1997). Physical punishment/abuse during childhood and adjustment in young adulthood. *Child Abuse & Neglect*, 21(7), 617–630.

- Fergusson, D. M., & Mullen, P. E. (1999). *Childhood sexual abuse—An evidence based perspective*. Sage, CA: Thousand Oaks.
- Fleming, J., Mullen, P.E., Sibthorpe, B., & Bammer, G. (1999). The long-term impact of childhood sexual abuse in Australian women. *Child Abuse & Neglect*, 23, 145-159.
- Fisher, P. A., Gunnar, M. R., Chamberlain, P., & Reid, J.B. (2000). Preventive intervention for maltreated preschool children: Impact on children's behavior, neuroendocrine activity, and foster parent functioning. *Journal of American Academy of Child Adolescence and Psychiatry*, 39, 1356-1364.
- Ford, J. D. (2005). Treatment implications of altered neurobiology, affect regulation and information processing following child maltreatment. *Psychiatric Annals*, 35, 410-419.
- Galea, M. (2012). Studying the Incremental Validity of Family Environment among Maltese University Students with Past Mental Trauma. *Pastoral Psychology*, 61(2), 211-220.
- Gauthier, L., Stollak, G., Messe, L., & Aronoff, J. (1996). Recall of childhood neglect and physical abuse as differential predictors of current psychological functioning. *Child Abuse & Neglect*, 20, 549-559.
- Gilbert, P. (1997). The evolution of social attractiveness and its role in shame, humiliation, guilt and therapy. *British Journal of Medical Psychology*, 70, 113–147.
- Gilbert, P. (2005). Compassion and cruelty: a biopsychosocial approach. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 9–74). London: Routledge.
- Gilbert, P. (2009) Introducing compassion-focused therapy. *Advances in psychiatric treatment*, 15, 199-208.

- Gilbert, P. (2009). *The compassionate mind*. London: Constable.
- Gilbert, P., & Irons, C. (2005). Therapies for shame and self-attacking, using cognitive, behavioural, emotional imagery and compassionate mind training. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 263–325). London: Routledge.
- Gilbert, P. & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism; Overview and pilot study of a group therapy approach. *Clinical Psychology and Psychotherapy*, 13, 353-379.
- Gilligan, J. (2003). Shame, guilt and violence. *Social Research*, 70, 1149–1180.
- Gratz, K., & Chapman, A. (2007). The role of emotional responding and childhood abuse in the development and maintenance of deliberate self-harm among male undergraduates. *Psychology of Men & Masculinity*, 8(1), 1-14.
- Greenfield, E. & Marks, N. (2010). Identifying experiences of physical and psychological violence in childhood that jeopardize mental health in adulthood. *Child Abuse & Neglect*, 34, 161- 171.
- Hamby, S. L., Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2004). *The Juvenile Victimization Questionnaire (JVQ): Administration and scoring manual*. Durham, NH: Crimes Against Children Research Center.
- Harter, S. (1999). *The Construction of the Self: A Developmental Perspective*. New York: Guilford Press.
- Heimpel, S.A., Wood, J.A., Marshall, M.A., & Brown, J.D. (2002). Do people with low self-esteem really want to feel better? Self-esteem differences in motivation to repair negative moods. *Journal of Personality and Social Psychology*, 82, 128–147.

- Higgins, D., & McCabe, M. (2003). Maltreatment and family dysfunction in childhood and the subsequent adjustment of children and adults. *Journal of Family Violence, 18*(2), 107-120.
- Hutcherson, C., Seppala, E., & Gross, J. (2008). Loving-Kindness Meditation Increases Social Connectedness. *Emotion, 8*(5), 720-724.
- Kendall-Tackett, K. (2002). The health effects of childhood abuse: four pathways by which abuse can influence health. *Child Abuse and Neglect, 6*(7), 715- 730.
- Kendall- Tackett, K.A., Marshall, R., & Ness, K.E. (2000). Victimization, healthcare use, and health maintenance. *Family Violence & Sexual Assault Bulletin, 16*, 18-21.
- Kia-Keating, M., Sorsoli, L., & Grossman, F. (2010). Relational Challenges and Recovery Processes in Male Survivors of Childhood Sexual Abuse. *Journal of Interpersonal Violence, 25*(4), 666-683.
- Knight, R., Waal-Manning, J., Spears, G. (1983). Some norms and reliability data for the State-Trait Anxiety Inventory and the Zung Self-Rating Depression Scale. *British Journal of Clinical Psychology, 22*, 245–249.
- Lapsley, D., FitzGerald, D., Rice, K., & Jackson, S. (1989). Separation-individuation and the “new look” at the imaginary audience and personal fable: A test of an integrative model. *Journal of Adolescent Research, 4*, 483-505.
- Leary, M. R., Adams, C. E., & Tate, E. B. (2005). *Adaptive self-evaluations: Self-compassion versus self-esteem*. Paper presented at the annual meeting of the American Psychological Association: Washington, DC.
- Leary, M., Tate, E., Adams, C., Allen, A., & Hancock, J. (2007). Self-compassion and reactions

- to unpleasant self-relevant events: The implications of treating oneself kindly. *Journal of Personality and Social Psychology*, 92(5), 887-904.
- Lee, R., & Robbins, S. (1995). Measuring belongingness: The social connectedness and social assurance Scales. *Journal of Counseling Psychology*, 42, 232-241.
- Levant, R. (1996). The new psychology of men. *Professional Psychology: Research and Practice*, 27(3), 259-265.
- Liu, W. (2005). The study of men and masculinity as an important multicultural competency consideration. *Journal of Clinical Psychology*, 61(6), 685-697.
- Lutz, A., Greischar, L. L., Rawlings, N. B., Ricard, M., & Davidson, R. J. (2004). Long-term meditators self-induce high-amplitude gamma synchrony during mental practice. *Proceedings of the National Academy of Sciences*, 101, 16369–16373.
- MacMillan, H., Fleming, J., Streiner, D., Lin, E., Boyle, M., Jamieson, E., Duku, E., Walsh, C., Wong, M., & Beardslee, W. (2001). Childhood abuse and lifetime psychopathology in a community sample. *American Journal of Psychiatry*, 158, 1878–1883.
- MacKinnon, D. P., Fairchild, A. J., & Fritz, M. S. (2007). Mediation analysis. *Annual review of psychology*, 58, 593.
- Masten, A., & Wright, M. (2009). Resilience over the lifespan: Developmental perspectives on resistance, recovery, and transformation. In J. Reich (Ed.), *Handbook of adult resilience*. New York: Guilford Books.
- Mejia, X.E. (2005). Gender matters: Working with adult male survivors of trauma. *Journal of Counseling & Development*, 83, 29-40.
- Mikulincer, M., Shaver, P. R., & Pereg, D. (2003). Attachment theory and affect regulation: The dynamic development and cognitive consequences of attachment-related strategies.

- Motivation and Emotion*, 27, 77–102.
- Murphy, J.M., Nierenberg, A.A., Monson, R.R., Laird, N.M., Sobol, A.M., & Leighton, A.H. (2002). Self disparagement as a feature and forerunner of depression: Findings from the Stirling County study. *Comprehensive Psychiatry*, 43, 13–21.
- Neely, M., Schallert, D., Mohammed, S., Roberts, R., & Chen, Y. (2009). Self-kindness when facing stress: The role of self-compassion, goal regulation, and support in college students' well-being. *Motivation Emotion*, 3, 88–97.
- Neff, K. D. (2003a). Development and validation of a scale to measure self-compassion. *Self and Identity*, 2, 223–250.
- Neff, K. D. (2003b). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity*, 2, 85–102.
- Neff, K. D. (2004). Self-compassion and psychological well-being. *Constructivism in the Human Sciences*, 9(2), 27–37.
- Neff, K.D. (2009). The role of self-compassion in development: A healthier way to relate to oneself. *Human Development*, 52, 211–214.
- Neff, K.D. (2011). Self-compassion, self-esteem, and well-being. *Social and personality psychology compass*, 5(1), 1–12.
- Neff, K.D., Hsieh, Y., & Dejittthirat, K. (2005). Self-compassion, achievement goals, and coping with academic failure. *Self and Identity*, 4, 263–287.
- Neff, K., Kirkpatrick, K., & Rude, S. (2007). Self-compassion and adaptive psychological functioning. *Journal of Research in Personality*, 41, 139–154.
- Neff, K.D., Rude, S.S., & Kirkpatrick, K.L. (2007). An examination of self-compassion in

- relation to positive psychological functioning and personality traits. *Journal of research in personality*, 41, 908-916.
- Neff K., Leary M., & Hoyle R. (2009). Handbook of individual differences in social behavior. New York: Guilford Press; Self-Compassion; pp. 561–573.
- Neff, K. D., & McGehee, P. (2010). Self-compassion and psychological resilience among adolescents and young adults. *Self and Identity*, 9, 225–240.
- Neff, K.D., & Vonk, R. (2009). Self-compassion versus global self-esteem: Two different ways of relating to oneself . *Journal of Personality*, 77, 23–50.
- Pavot, W., & Diener, E. (1993). Review of the satisfaction with life scale. *Psychological Assessment*, 5(2), 164-172.
- Pavot, W., & Diener, E. (2008). The satisfaction with life scale and the emerging construct of life satisfaction. *The journal of positive psychology*, 3(2), 137-152.
- Pitzer, L., Fingerman, K. (2010). Psychosocial resources and associations between childhood physical abuse and adult well-being. *Journal of Gerontology: Psychological Sciences*, 65B(4), 425-433.
- Raes, F., Pommier, E., Neff, K. D., & Van Gucht, D. (2011). Construction and factorial validation of a short form of the Self-Compassion Scale. *Clinical Psychology & Psychotherapy*. 18, 250-255
- Rodgers, C., Langa,, A., Laffaye, C., Satz, L., Dresselhaus, T., Stein, M. (2004). The impact of individual forms of childhood abuse on health behavior. *Child Abuse & Neglect*, 28, 575–586.
- Roy, A., Carli, V., & Sarchiapone, M. (2011). Resilience mitigates the suicide risk associated with childhood trauma. *Journal of Affective Disorders*, 133(3), 591-594.

- Runtz, M., Schallow, J. (1997). Social support and coping strategies as mediators of adult adjustment following childhood maltreatment. *Child Abuse & Neglect*, 21(2), 211-226
- Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry*, 57(3), 316-331.
- Ryff, C., & Heidrich, S. (1997). Experience and well-being: Explorations on domains of life and how they matter. *International Journal of Behavioral Development*, 20, 193-206.
- Ryff, C., & Keyes, C. (1995). The structure of psychological well-being revisited. *Journal of personality and social psychology*, 69(4), 719-727.
- Ryff, C., & Singer, B. (2008). Know thyself and become what you are: A eudaimonic approach to psychological well-being. *Journal of happiness studies*, 9, 13-39.
- Schraufnagel, T., Davis, K., George, W., & Norris, J. (2010). Childhood sexual abuse in males and subsequent risky behavior: A potential alcohol use pathway. *Child Abuse & Neglect*, 34(5), 369-378.
- Senn T., Carey M., Vanable P., Coury-Doniger P., & Urban M. (2006). Childhood sexual abuse and sexual risk behavior among men and women attending a sexually transmitted disease clinic. *Journal of Consulting and Clinical Psychology*, 74, 720-731
- Shand, F. L., Degenhardt, L., Slade, T., & Nelson, E. C. (2011). Sex differences amongst dependent heroin users: Histories, clinical characteristics and predictors of other substance dependence. *Addictive Behaviors*, 36(1/2), 27-36.
- Silverman, A. B., Reinherz, H., & Giaconia, R. M. (1996). The long-term sequelae of child and adolescent abuse: A longitudinal community study. *Child Abuse and Neglect*, 20, 709-723.
- Sobel, M. (1982). Asymptotic confidence intervals for indirect effects in structural equations

- models. In S. Leinhardt (Ed.), *Sociological methodology 1982* (pp.290-312). San Francisco: Jossey-Bass.
- Spielberger , C., Gorsuch , R., & Lushene , R.(1970). Manual for the State Trait Anxiety Inventory. Palo Alto, CA: Consulting Psychologists Press.
- Springer, K., Sheridan, J., Kuo, D., Carnes, M. (2007). Long-term physical and mental health consequences of childhood physical abuse: Results from a large population-based sample of men and women. *Child Abuse & Neglect*, 31, 517–530.
- Swann, W. B. (1996). *Self-Traps: The Elusive Quest for Higher Self-Esteem*. New York: W. H. Freeman.
- Tanaka, M., Werkerle, C., Schmuck, M., & Paglia-Boak, A. (2011). The linkages among childhood trauma, adolescent mental health, and self-compassion in child welfare adolescents. *Child abuse and neglect*, 35, 887- 898.
- Thompson, B.L., & Waltz, J. (2008). Self-Compassion and PTSD symptom severity. *Journal of Traumatic Stress*, 21(6), 556- 558.
- U.S. Census Bureau, *2010 Census Redistricting Data (Public Law 94-171) Summary File*, Tables P1 and P2.
- Van Dam, N., Sheppard, S., Forsyth, J., & Eraleywine, M. (2011). Self-Compassion is a better predictor than mindfulness of symptom severity and quality of life in mixed anxiety and depression. *Journal of Anxiety Disorders*, 25, 123-130.
- Van Dorn R., Mustillo S., Elbogen E., Dorsey S., Swanson J., & Swartz M. (2005). The effects of early sexual abuse on adult risky sexual behaviors among persons with severe mental illness. *Child Abuse & Neglect*, 29, 1265–1279.
- Vetteese, L., Dyer, C., Li, W., & Wekerle, C. (2011). Does self-compassion mitigate the

- association between childhood abuse and later emotion regulation difficulties? A preliminary investigation. *International journal of mental health addiction*, 1, 1-12
- Vitaliano, P.P., Scanlan, J.M., Zhang, J., Savage, M., Brummett, B., Barefoot, J., & Siegler, I.C. (2001). Are the salutogenic effects of social supports modified by income? A test of an “added value hypothesis.” *Health Psychology*, 20, 155-165.
- Waldrop, A. E., Santa Ana, E. J., Saladin, M. E., McRae, M. L., & Brady, K. T. (2007). Differences in early onset alcohol use and heavy drinking among persons with childhood and adulthood trauma. *The American Journal on Addictions*, 16, 439-442.
- Wei, M., Liao, K., Ku, T., & Shaffer, P. (2011). Attachment, self-compassion, empathy, and subjective well-being among college students and community adults. *Journal of Personality*, 79(1), 191- 221.
- Widom, C. S., Weiler, B. L., & Cottler, L. B. (1999). Childhood victimization and drug abuse: A comparison of prospective and retrospective findings. *Journal of Consulting & Clinical Psychology*, 67(6), 867–880.
- Widom, C. S., & White, H. R. (1997). Problem behaviours in abused and neglected children grown up: Prevalence and co-occurrence of substance abuse, crime and violence. *Criminal Behaviour & Mental Health*, 7(4), 287–310.
- Williamson, Thompson, Felitti, and Anda (2004). *Child Abuse & Neglect*, 28(7), 715–722.
- Wilsnack S., Vogeltanz N., Klassen A., & Harris T. (1997). Childhood sexual abuse and women's substance abuse: National survey findings. *Journal of Studies on Alcohol*, 58, 264–271.
- Wood, A., & Joseph, S. (2010). The absence of positive psychological (eudemonic) well-being

- as a risk factor for depression: A ten year cohort study. *Journal of Affective Disorders*, 122, 213-217.
- Wright, M., Crawford, E., & Castillo, D. (2009). Childhood emotional abuse and later psychological distress among college students: The mediating role of maladaptive schemas. *Child Abuse and Neglect*, 33, 59–68.
- Young-Wolf, K., Kendler, K., & Prescott, C. (2012). Interactive effects of childhood maltreatment and recent stressful life events on alcohol consumption in adulthood. *Journal of Studies on Alcohol and Drugs*, 73(4), 559-569.
- Zanarini, M.C., Frankenburg, F.R., Bradford Reich, D., Marino, M.F., Haynes, M.C., & Gunderson, J.G. (1999). Violence in the lives of adult borderline patients. *Journal of Nervous and Mental Disease*, 187, 65-71.
- Zung W. (1965). A self-rating depression scale. *Archives of General Psychiatry*, 12, 63-70.
- Zuroff, D.C., Koestner, R., & Powers, T.A. (1994). Self-criticism at age 12: A longitudinal study of adjustment. *Cognitive Therapy and Research*, 18, 367–385.

Appendix A: Research Announcement

Purpose:

This study attempts to understand how men view themselves after facing challenges. Information will be gathered from men who **have**, and **have not** experienced abuse or neglect before turning 18 years old. You do not have to have experienced childhood mistreatment to participate in this study.

Requirements:

The **only** eligibility requirements to participate in this study are that:

1. You must be male.
2. You must be 18 years of age or older.

Additional Information:

If you chose to participate in this study, **you will also be asked** if you experienced childhood abuse and/or neglect. This means that before you turned 18 years old:

- You experienced harm at the hands of your parents or another individual who was supposed to care for you or a parent or another individual who was supposed to care for you did not do so in an appropriate or supportive way. This may include **physical abuse**, **physical neglect**, **emotional abuse**, **emotional neglect**, and/or **sexual abuse**.

You **MAY** still participate in this study even if you have **not** experienced childhood abuse or neglect.

Appendix B: Informed Consent for Radford University

You are being asked to participate in a study designed to understand the role of self-compassion on psychological well-being for men. Specifically, we ask you to participate in this study to help us better understand how men feel about themselves after they have experienced maltreatment as children. Approximately 150 people will be asked to respond to this survey.

If you decide to be in this study, you may choose not to answer certain questions or not to be in certain parts of this study. Your individual responses to items will not be shared with others unless required to do so by law. If we present or publish the results of this study, your name will not be linked in any way to what we present. If at any time you want to stop being in this study, you may stop being in the study without by exiting the survey or contacting: Dominique N. Boone, M.S.[dnboone@radford.edu] or Tracy Cohn, Ph.D (tcohn@radford.edu; 540-831-6890).

This study has some risks. You will be asked about the abuse or neglect you experienced as a child, your feelings relevant to these events. Some of these questions may make you feel psychologically or emotionally uncomfortable. You may withdraw from this study at any time and you should withdraw from this study if you believe the distress is too much for you to manage.

There is no compensation from being in this study and there are no direct benefits to you for being in the study. There are no costs to you for being in this study.

If you have questions now about this study, ask [dnboone@radford.edu; 540-831-6816] or Tracy Cohn, Ph.D (tcohn@radford.edu; 540-831-6890) before you click the “Begin” button below.

If you have any questions later, you may talk with Dominique Boone, M.S. [dnboone@radford.edu; 540-831-6816] or Tracy Cohn, Ph.D (tcohn@radford.edu; 540-831-6890).

If this study raised some issues that you would like to discuss with a professional, you may contact Dominique Boone, M.S. [dnboone@radford.edu; 540-831-6816] or Tracy Cohn, Ph.D (tcohn@radford.edu; 540-831-6890) who will refer you to a professional or you may go to (<http://www.findapsychologist.org/>). Additionally, in the event that you feel psychologically distressed by participation in this study, we encourage you to call the National Suicide Prevention Hotline: 1-800-273-TALK (8255).

This study has been approved by the Radford University Institutional Review Board for the Review of Human Subjects Research. If you have questions or concerns about your rights as a research subject or have complaints about this study, you should contact Greg Sherman, PhD, gsherman2@radford.edu, 1-540-831-6859.

It is your choice whether or not to be in this study. What you choose will not affect any current or future relationship with Radford University.

If all of your questions have been answered and you would like to take part in this study, then please click below.

--button to move on to the web survey will go here---

You will be offered a copy of this form to keep.

Thank You!

You are making a decision whether to participate. Your signature indicates that you have read the information provided above and have decided to participate. You may withdraw at any time without prejudice after signing this form should you choose to discontinue participation in this study.

Signature

Date

Signature of Investigator

Appendix C: Demographic Questionnaire Form

1. What is your sex?
 - a. Male
 - b. Female
 - c. Other: _____
2. What is your race/ethnicity? (Please select all that apply)
 - a. African American or Black
 - b. Asian American/ Pacific Islander
 - c. Caucasian or White
 - d. Multiracial
 - e. Latino (a)
 - f. Middle Eastern
 - g. Native American
 - h. Other: _____
3. What year were you born?

4. Please check if you have experienced the following prior to turning 18 years old (please check as many as apply):

_____ **Physical Abuse** (for example, were you **attacked with things or beaten** by your parents or someone who was trusted to take care of you?)

_____ **Physical Neglect** (for example, were you **not provided with food, shelter, or appropriate clothing**? Were you often **left alone for excessive periods of time** considering your age? Were **you forced to provide childcare** for your siblings or others before you were old enough to do so responsibly and legally?)

_____ **Emotional Abuse** (for example, were you **called names or put down** by your parents or someone who was trusted to take care of you?)

_____ **Emotional Neglect** (for example, did you feel scared of really bad about yourself because your parents or someone who was trusted to take care of you made you **feel unwanted or unloved**?)

_____ **Sexual Abuse** (for example, did a parent or someone who was trusted to take care of you **touch your private parts** when you didn't want it or **make you touch their private parts**? Did a parent or someone trusted to take care of you ever **force you to have sex** with them? When you were a child did you do **sexual things with anyone 18 or older**, even things you both wanted to do?)
5. Approximately length of **childhood** abuse and neglect:

- a. The abuse or neglect happened **one time**.
- b. The abuse or neglect happened several times for many **weeks**.
- c. The abuse or neglect happened several times for many **months**.
- d. The abuse or neglect happened several times for many **years**.

Appendix D: Self-Compassion Scale (Short Form)

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

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

**Almost
never**

1

2

3

4

**Almost
always**

5

- _____ 1. When I fail at something important to me I become consumed by feelings of inadequacy.
- _____ 2. I try to be understanding and patient towards those aspects of my personality I don't like.
- _____ 3. When something painful happens I try to take a balanced view of the situation.
- _____ 4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
- _____ 5. I try to see my failings as part of the human condition.
- _____ 6. When I'm going through a very hard time, I give myself the caring and tenderness I need.
- _____ 7. When something upsets me I try to keep my emotions in balance.
- _____ 8. When I fail at something that's important to me, I tend to feel alone in my failure.
- _____ 9. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
- _____ 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 disapproving and judgmental about my own flaws and inadequacies.
- _____ 12. I'm intolerant and impatient towards those aspects of my personality I don't like.

Appendix E: Zung Self-Rating Depression Scale

For each item below, please indicate which best describes how often you felt or behaved this way during the past several days.

- (1) A little of the time**
- (2) Some of the time**
- (3) Good part of the time**
- (4) Most of the time**

1. I feel down-hearted and blue.
2. Morning is when I feel the best.
3. I have crying spells or feel like it.
4. I have trouble sleeping at night.
5. I eat as much as I used to.
6. I still enjoy sex.
7. I notice that I am losing weight.
8. I have trouble with constipation.
9. My heart beats faster than usual.
10. I get tired for no reason.
11. My mind is as clear as it used to be.
12. I find it easy to do the things I used to.
13. I am restless and can't keep still.
14. I feel hopeful about the future.
15. I am more irritable than usual.
16. I find it easy to make decisions.
17. I feel that I am useful and needed.
18. My life is pretty full.
19. I feel that others would be better off if I were dead.
20. I still enjoy the things I used to do.

Appendix F: Satisfaction with Life Scale

DIRECTIONS: Below are five statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by placing the appropriate number in the line preceding that item. Please be open and honest in your responding.

- 1 = Strongly Disagree
- 2 = Disagree
- 3 = Slightly Disagree
- 4 = Neither Agree or Disagree
- 5 = Slightly Agree
- 6 = Agree
- 7 = Strongly Agree

- _____ 1. In most ways my life is close to my ideal.
- _____ 2. The conditions of my life are excellent.
- _____ 3. I am satisfied with life.
- _____ 4. So far I have gotten the important things I want in life.
- _____ 5. If I could live my life over, I would change almost nothing.

Appendix G: Scales of Psychological Well-Being

Please answer the questions using the following scale:

- (1) Strongly Disagree
- (2) Moderately Disagree
- (3) Slightly Disagree
- (4) Slightly Agree
- (5) Moderately Agree
- (6) Strongly Agree

1. ____ I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people.
2. ____ In general, I feel I am in charge of the situation in which I live.
3. ____ I am not interested in activities that will expand my horizons.
4. ____ Most people see me as loving and affectionate.
5. ____ I live life one day at a time and don't really think about the future.
6. ____ When I look at the story of my life, I am pleased with how things have turned out.
7. ____ My decisions are not usually influenced by what everyone else is doing.
8. ____ The demands of everyday life often get me down.
9. ____ I don't want to try new ways of doing things--my life is fine the way it is.
10. ____ Maintaining close relationships has been difficult and frustrating for me.
11. ____ I tend to focus on the present, because the future nearly always brings me problems.
12. ____ In general, I feel confident and positive about myself.
13. ____ I tend to worry about what other people think of me.
14. ____ I do not fit very well with the people and the community around me.
15. ____ I think it is important to have new experiences that challenge how you think about yourself and the world.
16. ____ I often feel lonely because I have few close friends with whom to share my concerns.
17. ____ My daily activities often seem trivial and unimportant to me.
18. ____ I feel like many of the people I know have gotten more out of life than I have.
19. ____ Being happy with myself is more important to me than having others approve of me.
20. ____ I am quite good at managing the many responsibilities of my daily life.
21. ____ When I think about it, I haven't really improved much as a person over the years.
22. ____ I enjoy personal and mutual conversations with family members or friend.
23. ____ I don't have a good sense of what it is I'm trying to accomplish in life.
24. ____ I like most aspects of my personality.
25. ____ I tend to be influenced by people with strong opinions.
26. ____ I often feel overwhelmed by my responsibilities.
27. ____ I have the sense that I have developed a lot as a person over time.
28. ____ I don't have many people who want to listen when I need to talk.
29. ____ I used to set goals for myself, but that now seems like a waste of time.
30. ____ I made some mistakes in the past, but I feel that all in all everything has worked out

for the best.

- 31. ____ I have confidence in my opinions, even if they are contrary to the general consensus.
- 32. ____ I generally do a good job of taking care of my personal finances and affairs.
- 33. ____ I do not enjoy being in new situations that require me to change my old familiar ways of doing things.
- 34. ____ It seems to me that most other people have more friends than I do.
- 35. ____ I enjoy making plans for the future and working to make them a reality.
- 36. ____ In many ways, I feel disappointed about my achievements in life.
- 37. ____ It's difficult for me to voice my own opinions on controversial matters.
- 38. ____ I am good at juggling my time so that I can fit everything in that needs to get done.
- 39. ____ For me, life has been a continuous process of learning, changing, and growth.
- 40. ____ People would describe me as a giving person, willing to share my time with others.
- 41. ____ I am an active person in carrying out the plans I set for myself.
- 42. ____ My attitude about myself is probably not as positive as most people feel about themselves.
- 43. ____ I often change my mind about decisions if my friends or family disagree.
- 44. ____ I have difficulty arranging my life in a way that is satisfying to me.
- 45. ____ I gave up trying to make big improvements or changes in my life a long time ago.
- 46. ____ I have not experienced many warm and trusting relationships with others.
- 47. ____ Some people wander aimlessly through life, but I am not one of them.
- 48. ____ The past had its ups and downs, but in general, I wouldn't want to change it.
- 49. ____ I judge myself by what I think is important, not by the values of what others think is important.
- 50. ____ I have been able to build a home and a lifestyle for myself that is much to my liking.
- 51. ____ There is truth to the saying you can't teach an old dog new tricks.
- 52. ____ I know that I can trust my friends, and they know they can trust
- 53. ____ I sometimes feel as if I've done all there is to do in life.
- 54. ____ When I compare myself to friends and acquaintances, it makes me feel good about who I am.

Appendix H: Trauma Symptom Checklist-40

How often have you experienced each of the following in the last two months?

0 = Never 3 = Often

- | | |
|--|---------|
| 1. Headaches | 0 1 2 3 |
| 2. Insomnia (trouble getting to sleep) | 0 1 2 3 |
| 3. Weight loss (without dieting) | 0 1 2 3 |
| 4. Stomach problems | 0 1 2 3 |
| 5. Sexual problems | 0 1 2 3 |
| 6. Feeling isolated from others | 0 1 2 3 |
| 7. "Flashbacks" (sudden, vivid, distracting memories) | 0 1 2 3 |
| 8. Restless sleep | 0 1 2 3 |
| 9. Low sex drive | 0 1 2 3 |
| 10. Anxiety attacks | 0 1 2 3 |
| 11. Sexual overactivity | 0 1 2 3 |
| 12. Loneliness | 0 1 2 3 |
| 13. Nightmares | 0 1 2 3 |
| 14. "Spacing out" (going away in your mind) | 0 1 2 3 |
| 15. Sadness | 0 1 2 3 |
| 16. Dizziness | 0 1 2 3 |
| 17. Not feeling satisfied with your sex life | 0 1 2 3 |
| 18. Trouble controlling your temper | 0 1 2 3 |
| 19. Waking up early in the morning and can't get back to sleep | 0 1 2 3 |
| 20. Uncontrollable crying | 0 1 2 3 |
| 21. Fear of men | 0 1 2 3 |
| 22. Not feeling rested in the morning | 0 1 2 3 |
| 23. Having sex that you didn't enjoy | 0 1 2 3 |
| 24. Trouble getting along with others | 0 1 2 3 |
| 25. Memory problems | 0 1 2 3 |
| 26. Desire to physically hurt yourself | 0 1 2 3 |

27. Fear of women	0 1 2 3
28. Waking up in the middle of the night	0 1 2 3
29. Bad thoughts or feelings during sex	0 1 2 3
30. Passing out	0 1 2 3
31. Feeling that things are "unreal"	0 1 2 3
32. Unnecessary or over-frequent washing	0 1 2 3
33. Feelings of inferiority	0 1 2 3
34. Feeling tense all the time	0 1 2 3
35. Being confused about your sexual feelings	0 1 2 3
36. Desire to physically hurt others	0 1 2 3
37. Feelings of guilt	0 1 2 3
38. Feelings that you are not always in your body	0 1 2 3
39. Having trouble breathing	0 1 2 3
40. Sexual feelings when you shouldn't have them	0 1 2 3

Appendix I: Mental Health Services Form

It is possible that thinking about past traumatic events has created difficult or troubling feelings for you. If you have experienced difficult emotions and would like support please use the contact information provided below.

If you feel like you may hurt yourself or someone else:

Please call 911 or the National Suicide Prevention Lifeline at 1-800-273-TALK (8255)

- The National Suicide prevention hotline is a 24/7 free and confidential hotline that is available nationwide.
 - www.suicidepreventionlifeline.org

If you would like information on mental health providers in your area:

Please contact the Mental Health Association Hotline by dialing 211 on your phone.

- The Mental Health Association Hotline will provide mental health resources specific to your area.

If you are interested in learning more about Post-traumatic Stress Disorder and associated symptoms:

- Please visit the National Alliance of Mental Health website.
 - http://www.nami.org/Template.cfm?Section=Posttraumatic_Stress_Disorder

Thank you again for taking the time to assist with this research endeavor. Your participation is greatly appreciated!