Research article

From childhood emotional maltreatment to depressive symptoms in adulthood: The roles of self-compassion and shame

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A B S T R A C T

Background: Emotional abuse is a form of maltreatment that most strongly predicts adult depressive symptoms in community samples. Introject theories suggest that some depressive symptoms stem from survivors having learned to treat themselves the way they were treated by their perpetrators.
Objective: Malevolent introjects may undermine self-compassion, which may subsequently maintain feelings of shame. Thus, we hypothesized that self-compassion and shame would mediate the path from retrospective reports of maltreatment to concurrent depressive symptoms in adulthood.
Participants and Setting: Participants were 244 adult community members and college students living in a Southwestern American metroplex.
Method: We ran a multiple mediator path model with emotional abuse as the independent variable. We specified four covariates: physical abuse, sexual abuse, physical neglect, and emotional neglect, and held constant the variance they explained in self-compassion, shame, and depression.
Results: Our final model accounted for 53.1% of the variance in adult depressive symptoms. A significant indirect effect from emotional abuse passed through both mediators and ended in adult depressive symptoms. We also found an indirect path from emotional neglect to depression passing through both mediators.
Conclusions: It appears emotional abuse and emotional neglect can undermine the formation of self-compassion. Low self-compassion predicts greater shame and depressive symptoms. Our model suggests self-compassion may be a particularly effective intervention point for survivors of emotional maltreatment.

1. Introduction

Childhood maltreatment (henceforth maltreatment), a pervasive problem in the United States, is associated with various adverse developmental outcomes (Brom, Pat-Horenczyk, & Ford, 2009; Finkelhor, Turner, Shattuck, & Hamby, 2015). One especially common outcome of experiencing maltreatment is more persistent and recurring forms of depression (Horwitz, Widom, McLaughlin, & White, 2001). A meta-analysis indicates that those who endured maltreatment are twice as likely to experience more persistent and recurring depressive episodes compared to those who did not (Nanni, Uher, & Danese, 2012). The findings also suggested that depressed maltreatment survivors were less likely to benefit from therapeutic treatments than depressed individuals who did not

endure maltreatment (Nanni et al., 2012). Further, there may be unique psychological processes explaining the path from maltreatment to adult depression since comorbid psychiatric symptomology only partially accounted for this relationship (e.g., Kessler, 1997).

While various forms of maltreatment have been associated with adult depressive symptoms, theory and research suggest that emotional maltreatment accounts for the damaging effects of other forms of maltreatment (e.g., Garbarino, 2011; Navarre, 1987). Emotional abuse is particularly tied to depressive symptoms in adulthood; a recent meta-analysis identified emotional abuse as the strongest predictor of adult depression in community samples (Mandelli, Petrelli, & Serretti, 2015). Since most types of maltreatment typically co-occur (Kinard, 1994), other forms of maltreatment may confound the effect of emotional abuse. One potential means of identifying the unique impact of emotional abuse is by considering it alongside other forms of maltreatment during data analysis. Researchers who employed this approach have found that emotional abuse is the strongest predictor of depression in a sample of 2637 college students, occurring either by itself or alongside other forms of abuse (Berzenski & Yates, 2011). The authors noted that multiple forms of past maltreatment without emotional abuse predicted depression and anxiety less strongly.

1.1. Applying an introjection framework

Some scholars have suggested that one consequence of maltreament is children coming to treat themselves the way they were treated by their primary caregivers (e.g., Benjamin, 2003; Ney, 1987). A study by Stark, Schmidt, and Joiner, (1996) illustrates the impact of children's negative view of themselves matching their perception of their parents sending them similar messages. Specifically, perceived messages from parents about oneself, the world, and the future predicted children's depressive symptoms, and this path was mediated by children's own beliefs about themselves, the world, and the future. Internalizing the treatment and views directed at the self by important others in one's life is a process some theorists call *introjection* (Sullivan, 1953, Benjamin, 2003; Freud, 1924; Kernberg, 1966). Individuals adopt the verbal dialogue, motor behaviors, and appraisals directed at the self by others and turn it inward on the self, either consciously or unconsciously (Henry, Schacht, & Strupp, 1990). Similarly, Mead (1913) posited that mental states (i.e., attitudes) directed at the self stem from internalized representations of real interactions with one's parents and others in general.

Benjamin (2003) articulates that the quality of one's introjects stems largely from the set of mental representations of self, others, and relationships that constitute the attachment theory construct of *internal working models* (IWM; Bowlby, 1973). Bowlby (1979) articulated that the child-caregiver relationship in the early years has a significant impact on the formation of IWMs. Benjamin's *copy process theory* (2003) posits that introjected behavior corresponds in part with mental representations of attachment figures' behavior directed at the self. This theory indicates that threat, pain, danger, and other forms of stress activate introjects to create the implicit sense that attachment figures are present, what Benjamin (2003) refers to as *psychic proximity*. This theory articulates that individuals are invested in their introjects, whether they are destructive or supportive, because of the psychic proximity they impart in the face of distressing circumstances.

1.2. The impact on self-compassion

The self-blame (Swannell et al., 2012), and self-criticism (Glassman, Weierich, Hooley, Deliberto, & Nock, 2007) that characterize the hostile introjects of survivors of childhood maltreatment starkly contrast with those that are self-compassionate. Self-compassion is a multifaceted construct in which one responds to oneself in a kind and gentle manner in the face of adversity (Neff, 2003). Self-compassion consists of three interrelated components: a) self-kindness, in which understanding is extended to one's own pain, b) common humanity, which refers to the self not being viewed as alone in one's suffering, and c) mindfulness, in which one strikes a balance between over-identifying with and distancing oneself from one's psychological experiences. Neff's theory (2003) posits that each of these facets of self-compassion hold bidirectional causal relationships with each other.

There is evidence suggesting that children develop self-compassion from supporting themselves in ways similar to how supportive family members treated them. Specifically, individuals who reported higher past maternal support and greater overall family functioning were more self-compassionate than people with less supportive and more dysfunctional families (Neff & McGehee, 2010). Those who develop higher levels of self-compassion enjoy various positive psychological outcomes, including greater optimism and happiness (e.g., Neff, Rude, & Kirkpatrick, 2007). There is also some longitudinal evidence based on brief interventions suggesting that practicing self-compassion increases positive outcomes (Neff et al., 2007; Shapira & Mongrain, 2010) and decreases the severity of adverse outcomes, including depression (Johnson & O'Brien, 2013; Shapira & Mongrain, 2010)

1.3. Shame and depression

Theory (e.g., Gilbert, 2005) and empirical evidence (e.g., Kelly & Carter, 2013) indicate that feelings of shame, in part, account for the link between difficulties practicing self-compassion and the development and maintenance of psychopathology. Shame is a painful and often emotionally overwhelming (Lewis, 1971) negative evaluation of the whole self (Tangney, 1995; Tangney & Dearing, 2002), in which one feels internally isolated (Miller, 1988). Some theorists (e.g., Benjamin, 2003; Henry et al., 1990) suggest that different introjects underlie different affects. This affective theory suggests that self-criticism, self-blame, and other non-compassionate, introjects underlie feelings of shame.

Apart from viewing shame as an emotion stemming from a harsh internalized voice, other scholars have posited alternative arguments to account for the ubiquitous development of shame among survivors of maltreatment (e.g., Andrews, 1995, 1998; Webb,

Heisler, Call, Chickering, & Colburn, 2007). For example, some suggest that shame develops in survivors of child abuse either due to feeling disparaged by others or from having one's personal boundaries violated growing up (Fossum & Mason, 1986; Herman, 1997). Similarly, Gilbert (1997) suggests that feelings of shame characterize a sense of being dominated or defeated.

Since the development of children's self-image and self-worth is strongly influenced by their primary caregivers (Bowlby, 1973), it follows that maltreatment produces greater shame in the context of children's attachment relationships (e.g., Shahar, Doron, & Szepsenwol, 2014; Stuewig & McCloskey). Indeed, Platt and Freyd (2015) demonstrated empirical findings supporting the notion that the level of interpersonal closeness between survivor and perpetrator exacerbates the impact of maltreatment on shame. Some theorists argue that maltreatment in the context of attachment worsens the development of a negative self-image because of the adaptive role shame plays in these relationships (Herman, 1997). Specifically, efforts to forget, distort, or otherwise dissociate (Platt & Freyd, 2015) memories and experiences of abuse from oneself serve to preserve a relationship with one's attachment figures. In other words, children may feel shame because of blaming themselves (Herman, 1997) or feeling like they deserve the maltreatment (Feiring & Taska, 2005) in order to avoid facing the more distressing reality of their caretakers being dangerous and unpredictable. Emotional abuse may be particularly impactful in developing shame because of its capacity to damage self-worth (Shi, 2013). Stuewig and McCloskey (2005) indicate that harsh parenting in childhood longitudinally predicted shame-proneness in adolescence, and rejecting parenting behavior in adolescence mediated this association. Similarly, reports of past emotionally abusive (but not necessarily physically abusive) parenting positively predicted shame-proneness in college students (Hoglund & Nicholas, 1995).

Cognitions that closely resemble depressogenic beliefs typically accompany shame (Clark & Beck, 1999; Van Vliet, 2009). Examples include completely blaming oneself for negative events while discounting situational factors and feeling powerless to change one's personal issues. A sense of disempowerment and total blame on self may explain why shame predicts a more long-lasting course of depression (Andrews, Qian, & Valentine, 2002; De Rubeis & Hollenstein, 2009) among survivors of maltreatment (Stuewig & McCloskey, 2005). It follows that meta-analytic findings (Kim, Thibodeau, & Jorgensen, 2011) would reveal that shame predicts depression more strongly ($r = 0.43$) than guilt ($r = 0.28$) since feelings of guilt stem from viewing one's mistakes as behaviors within one's own control (Lewis, 1971).

1.4. The current study

The purpose of the current study is to shed light on mechanisms underlying depression in adult survivors of childhood maltreatment with our proposed model (see Fig. 1). Physical abuse, sexual abuse, emotional neglect, and physical neglect were covariates, and we assigned emotional abuse as our predictor variable because of its strength in predicting depression in community samples (Berzenski & Yates, 2011; Mandelli et al., 2015). Our model posits that emotional abuse will negatively predict self-compassion, which in turn will negatively predict shame, which will positively predict adult depressive symptoms. We anticipated demonstrating a significant indirect effect from emotional abuse passing through the two mediators in this model (self-compassion and shame), even after controlling for other forms of maltreatment. We expected to find a direct path from emotional abuse to shame because self-compassion deficits capture only one of the various mechanisms implicated in shame stemming from maltreatment. Finally, we hypothesized that a direct path from emotional abuse to depression would obtain in the model considering the robustness of this relationship.

2. Method

2.1. Participants

Participants were 244 community members and college students in the Dallas-Fort Worth metroplex (mean age = 20.80, SD = 3.826). Inclusion criteria were as follows: living in the Dallas-Fort Worth metroplex, being fluent in English, and being at least 18 years or older. One hundred and eighty-seven of these participants identified as female, 53 identified as male, two identified as transgender male, and two identified as gender-fluid. In terms of ethnic and racial demographics, 49.2% identified as White, 25.8% identified as Latin American or Hispanic, 16.8% identified as African American or Black, 6.6% identified as Asian American, 3.3% identified as Middle Eastern American, 2.9% identified as bi- or multicultural, and 2.0% identified as Native American or from any other indigenous population. Regarding relationship status, 63.9% reported being single or single and dating, 33.2% reported being in a committed relationship, 7.0% reported living together, 3.7% reported being married, and 0.8% reported being divorced. Participants reported on their therapy history as well; 15.6% of participants were in weekly psychotherapy at the time of the study, and 34.4% stated they had attended therapy in the past as an adult. The highest level of participant education was as follows: 23.0% were a high school graduate or received their GED, 55.7% attained partial college, 13.9% graduated college, and 1.6% received graduate training.

2.2. Measures

2.2.1. Childhood trauma questionnaire

The Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998) is a 28-item self-report measure of childhood maltreatment. The CTQ is made up of five 5-item maltreatment subscales plus a 3-item minimization/denial scale to assess validity of responses. Each subscale measures a different form of childhood maltreatment, generally within one's family of origin: physical abuse, sexual abuse, emotional abuse, emotional neglect, and physical neglect. Responses to items range from 1 to 5, with greater scores indicating
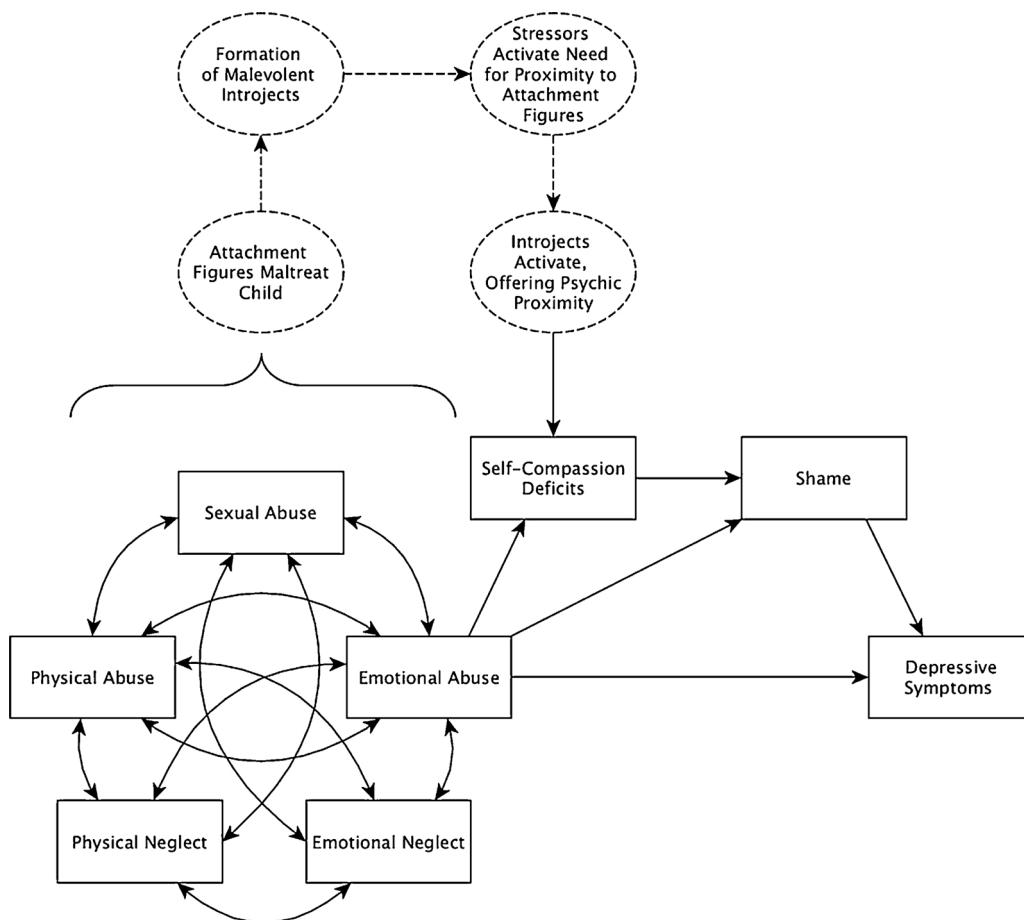
Fig. 1. Hypothesized mediational model. Rectangular constructs represent variables measured in the current path model. Oval constructs represent untested components of underlying theory linking maltreatment to self-compassion deficits.

greater maltreatment. The validity scale is comprised of three items that identify potential minimization or denial of past childhood maltreatment. In the current study, reliabilities ranged from $\alpha = 0.69$ for physical neglect and $\alpha = 0.92$ for sexual abuse.

2.2.2. Self-compassion scale

The 26-item Self-Compassion Scale (Neff, 2003) is composed of six 4-to-5 item subscales: self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification. Response choices for items range from 1 (*Almost Never*) to 5 (*Almost Always*). Neff (2003) recruited undergraduates to establish psychometric properties for the self-compassion scales and reported a test-retest reliability for the overall self-compassion scale of $r = 0.93$. In the current study, the Cronbach's alpha for the scale as a whole was $\alpha = 0.93$. Internal consistencies for subscales ranged from $\alpha = 0.74$ (over-identification) to $\alpha = 0.85$ (self-kindness). Neff (2003) outlines a list of constructs that hold relationships with self-compassion in ways that support its convergent and discriminant validity.

2.2.3. Internalized shame scale

The Internalized Shame Scale (ISS; Cook, 1994, 2001) taps phenomenological aspects of trait shame. The ISS contains 30 items; del Rosario and White (2006) indicated that two factors emerged from their study validating the ISS: shame (24 items) and self-esteem (six reverse-coded items). Cook (1994) found adequate convergent and discriminant validity for the ISS. The current study used only the shame subscale of the ISS, which yielded a reliability of $\alpha = 0.97$.

2.2.4. Center for epidemiological studies depression scale—Revised

The Center for Epidemiological Studies Depression Scale—Revised (CESD-R; Eaton, Smith, Ybarra, Muntaner, & Tien, 2004) is a 20-item self-report measure of mood, somatic, and motor symptoms of depression. Eaton et al. (2004) created the items for the CESD-R that would closely reflect the DSM-IV criteria for major depression. Van Dam and Earleywine (2011) demonstrated convergent validity for the CESD-R; the CESD-R Cronbach's alpha for the current study was $\alpha = 0.95$.

2.2.5. Demographic questionnaire

We collected information on participant age, race, gender, sexual orientation, relationship status, educational background and therapy history. We presented the demographic questionnaire as the final measure to reduce the effects of stereotype threat.

2.3. Procedure

Following IRB approval, participants were recruited using flyers posted on campus and in the community. Participation took place entirely online using Qualtrics (see www.qualtrics.com). We instructed participants to complete the study in a private setting without distraction. After reading and agreeing to the Informed Consent notice, participants encountered one of three random counter-balanced presentations of four questionnaires, with the demographic survey at the end of each counterbalanced condition. A progress bar tracked participants' overall progress as they moved through.

We reduced risk in a number of ways. First, we indicated in our informed consent notice that our study would ask questions about childhood maltreatment. Additionally, crisis resource referrals were presented at the beginning and end of the study. Finally, each item was accompanied by an option stating *I choose to not answer this item* so as to not force participants to respond to any items. Forty-eight (19.7%) participants chose to be compensated by entrance in a raffle for $25, and 196 (80.3%) received extra credit to be used in certain psychology courses.

3. Results

3.1. Preliminary analyses

An a priori minimum sample size and power analysis was calculated using methods based on the *RMSEA* model fit index as outlined in Preacher and Coffman (2006). This method calculates a minimum sample size that is needed to detect a poor fitting model (close fit). The minimum sample size analysis is based on a choosing: 1) a threshold for *RMSEA* that qualifies as poor fit, assuming our hypothesized model is the true population model; 2) choosing a threshold for *RMSEA* that indicates close fit, assuming our hypothesized model is the true population model; 3) the alpha error rate; and 4) the desired power. With respect to our hypothesized model (df = 13), we assume a poor fit of the hypothesized model, assuming our model is the true population model, when $RMSEA > 10$. We assume our model is a close fit, assuming our model is the true population model, when $RMSEA \leq 0.040$. Fixing alpha error rate at 0.05 and the power at 0.80 requires a minimum sample size of 200 participants. This sample size of 200 gives 80% chance of rejecting the statistical test that H_0: $RMSEA \leq 0.040$, if the true value of $RMSEA$ is 0.10 in the population. For the actual collected sample size $n = 244$, the a priori power equals 0.88 using the previous thresholds.

Three hundred and thirty-one participants completed the study online, and we excluded 87 participants from analysis during the data cleaning process. Forty-eight participants were excluded based on their response times for the protocol being faster than our pilot-testers who were asked to respond as quickly as possible with comprehension. Sixteen participants showed patterns of uniform response or skipped entire measures. Five participants were removed because they did not list their age; our experience at our university suggests these participants were minors who did not want to acknowledge having slipped past the inclusion criterion of being at least 18 years old. Finally, Bernstein and Fink (1998) indicated that participants who answered *very often true* to any of the three minimization/denial items in the CTQ may be underreporting maltreatment. We removed 18 participants from our dataset who responded *very often true* to all three of these items. Among participants who were retained in our model, less than 1% of values among all items were missing. Since less than 10% of data were missing for each variable in our model, we employed expectation maximization to impute missing values at the item level (Hair, Black, Babin, & Anderson, 2010).

3.2. Main analyses

Path models were estimated using the R package *lavaan* (Yves Rosseel, 2012) and the R statistical computing environment (R Development Core Team, 2017). Path models were estimated using robust estimators for the sample covariances (Yuan & Tian, 2015; Yuan & Bentler, 1998); and the robust covariances were calculated using the R package *covRobust* (Wang & Raftery, 2002). Bootstrap standard errors and 95% confidence intervals for path coefficients, indirect and total effects, are based on 5000 bootstrap samples. Confidence intervals that contain a value of zero imply null hypotheses on path coefficients that cannot be rejected. Confidence intervals that do not contain a value of zero imply path coefficients that are significantly different from a null hypothesized value of zero in the population.

Post-hoc explorations examining the degree of model misspecification in the originally hypothesized path model carried out by employing a global model

specification search utilizing a Tabu search algorithm programmed in the R language (Marcoulides, Drezner, & Schumacker, 1998; Marcoulides & Falk, 2018). All models in the model specification search were scored using Akaike Information Criterion (*AIC*) scoring. Paths that contributed to poorer models were fixed to zero such that the total number of variables and paths (both fixed and free) were held constant across candidate models. Models thus differed by the number of free parameters in the model. The global search was initialized using the saturated version of the hypothesized model.

A total of 176 of our 244 participants endorsed no sexual abuse history, making sexual abuse a highly censored variable (see Fig. 2). The combined effects of a censored distribution for sexual abuse, and the low correlations it held with self-compassion, shame, and depression, caused numerical instabilities in the fitting of models, and in the model selection stages. Consequently, we did not allow
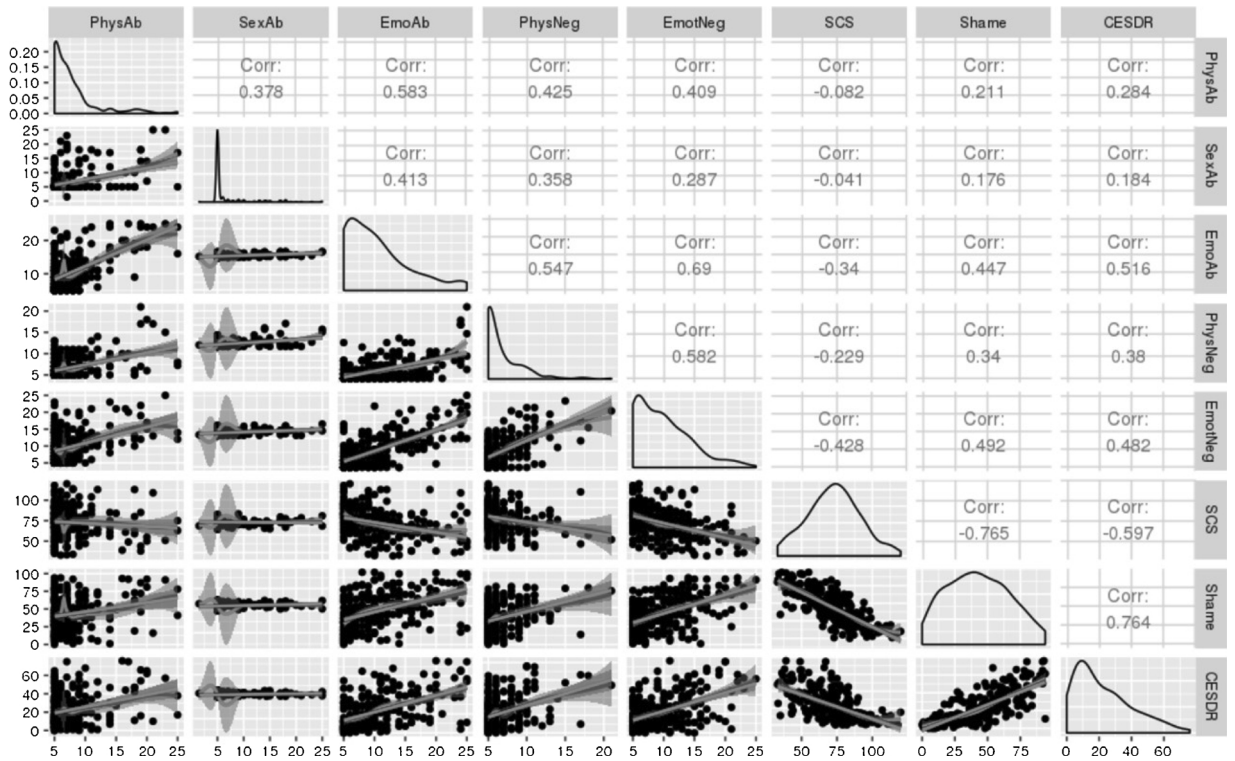
Fig. 2. Scatterplot correlation table of our variables of interest. Note the extremely leptokurtic and positively skewed distribution of sexual abuse scores. SCS = Self-Compassion Scale; CESDR = Adult Depressive Symptoms.

sexual abuse to predict self-compassion, shame, and depression. Nonetheless, we included sexual abuse was as a covariate, and we controlled for the effects of physical abuse, physical neglect, and emotional neglect on self-compassion, internalized shame, and depression.

The overall fit of the initial saturated model was adequate ($\chi^2(13) = 42.824$, $p < 0.001$, $RMSEA = .058$, 90% CI [0.00, 0.14], $CFI = 1.00$, $TLI = 0.96$, $SRMR = 0.014$, $AIC = 11,639.318$, $ECVI = 0.293$). The Tabu search saved 13 of the top ranked AIC-scored models. Of these top ranked models, models with a larger AIC value, that differed by no more 5 from the minimum AIC value, were
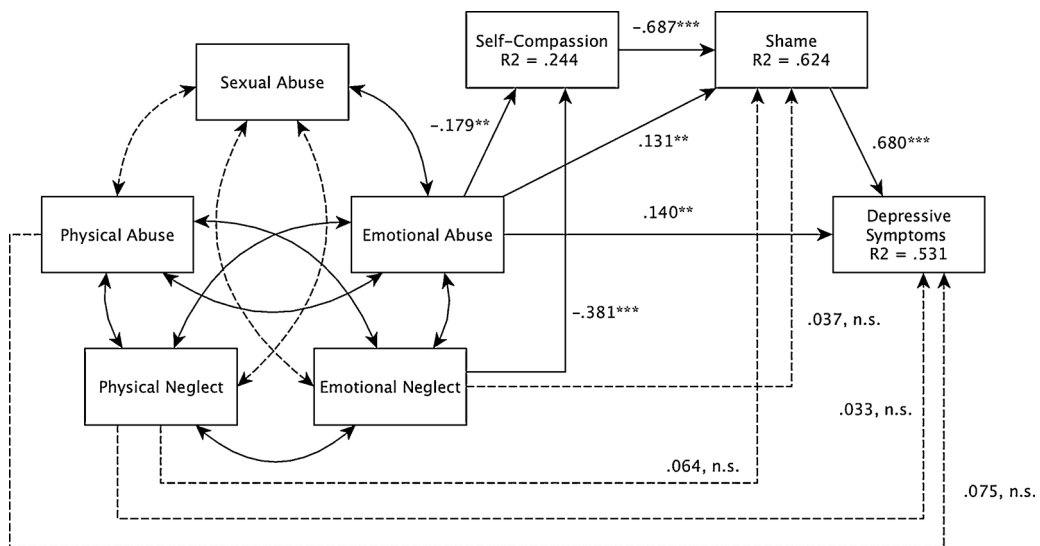

Fig. 3. Path Model with Associated R^2 Values and Coefficients of Significant Paths. Dashed lines indicate insignificant paths that were included in the model fit. The correlation between emotional neglect and sexual abuse approached significance r = .123, p = .051.* p = .050,** p < .01,*** p < .001.

examined for further scrutiny. The final selected model differed from the minimum *AIC* model by approximately 5. This final model (see Fig. 3), which was chosen from the top ranked models, was closest in theoretical alignment with our a priori hypothesized model (see Fig. 1). Overall fit indices suggest that the optimal path model fit the data very well ($\chi^2(8) = 5.932$, $p = 0.655$, *RMSEA* < 0.001, 90% CI [0.00, 0.06], *CFI* = 1.00, *TLI* = 1.00, *SRMR* = 0.016, *AIC* = 11,629.762, *ECVI* = 0.254). The *AIC* and the *ECVI* (expected cross-validation index) model performance indicators of our final model are smaller than that of the saturated model, and smaller than the original hypothesized model (see Fig. 1), providing support that our hypothesized model, minimally modified by the Tabu Search selection, produced a final model that overfits the data less than the saturated or originally hypothesized model (Burnham & Anderson, 2002). Our covariates correlated significantly with each other and emotional abuse, with the exception of the three correlations (see Fig. 2). Additionally, there were four paths leading from a covariate to one of our mediators or depression that were insignificant but left free to vary.

Results from this model demonstrated a significant indirect path beginning with emotional abuse passing through self-compassion and shame, and ending in adult symptoms of depression $\beta = .084(.032)$, $p = .008$, 95% CI [0.03, 0.13]. Individual path coefficients within this indirect path consisted of the following: emotional abuse scores negatively predicted self-compassion scores $\beta = -.179(.067)$, $p = .007$, 95% CI [$-.31$, -0.06], which in turn negatively predicted ISS scores $\beta = -.687(.038)$, $p < .001$, 95% CI [-0.75, -0.60], which in turn positively predicted symptoms of depression $\beta = .680(.038)$, $p < .001$, 95% CI [0.54, 0.73]. Findings yielded a direct path from emotional abuse to shame $\beta = .131(.049)$, $p = .008$, 95% CI [0.04, 0.23] and an indirect path from emotional abuse to depression through shame $\beta = .089(.033)$, $p = .008$, 95% CI [0.01, 0.15].

Contrary to our initial model, our final path model produced a significant path from emotional neglect to self-compassion $\beta = -.381(.064)$, $p < .001$, 95% CI [-0.51, -0.22]. Thus, our model demonstrated a significant indirect path from emotional neglect to depression passing through self-compassion, followed by shame $\beta = .178(.034)$, $p < .001$, 95% CI [0.11, 0.25]. The final model explained a significant proportion of the variance in depressive symptoms $R^2 = .531(.042)$, 95% CI [0.47, 0.66]. Fig. 3 displays the multiple R^2 values for each mediator.

We conducted a post-hoc multiple regression in to determine the unique variance of shame explained by self-compassion and the five maltreatment predictor variables (see Table 1). This model accounted for 63.7% of the variance in internalized shame scores $R^2 = .637$, $F(6, 237) = 69.232$, $p < .001$. The unique variance in shame explained by self-compassion was 36.7% ($sr^2 = .367$), whereas no other predictor variable in this model explained any unique variance above .3% (i.e., emotional abuse $sr^2 = .003$). This suggests that self-compassion itself can account for well over half of the explained variance in shame.

We ran a post-hoc multiple regression to explore the unique contributions of our maltreatment variables, self-compassion, and shame in explaining depressive symptoms. The multiple regression explained 62.6% of the variance in depression $R^2 = .626$, $F(7, 236) = 56.337$, $p < .001$. Of the seven predictors, shame explained the highest amount of unique variance (14.8%) in depressive symptoms $sr^2 = .148$. Emotional abuse was the only other significant predictor in this multiple regression, and it uniquely accounted for 1.5% of the variance in depression, $sr^2 = .015$ (see Table 2).

4. Discussion

We investigated whether deficits in self-compassion associated with emotional abuse would explain feelings of shame and offer an account for the path from maltreatment to depression. We drew on a theoretical framework stating that survivors treat themselves the way they were treated by their caregivers, a process called *introjection* (Benjamin, 2003). We hypothesized that self-compassion and shame would partially mediate the direct path from emotional abuse to symptoms of depression in adulthood. Consistent with our proposed model, we found a significant path from emotional abuse to depression, and a significant indirect path that passed through self-compassion and shame. The findings suggest that emotional abuse interferes with the formation of a kind relationship with oneself. These difficulties practicing self-compassion uniquely accounted for over half of the explained variance in shame. Shame, in turn, partially predicted the extent to which one experiences depression following maltreatment. The final model suggests that shame predicted depression severity more strongly than emotional abuse, indicating the importance of addressing shame in recovering from past maltreatment.

The fact that an indirect path passing through both mediators did not exist when shame preceded self-compassion in both saturated and reduced models supports our proposed sequencing of mediators. Physical abuse, sexual abuse, and physical neglect held relationships with shame and depression independently (see Fig. 2). However, when they acted as covariates, they held no relationship with any of our mediators or with depression in the context of our multiple mediator model. Contrary to expectations,

Table 1
Multiple Regression Results: DV = Internalized Shame.

Independent Variable	b	SE	t	p	Semipartial R^2	F	df1, df2
Physical Abuse	.142	.308	.460	.646	.000	79.744[***]	6, 237
Sexual Abuse	.341	.263	1.300	.195	.002		
Emotional Abuse	.426	.286	1.489	.138	.003		
Physical Neglect	.534	.470	1.136	.257	.001		
Emotional Neglect	.398	.320	1.241	.216	.002		
Self-Compassion	−.881	.057	−15.475	.000	.367		

*** $p < .001$.

Table 2
Multiple Regression Results: DV = Depressive Symptoms.

Independent Variable	b	SE	t	p	Semipartial R^2	F	df1, df2
Physical Abuse	.129	.235	.547	.585	.000	53.059[***]	7, 236
Sexual Abuse	−.171	.202	−.850	396	.001		
Emotional Abuse	.678	. 220	3.083	.002	.015		
Physical Neglect	.416	.360	1.156	.249	.002		
Emotional Neglect	−.080	.246	−.328	.744	.000		
Self-Compassion	−.033	.062	−.539	.590	.000		
Shame	.480	.050	9.671	.000	.148		

[***] $p < .001$.

significant direct paths from our emotional neglect covariate to self-compassion obtained in our final model. These findings suggest that when we control for the contributions of physical neglect, sexual abuse, and physical abuse, the effects of emotional neglect and emotional abuse on self-compassion remained significant. These findings support the theory that, while holding constant other forms of maltreatment, emotional maltreatment plays a major role in shaping adult survivors' construction of meaning around the adversity they endured. We argue that it is this meaning that gives maltreatment its destructive force (Garbarino, 2011). Additionally, the greater explanatory power of emotional abuse and neglect may be due to the greater prevalence and variability of these forms of maltreatment relative to the other three forms of maltreatment (see Table 3).

The strongest indirect path in our model was from emotional neglect to depression, passing through self-compassion and shame. This suggests that emotional neglect may undermine the development of self-compassion more than does emotional abuse. Drawing on an introject theory framework, it seems that low self-compassion stems more from internalizing emotional neglect rather than emotional abuse. This suggests that the internalized omission of emotional support hurts self-compassion more than internalizing the comission of emotionally abusive familial interactions.

4.1. Counseling implications

The model suggests that shame plays an important role in explaining the path from maltreatment to depression. This finding is consistent with previous research suggesting that shame longitudinally predicts the course of depression (e.g., De Rubeis & Hollenstein, 2009). It may be the case that shame instills a sense of feeling trapped in a defective state of being and, therefore, interferes with survivors' beliefs around change and personal growth. The notion of shame sustaining psychopathology is supported by research demonstrating how reductions in shame precipitate decreases in psychopathology (e.g., Øktedalen, Hoffart, & Langkaas, 2015). Thus, exploring and processing feelings of shame as a therapeutic goal may be particularly relevant in the recovery process of survivors of maltreatment.

Our model suggests that improving self-compassion may be a highly viable means of reducing shame. While deficits in self-compassion did not predict depression in the path model, it uniquely explained over half of the explained variance in shame after holding constant the effects of emotional abuse, physical abuse, physical neglect, sexual abuse, and emotional neglect. Thus, while self-compassion does not directly predict depressive symptoms in our model, the strong relationship between self-compassion and shame suggests that improvements in self-compassion may indirectly lower symptoms of depression by way of its effect of lessening shame. This supports research and theory that conceptualize self-compassion as an intervention point for reducing psychopathology and feelings of shame (e.g., Gilbert & Procter, 2006; Johnson & O'Brien, 2013).

Table 3
Descriptive Statistics for All Measures and Subscales of Interest (n = 244).

Measure	Mean	Standard Deviation	Observed Range
Physical Abuse	7.75	3.83	20.00
Sexual Abuse	6.75	4.00	23.52
Emotional Abuse	10.45	5.22	20.00
Physical Neglect	6.74	2.56	16.00
Emotional Neglect	9.82	4.42	20.00
Self-Compassion	72.86	18.34	87.00
Self-Judgment	12.49	4.64	20.00
Isolation	10.50	4.04	16.00
Over-Identification	10.49	3.67	16.00
Self-Kindness	13.98	4.33	20.00
Common Humanity	12.43	3.72	16.00
Mindfulness	12.96	3.27	16.00
ISS Shame Subscale	43.18	23.61	94.00
Adult Depressive Symptoms	22.69	17.75	76.00

4.2. Limitations

While 50.8% of our sample is ethnically or racially diverse from the majority White community where this study took place, it is largely a college convenience sample, 76.6% of which was composed of female participants. Additionally, since 80.3% of respondents chose to be compensated with extra credit, we can infer that college students comprise most of our sample. Thus, it is difficult to generalize our findings beyond female, traditional college-age student populations. Findings from the current study need to be replicated in a sample of community members. The absence of past or current socioeconomic data for the current sample interferes with our ability to understand the socioeconomic backgrounds to which our findings generalize. Since the current study did not account for SES in the path model due to excessive missing data, we could not control for the effects of poverty on any of our variables of interest. Additionally, the low reliability for our physical neglect variable limits our interpretation of the effects of physical neglect on our model.

The cross-sectional correlational nature of the findings makes it impossible to establish causality among the relationships of the variables of interest. All data were collected via self-report, thus making responses susceptible to various forms of error, such as social desirability and limited self-awareness. In a review of the literature, Hardt and Rutter (2004) identified underreporting as a source of potential error in retrospective reports of abuse and neglect. While we removed 18 participants who showed excessive signs of underreporting, we retained in our final data set 64 participants who endorsed *very often true* on at least one CTQ minimization and denial item (Bernstein & Fink, 1998). Minimizing and denying past adversity may extend to other areas of the present, such that participants may have also underreported current symptoms of depression, deficits in self-compassion, and feelings of shame. While emotional state and psychiatric diagnosis may influence retrospective reporting of maltreatment, a review of the literature suggests these sources of error are likely marginal (Brewin, Andrews, & Gotlib, 1993).

4.3. Future directions

The path model accounted for a moderate portion of variance in self-compassion. Considering how increasing self-compassion may be a viable point of intervention, future studies may focus on understanding developmental factors that promote or undermine the development of self-compassion. Intervention efforts will need to rely on future research addressing how to promote self-compassion among those who currently exhibit difficulties practicing it.

Benjamin (2003) suggests that when survivors are confronted with stress in their daily lives, they experience the need to feel close to their attachment figures. Survivors therefore activate harsh and neglectful introjects in order to instill an implicit sense of proximity to one's attachment figures, a phenomenon called *psychic proximity*. Thus, some individuals may be resistant to practicing self-compassion because it leaves behind the sense of psychic proximity instilled by activating whatever other harsh, introjected voices they may carry. Since chronic developmental exposure to maltreatment may intensify the need to turn to mental representations of attachment figures (Benjamin, 2003), survivors of more severe maltreatment may experience greater difficulty relinquishing self-destructive introjects. Future research may explore developmental and concurrent factors that shed light on resistance to practicing self-compassion. Moreover, future research could identify ways of testing psychic proximity as the underlying mechanism accounting for the nature of the relationship survivors form with themselves.

Additional research is needed to clarify the path from emotional maltreatment to the variables of interest in this study. Namely, future research may focus on identifying additional factors that bring the strength of the direct path from emotional abuse to depressive symptoms in adulthood below significance. Additionally, the strong correlation between emotional neglect and shame in our sample corroborates past work identifying a correlation between a) shame and emotional neglect (Webb et al., 2007) and b) shame and unspecified, categorical neglect (Bennett et al., 2010). However, Shahar et al. (2014) did not find an association between shame and emotional neglect. The field may benefit from establishing the conditions that determine when past emotional neglect predicts current feelings of shame.

Author note

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