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Parenting Style as a Predictor of Self Compassion among a Group of Adolescents

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ABSTRACT

Self-compassion is a healthy way of relating to oneself when considering personal failures, inadequacies or difficult life events. There are three interrelated components which comprise self-compassion: self-kindness versus self-judgement, common humanity versus isolation and mindfulness versus over-identification. Self-compassion has been related to many positive outcomes, yet little is known what contributes to individual differences in self-compassion. It has been suggested that self-compassion most likely originates from early relationships with primary caregivers. Therefore the parent-child relationship is important in understanding the development of self-compassion. Adolescence is a period marked by significant transformation and change, with the primary developmental task during this time being that of establishing an identity separate to one’s parents. It is therefore expected that the parent-child relationship will encounter significant changes during this time. Parent-child relationships are typically characterised by a particular style employed by the parent. Four parenting styles have been identified in the literature by combining two dimensions; namely, parental responsiveness, which refers to warmth, support, affection and acceptance, and parental demandingness which refers to control, rules and the limits placed on the child. The four parenting styles are consequently, authoritative, authoritarian, permissive and uninvolved.

The broad aim of this study was to examine the relationship between parenting style and self-compassion among adolescents, and to determine whether parenting style could predict self-compassion among a group of adolescents. To achieve this aim, a quantitative, cross-sectional, survey design was implemented. The sample consisted of a group of adolescents from a school in Johannesburg, South Africa, \( n = 188 \), with a mean age of 14.4 years. Neff’s (2003a) Self-Compassion Scale was employed to measure self-compassion and the
Parenting Style Inventory II (Darling & Toyokawa, 1997) was administered to measure adolescents’ perceptions of their parents parenting style.

A correlational analysis was conducted to examine the relationship among the variables. The demandingness dimension for both parents was not significantly related to self-compassion (Mothers’ Demandingness \( r = .02; \) Fathers’ Demandingness \( r = .07 \)), demonstrating that discipline, structure, restrictiveness or any kind of rule setting and supervision is not related to self-compassion. However the responsiveness dimension for both parents demonstrated a statistically significant relationship with self-compassion (Mothers’ Responsiveness \( r = .18; \) Fathers’ Responsiveness \( r = .26, \ p \leq 0.01 \)). Gender was included as a control variable and it was also found to have a correlation with self-compassion \( (r = -.202, \ p \leq .01) \).

A standard multiple regression analysis was performed to examine the unique variance of each predictor (mother’s responsiveness, father’s responsiveness and gender) on the dependent variable (self-compassion). The demandingness subscale was excluded from the analysis as it demonstrated no relation to self-compassion. The analysis revealed that 11.5% of the variance in self-compassion experienced by adolescents can be explained by the gender of the respondent and the responsiveness of the mother and father respectively.

However, while all three variables correlated with self-compassion, the strongest predictor of self-compassion was the father’s responsiveness, indicating the unique contribution the father makes to the development of self-compassion during adolescence.

It appears evident that responsive parenting, characterised by sensitivity, warmth, acceptance and nurturance is related to the ability to develop self-compassion in adolescence.
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“If your compassion does not include yourself it is incomplete”

(Kornfield, 1994, p.28)

“Having compassion starts and ends with having compassion for all those unwanted parts of ourselves, all those imperfections that we don't even want to look at. Compassion isn't some kind of self-improvement project or ideal that we're trying to live up to”

(Chödrön, 1997, p.106)
CHAPTER 1 – INTRODUCTION, RESEARCH AIMS AND OVERVIEW

1.1 Introduction

Compassion in psychology has been typically understood in terms of being moved by and wanting to alleviate suffering in others. However, Buddhism emphasises the importance of compassion not only for others but also for oneself (Brach, 2003; Davidson & Harrington, 2002). Self-compassion entails extending the same kindness and compassion to oneself that one would offer to others during times of pain and suffering (Germer, 2009; Neff, 2011a). Self-compassion is a healthy way of relating to oneself when faced with personal failures, inadequacies, or negative life events (Neff, 2003a, 2003b; Neff & Lamb, 2009). During times of emotional pain or challenging circumstances, one is at risk of feeling isolated and overwhelmed. Paradoxically, many people become self-critical when considering personal inadequacies, failures or shortcomings which could serve only to intensify negative feelings and generate a vulnerability to mental disorders, such as, depression (Beck, 1963; Brach, 2003; Germer, 2009; Gilbert & Irons, 2009; Gilbert & Proctor, 2006). Self-compassion therefore involves being kind, sympathetic and accepting to one’s own suffering (Neff, 2003b). It comprises three interrelated elements; first, self-kindness versus self-criticism, second, recognition of a shared common humanity as opposed to a sense of isolation, and third, a balanced mindful acceptance versus over identifying with negative thoughts or feelings (Neff, 2003a, 2003b, 2011b).

Research indicates that self-compassion is associated with many positive outcomes, including emotional and physical wellbeing (Bluth & Blanton 2014; Hall, Row, Wuensch, & Godley, 2013; Neff, 2011b), adaptive coping (Batts Allen & Leary, 2010; Neff, Hsieh & Dejitterat, 2005), self-efficacy, pursuit of mastery goals (Bluth & Blanton, 2014; Breines & Chen, 2012;
Iskender, 2009; Neff et al., 2005), as well as well-being and resilience in adolescents (Neff & McGehee, 2010).

However, little is known about what contributes to individual differences in self-compassion. Research suggests that factors contributing to individual differences in self-compassion include, age (Bluth & Blanton, 2014; Homan, 2016; Hwang, Kim, Yang, & Yang, 2016; Neff & Vonk, 2009), gender (Bluth & Blanton, 2014; Neff & Vonk, 2009; Yarnell et al., 2015), culture (Neff, Pisitsungkagarn, & Hsieh, 2008; Yamaguchi, Kim, & Akutsu, 2014) and personality traits (Hollis-Walker & Colosimo, 2011; Neff, Rude, & Kirkpatrick, 2007; Thurackal, Corveleyn, & Dezutter, 2016). In terms of the development of self-compassion, some researchers have suggested that self-compassion probably originates in early relationships with primary caregivers (Germer, 2009; Gilbert & Irons, 2009; Irons, Gilbert, Baldwin, Baccus, & Palmer, 2006; Kelly & Dupasquier, 2016; Neff, 2011a; Neff & McGehee, 2010; Pepping, Davis, O'Donovan & Pal, 2015). The parent-child relationship may therefore be important in understanding the development of self-compassion during various developmental phases, such as adolescence.

Adolescence is a period marked by significant transformation and rapid physical, cognitive and psychosocial development. According to Erikson’s (1977) psychosocial theory, the developmental task during this time is that of developing an identity separate from those of one’s parents. The parent-child relationship is therefore expected to encounter substantial changes during this time as the adolescent seeks to cultivate independence and a unique identity. If the parent-child relationship is characterised by conflict, and the adolescent perceives the parent as cold, critical and rejecting, the adolescent is likely to feel alone, will internalise negative judgments about themselves, become self-critical and easily overwhelmed by negative emotions. Peer relationships also become increasingly prominent during this time, but these can be fraught with conflict and change. Negative social
comparisons may occur, amplified by adolescent ego-centrism (Elkind, 1967), which could also contribute to an adolescent developing self-criticism. These changes within themselves and their relationships can be challenging and tumultuous, which may affect the development of self-compassion. Moreover, according to both theory and research, there is a considerable risk during this time that the adolescent will develop depression. (Beck, 1963; Gilbert & Irons, 2009; Gilbert & Proctor, 2006; Neff & McGehee, 2010; Potter, Yar, Francis, & Schuster, 2014). In fact, Erikson (1977) suggested that failure to develop a coherent identity during this time would lead to depression. It would thus seem that the development of self-compassion has significant relevance for mental health among adolescents as they navigate and explore various aspects of their identity formation.

Parent-child relationships are typically characterised by a particular parenting style adopted by the parent. Parenting style refers to behaviours or practices by parents directed at the child in various situations in a specific emotional climate (Berk, 2013; Darling & Steinberg, 1993). Four parenting styles have been identified by combining two dimensions: parental responsiveness, which refers to warmth, support, affection and acceptance, and parental demandingness which refers to control, rules and limits placed on the child. The four parenting styles are consequently, authoritative, authoritarian, permissive and uninvolved (Baumrind, 1966; Maccoby & Martin, 1983). In the current study parenting style is examined from the viewpoint of adolescents’ perceptions of their parents’ interactions with them; as research indicates there is often a low level of agreement between parents and children on the measures of parenting style. In addition, adolescents’ perception of their parents’ parenting style is considered a better predictor of outcomes than the parents’ own measures (Schaefer, 1965; Spera, 2006; Steinberg, Lamborn, Dornbusch, & Darling, 1992).

To date, few studies have examined the possible associations between self-compassion and experiences of parenting in childhood (Irons et al., 2006; Kelly & Dupasquier, 2016; Neff &
High parental rejection, overprotection and low parental warmth predicted low self-compassion (Irons et al., 2006; Pepping et al., 2015; Potter et al., 2014). Maternal support was significantly associated with high self-compassion, whereas maternal criticism was found to be associated with low self-compassion (Kelly & Dupasquier, 2016; Neff & McGehee, 2010). It is evident that more research on adolescent samples is needed if there is to be greater understanding of the development of self-compassion, particularly among younger adolescent samples. Specifically, further research is needed on how experiences of parenting during adolescence may be related to individual differences in the development of self-compassion. The current study will examine both mothers’ and fathers’ parenting style separately and how it relates to self-compassion.

The concept of self-compassion reveals promising research findings, with studies outside the United States gaining augmentation. Given the Eastern origins of self-compassion and its emerging popularity in Western psychology, research in the South African context may also provide new insight into this construct. This study proposes to be the first of its kind in South Africa.

In this study the researcher aims to demonstrate the importance of early care-giving relationships in the development of self-compassion. The current study therefore aims to examine the interrelationship between self-compassion and parenting style among a South African adolescent sample.

1.2 Research Aims

The broad aim of the study is to examine the relationship between self-compassion and parenting style. The researcher is particularly interested in whether adolescents’ perceptions
of their parents’ parenting style could predict self-compassion. These broad aims are therefore addressed by the following specific objectives:

- To determine levels of self-compassion among a group of adolescents.
- To determine the prevalence of the four parenting styles: authoritarian, authoritative, permissive and uninvolved among a group of adolescents.
- To determine gender differences in self-compassion: i.e. scores for boys and girls.
- To determine gender differences in adolescents’ perception of parenting styles: i.e. scores for boys and girls.
- To determine maternal/paternal differences in adolescents’ perception of parenting styles: i.e. scores for mothers’ parenting style and fathers’ parenting style.
- To determine the relationship between parenting style and self-compassion.
- To determine how much variance in self-compassion scores is explained by parenting style.
- To determine the degree to which adolescents’ experiences of mothers’ and fathers’ parenting style respectively predict self-compassion.

1.3 Chapter Overview

The dissertation is structured as follows: The current chapter served to introduce this study. A contextual background was provided and the research aims were specified.

Chapter two provides a review of the literature pertaining to the constructs of this study. Adolescence is explained in the context of theory, delineating the developmental processes involved during this period. Self-compassion is examined based on Neff’s conceptualization. A comprehensive definition of the three interrelated components of self-compassion is given and empirical evidence is examined. There is particular reference to findings in adolescent
populations. Parenting style is then described, examining specifically the two dimensions of responsiveness and demandingness.

The methodology is described in chapter three. The research aims are outlined, the research design is set out and the sampling procedures and the participants are described. Thereafter the procedure followed in the study is outlined. The measuring instruments, the ethical considerations and the data analysis are then explained.

Chapter four presents the findings from the statistical analyses conducted. Reliability indices and descriptive statistics for the scales are described. The findings from the inter-correlations among the variables are presented; thereafter, the statistics related to the specific aims of the study are delineated.

A discussion of the results is rendered in chapter five. Possible explanations and interpretations in the context of the existing literature are examined. Each research aim is discussed, after which the limitations of the study are considered, recommendations for future research are proposed and implications of the study are put forward. Finally the concluding remarks are offered, including a personal reflection by the researcher.
CHAPTER 2 – LITERATURE REVIEW

Adolescence, Self-Compassion and Parenting Styles

2.1. Introduction

Adolescence is a period of significant transformation during which an individual transitions from childhood into adulthood. Adolescence converges in various domains, and includes, physical and biological growth, brain and cognitive development and psychosocial maturity. The importance of understanding the developmental tasks within these domains has implications for adolescent wellbeing, as these tasks can be challenging. Self-compassion provides a way of thinking and of behaving to oneself that is supportive in the successful transition into adulthood. The parent-child relationship undergoes major changes during this time. Therefore adolescents’ perception of their parents’ parenting style possibly has implications for successful transitioning into adulthood and the ability to be self-compassionate in the process. This study explores the nature of the interaction between parenting styles and self-compassion in terms of this developmental stage.

2.2. Adolescence

2.2.1 Defining Adolescence

Adolescence is a culturally constructed period of transition between childhood and adulthood marked by pronounced physical, cognitive, psychosocial and emotional transformation (Berk, 2013; Carr, 2005; Mwale, 2012). Current research has found that the notion that this transformation is characterised by stress, conflict, negativity and emotional turbulence has been overstated (Graham, 2004; Hazen, Schlozman, & Beresin 2008; Siegel, 2013; Steinberg, 2015). While some adjustment disturbance is expected, not all adolescents encounter serious difficulties during their development (Berk, 2013; Siegel, 2013).
The age which is defined as the period of adolescence varies between the cultural, social, legal and biological spheres (Cohen, Bonnie, Taylor-Thompson, & Casey, 2016; Graham, 2004; Steinberg, 2015). Some researchers assert that the onset of puberty has been showing a decline in recent decades, with some data showing puberty starting as early as seven or eight years old for both girls and boys (Steinberg, 2015). However, other researchers have disputed this claim by proposing that this phenomenon is not new, but has merely been recently discovered (Graham, 2004). The end of adolescence raises further debate, with some researchers positing that adolescence ends in biological markers, like the cessation of bone growth (Roenneberg et al., 2004). However, many researchers maintain that social and cultural markers signal the end of adolescence, for instance, marriage (Steinberg, 2015), school leaving, and the commencement of work (Graham, 2004). Erikson (1977) posited that adolescence was concluded by the successful formation of an ego identity, while Chapman (2016) suggested that adolescence is marked by developing an identity and independence. The developmental psychologist John Santrock (1990) proposed that adolescence begins in biology and ends in culture. However, the literature is unclear as to the age at which this may occur. Given these inconsistencies, it is suggested that the definition of adolescence be centred on the developmental tasks required of this stage (Hazen, et al., 2008). These tasks can be divided into physical, cognitive and psychosocial domains. A discussion of these domains follows.

2.2.2. Physical Development

A distinct increase in hormones results in rapid changes in body proportions and sexual maturation, known as puberty. Adolescents grow not only in height and weight proportions, referred to as a ‘growth spurt’, but also in developing characteristics related to sexual functioning. The primary sexual characteristics involve the reproductive organs, i.e. the ovaries, uterus and vagina in females, and penis, scrotum and testes in males. Secondary
Sexual characteristics are those features which are visible on the outside of the body, like breast development in females and underarm and pubic hair in both sexes (Berger, 2014; Berk 2013; Carr, 2005).

Girls typically begin puberty between the ages of 8 and 13 years of age, with boys lagging behind, beginning puberty at around the age of 12 years (Hazen, et al., 2008). The ability to accept and cope with such physical changes may present challenges for adolescents as they navigate this time of their development. In addition, the age of the onset of puberty varies and this may present social and psychological challenges for adolescents. Differences in physical appearance, sexual maturation and cognitive development of their peers of the same chronological age may affect psychological adjustment as comparisons with peers may lead to feelings of isolation and uncertainty (Berk, 2013; Hazen et al., 2008). It has also been suggested that these feelings of isolation and uncertainty, experienced as a lack of social support, is more evident for boys than for girls (Berk, 2013).

When it comes to the increased hormone levels in adolescents and their purported link to moodiness, research shows that, while adolescents show fluctuations in mood, hormones are not entirely responsible. It would seem that changes in relationships, sleep patterns, brain development and negative life events play a more significant role in adolescent mood than hormones alone (Berk, 2013; Steinberg, 2015). It is evident that the interplay between physical and other developmental domains has important implications for adolescent wellbeing. An area which has seen significant increase in research and attention in recent years is that of adolescents’ brain development. Contrary to earlier views that brain development was complete by early childhood, structural brain imaging studies now show that significant brain development occurs during adolescence, which forms an important role in adolescent maturation, as it relates to cognitive and psychosocial development (Hazen et al., 2008; Kuhn & Franklin, 2008).
2.2.3. Brain and Cognitive Development

The limbic system, the area associated with instinctual and emotional responses, matures before the prefrontal cortex, the area in the brain associated with planning, analytical reasoning and emotional regulation. During adolescence two kinds of changes occur. The first is in the grey matter, showing a decrease or ‘pruning’ of neural connections which are idle. The second change occurs in the white matter, whereby increased myelination improves the efficiency of established neural connections (Berger, 2014; Berk, 2013; Hazen et al., 2008; Kuhn & Franklin, 2008). Therefore, as the brain develops through adolescence it becomes more selective in its attention and moves towards novelty seeking, deep emotions, social engagement and creative exploration (Berk, 2013; Siegel, 2013). This developmental process also suggests that the behaviours typically associated with adolescent development, such as risk-taking and impulsivity, are, in part explained by biological processes (Hazen, et al., 2008). The ability to respond appropriately to changing emotions and to assess the risk and reward from certain behaviours may be challenging for some adolescents. However, others are able to be more self-regulatory, as they are able to practise mindful awareness of their emotions and thoughts without being overwhelmed by them (Bluth & Blanton, 2014; Bluth, Roberson, & Gaylord, 2015; Burke, 2010).

Piaget’s (1928) theory of cognitive development may provide further understanding of the biological processes and possible emotional responses involved during this developmental phase.

2.2.3.1. Piaget’s cognitive development theory.

According to Piaget’s (1928) cognitive development theory, children move through four stages of cognitive change. From age 11, adolescents enter the formal operational stage in which they develop the ability to reason abstractly, think systematically and logically and
become capable of hypothetico-deductive reasoning. This is the capacity to test possibilities; it is reasoning through ‘if-then’ ideas, whereby they are able to hypothesize or predict an outcome, which can be tested in the real world. The second important ability adolescents develop during this stage is that of propositional thought, which is the ability to evaluate propositions without referring to external circumstances (Berger, 2014; Berk, 2013).

Another characteristic of this stage is ‘metacognition’, which is the ability to think about and monitor one’s own thought processes. However, basing his exposition on Piaget’s work, Elkind (1967) proposed that the adolescent’s ability to self-reflect, combined with the physical and psychological changes they are experiencing, leads to egocentrism. Elkind (1967) suggests that this egocentrism results in two distorted cognitions. First, the ‘imaginary audience’ created in the adolescent’s mind leads to the belief that they are the centre of others’ attention and that this audience is either fault-finding or admiring. The second distorted cognition is the ‘personal fable’, in which adolescents are convinced that others are thinking about them and consequently develop an overinflated sense of self-importance and high opinion of themselves thinking that they are special and unique. The personal fable gives rise to feelings of invulnerability, sometimes referred to as the invincibility fable (Berger, 2014), which is the belief that death will not occur unless it is destined and therefore risk-taking behaviours are not necessarily harmful (Alberts, Elkind, & Ginseng, 2007; Berger, 2014; Berk, 2013; Carr, 2005; Elkind, 1967; Piaget, 1928). However, the personal fable is expressed in different ways among adolescents and there are mixed findings in the literature as to gender differences in this regard (Alberts, et al., 2007; Berger, 2014; Steinberg, 2015).

The adolescent’s changing brain and cognitive development also has an influence on the development of their self-concept and their self-expression. This is elucidated by psychosocial development.
2.2.4. **Psychosocial Development**

Adolescence is a time marked by increased differentiation of the self-concept. While by the age of sixteen adolescent cognitive abilities are similar to those of adults, psychosocial functioning, characterised by intense, high emotions and peer influence, is much less mature (Chapman, 2016; Seigel, 2013; Steinberg, Caufmann, Woolard, Graham, & Banich, 2009). The adolescent seeks to develop an identity and find meaningful and acceptable ways of expressing this identity among peers, family and society at large. This can result in conflict and uncertainty in these relationships. The development of a healthy and coherent self-concept gives rise to a stable self-image and the adolescent’s primary challenge is to develop a self-concept that integrates the adolescent’s view of himself as opposed to the perceptions of how others view them (Hazen et al., 2008; Shaffer, 2005). Erik Erikson’s (1977) psychosocial theory will be explored in relation to this domain, as it provides an insight into the challenges associated with this stage of development. Following this, relationships with peers and parents will be discussed.

2.2.4.1 *Erikson’s psychosocial theory.*

Erik Erikson (1977) was a German scholar who proposed eight stages of development across the human life span. According to Erikson, a key developmental task of adolescence is identity formation (Erikson, 1977; Flemming, 2004). He asserted that, at each stage, an individual is faced with challenges which they have to overcome. He referred to the challenges as crises which present themselves as binary tasks which the individual has to resolve in order to move on successfully to the next stage. Erikson refers to this crisis in adolescence as ‘identity versus role confusion’. At this juncture, adolescents need to separate from their parents, particularly the parent of the same sex and develop a coherent identity of their own, encompassing their own values and morals. He asserted that the formation of an
identity is essential to the ability to form committed, lasting, intimate relationships. Failure to establish an identity would result in role confusion; and long-term failure in this regard, leading eventually to loneliness, low confidence and depression (Erikson, 1977; Fleming, 2004; Hazen et al., 2008; Shaffer, 2005). Erikson suggested that the adolescent may explore various aspects of their identity, including their religious, political, vocational and sexual identity. This process of exploration occurs within a dynamic of social influences from peers and parents alike, whereby the adolescent seeks to integrate all the identifications offered in various social roles (Berger, 2014; Erikson, 1977; Fleming, 2004). Consolidating their identity may be fraught with interpersonal difficulty as the adolescent navigates separation from their parents and finds a peer group with whom they can identify.

2.2.4.2. Relationships with peers.

As children progress through adolescence, peer interaction undergoes a significant shift. Relationships with peers, in terms of both friendships and romantic relationships become increasingly important. Peer groups often change during this time as peer interaction becomes less closely supervised by adults and contact occurs across a variety of settings (Furman, McDunn, & Young, 2009).

Compared with younger children, adolescents place more emphasis on social descriptors of the self and evaluate themselves against the feedback they receive from others. They judge their worth in various domains (academic, social, athletic, physical appearance), depending on the relative importance of each domain (Berk, 2013; Marsh & Ayotte, 2003; Graham, 2004; Shaffer, 2005; Siegel, 2013). This evaluative component is called self-esteem. The quality of friendships within those domains as well as romantic appeal, is central to the development of adolescents’ self-worth and consequently, self-esteem (Shaffer, 2005). Adolescent friendships are characterised primarily by intimacy or personal disclosure, loyalty
and mutual support. Conflict is common in adolescent friendships, and while many adolescents successfully resolve conflicts, unresolved conflict and the termination of friendships is often associated with loneliness, depression, guilt and anger (Berk, 2013; Furman et al., 2009).

Another significant change in peer relationships is the formation of relationships with the opposite sex. Personal body image and physical status in relationship to peers plays a significant role in romantic relationships and has an important effect on adolescents’ self-concept. Being accepted by the opposite sex or having a romantic partner is associated with positive affect and psychosocial adjustment, whereas rejection or being alone is associated with negative affect, social anxiety and depression (Collins & Steinberg, 2008; Furnam et al., 2009). Further research is necessary in order to explore the outcomes associated with same sex relationships and cultural differences in this regard (Berger, 2014).

Relationships with parents also undergo significant transformation during adolescence, which will be explained below.

2.2.4.3. Relationship with parents.

It is during this time that adolescents seek to establish an identity outside of their family of origin, particularly distinguishing themselves from their parents. According to Erikson (1977), failure to form a separate sense of self during this time results in role confusion whereby the adolescent progresses into adulthood without a coherent identity. This stage is often characterised by parental conflict within various domains, whereby the adolescent questions and challenges the parents’ values and morals while seeking to establish their own (Chapman, 2016). However, research shows that conflict between adolescents and parents is not necessarily frequent but increases in intensity (Collins & Steinberg, 2008). The parent-child relationship during this time may be also characterised by cyclical independence,
pulling away from parents, and dependence, needing caretaking from parents as adolescents navigate this complex time (Hazen, et al., 2008). Studies demonstrate that parental monitoring and supervision, particularly when it is characterised by warmth and support from the parents, is significantly associated with psychological adjustment and positive outcomes in adolescents (Berger, 2014; Collins & Steinberg, 2008). Further, a lack of parental support coupled with frequent parental conflict can increase depressive symptoms and loneliness in adolescents (Laursen & Hartl, 2013). The nature of parent-child interactions will be discussed in further detail in the section on parenting styles.

2.2.5. Conclusion

Adolescence is a time marked by major transformation, and while some adolescents experience this transformation less turbulently than others do, it seems inevitable that during this process, psychological disturbance of some kind is to be expected. The interplay between the developmental domains, i.e. physical, cognitive and psychosocial, has implications for adolescents’ wellbeing as they negotiate physical changes, sexual maturation, relationship changes, cognitive advancement and independence from parents.

According to Erikson’s (1977) psychosocial theory, the developmental task required at this juncture is that of forming an identity, which may prove to be challenging for the adolescent. However, failure to develop an identity would result in role confusion, and would eventually lead to depression (Shaffer, 2005). As adolescents grow and develop, the way in which they view success and failure, including disappointments, inadequacies and weaknesses, is important to the development of their identity and in turn affects their self-esteem. Adolescents are at risk of being self-critical specifically when they may consider their inadequacies, or are faced with failures or negative life events; and both theory and research support the relationship between self-criticism and depression (Beck, 1963; Ehret, Joormann,
Furthermore isolation and loneliness may occur if adolescents do not fit into a peer group or feel rejected in romantic relationships. In fact Erikson (1977) asserted that the formation of an identity is a criterion in forming meaningful intimate relationships (Shaffer, 2005). The distorted cognitions the adolescents experiences in terms of the ‘personal fable’ and ‘imaginary audience’ may have an isolating effect on the adolescent; and this may have important implications in terms of how the adolescent views him/herself, as well as their relationships with others, including parental relationships.

Self-compassion in this regard may therefore be an important aspect of adolescent development which may promote resilience and wellbeing in adolescents, as well as protect against feelings of isolation and negative self-evaluations. A review of the literature pertaining to self-compassion follows.

2.3. Self-Compassion

2.3.1. History and Background

Self-compassion has, in recent years, become more recognised in Western psychology. This is partly owing to the increasing acceptance of Buddhist philosophy in Western psychology. Buddhist teaching emphasizes mindfulness and compassion, and consequently teachings by writers such as Brach (2003), Goldstein (2015), Hanh (1997), Kabat-Zinn (2011, 2013), Kornfield (1993) and Salzberg (2010) have become more popular and widely disseminated.

Mindfulness can be described as an informal awareness practice, while meditation can be thought of as a more formal practice, whereby one sits for a period of time and focuses on the
breath, for example (Kabat-Zinn, 2011, 2013; Williams & Penman, 2011). In addition, mindfulness-based interventions are becoming increasingly recognised as viable alternatives to mainstream psycho-therapeutic approaches. For example, programs such as Mindfulness Based Stress Reduction - MBSR (Kabat-Zinn, 2013), Mindfulness Based Cognitive Therapy – MBCT (Kuyken et al., 2010; Teasdale et al., 2000), Compassion Focused Therapy (Gilbert, 2009a, 2009b, 2014), Compassionate Mind Training (Gilbert & Proctor, 2006), Compassion Cultivation Training (Jinpa, 2015) and more recently Mindful Self-Compassion (Germer & Neff, 2013; Neff & Germer, 2013) have been increasingly recognised. Research into these interventions has yielded promising results (Germer & Neff, 2013; Gilbert, 2009b, 2014; Kabat-Zinn, 2013; Kuyken et al., 2010; Neff & Germer, 2013; Teasdale et al., 2000).

In some instances self-compassion is better understood in the context of compassion in general, as compassion in Western psychology has, for the most part focused on compassion for others.

2.3.1.1. The context of compassion for others.

Self-compassion can best be understood within the broader context of compassion in general, because an understanding of compassion for others may lead to a more comprehensive understanding of compassion for oneself. Compassion permeates the culture and traditions of every religion worldwide, yet few people have a clear understanding of what compassion may mean (Jinpa, 2015). The word ‘compassion’ comes from the Latin word ‘compati’ – ‘to suffer with’ (Etymology Dictionary, 2017). Many writers, researchers and theorists have put forth various definitions of ‘compassion’. Some of the more applicable definitions are discussed below.

In their review of the role of compassion in mindfulness-based approaches, Feldman and Kuyken (2011) contend that compassion is a multi-textured response to pain and suffering,
including kindness, empathy, generosity and acceptance. They further propose that compassion includes courage, tolerance and equanimity in order to approach suffering. Thupten Jinpa (2015), the Dalai Lama’s English translator, notes that compassion is part of our fundamental human nature. Gilbert (2009a) suggests that compassion is a basic kindness and deep awareness of the suffering of oneself and others with the desire to relieve it. Like Jinpa (2015), he argues from the evolutionary perspective that humans are biologically programmed to respond with care and compassion for others based on one’s own innate soothing and contentment emotional system which evokes a sense of safety and peace (Gilbert, 2009a; Jinpa, 2015). In their empirical review of compassion, Goetz, Keltner and Simon-Thomas (2010) concur with Gilbert (2009a), proposing that the primary purpose of compassion is to facilitate cooperation and protection of the weak and those who suffer. They define compassion as ‘the feeling that arises when witnessing another’s suffering. This motivates a subsequent desire to help’ (Goetz, Keltner, & Simon-Thomas, 2010). Ricard (2015) maintains that compassion is a form of altruism encompassing sympathy, empathy and motivation. He suggests further that compassion is a heartfelt wish for others to be free from suffering and the causes of suffering, and that they may be truly happy and can flourish (Ricard, 2015). Brach (2003) simply states that compassion means to ‘be with, feel with, suffer with’ (Brach, 2003).

The overall view when considering the definition of compassion is that it is distinct from empathy, which is the ability to take the perspective of another and respond emotionally to their suffering (Gilbert & Choden, 2014). Indeed, in brain imaging studies conducted among long-term meditators, empathy and compassion activate different parts of the brain, demonstrating a distinct difference between compassion and empathy (Jinpa, 2015).

Compassion is also distinct from sympathy, which involves a spontaneous feeling of sorrow for another person, typically a loved one, which can be described as a feeling of sadness and
love (Gilbert & Choden, 2014; Goetz et al., 2010). Gilbert and Choden (2014) suggest that sympathy and empathy can evoke compassion. However, compassion is not being overwhelmed and remaining captured in feelings of sadness but is rather being motivated and moved to actions of kindness and care. Correspondingly, well-known mindfulness teacher, Sharon Salzberg (2010) states that ‘kindness is compassion in action’ and that practising compassion is not a denial of pain and suffering but rather channelling empathy and sympathy into action (Gilbert & Choden, 2014; Salzberg, 2010).

The question may arise as to why one should be compassionate or why one would ‘suffer with’ others. In addition to the human biological response to caring for the young and the weak (Gilbert, 2009a), many Buddhist teachers propose a shared connection with all others by being aware that others suffer just as we ourselves suffer (Brach, 2003; Salzberg, 2010). Adversity is inevitable and all human beings will encounter pain in life, be it in the form of death, aging, illness or psychological afflictions and therefore we should practise compassion. Further compassion brings healing, without implying that pain or suffering can necessarily be fixed or changed. Rather, suffering is more approachable and manageable within the bounds of compassion (Gilbert & Choden, 2014; Feldman & Kuyken, 2011).

Some researchers propose that one cannot feel compassion for others unless one is compassionate to oneself (Brach, 2003; Salzberg, 2010) Others suggest that it is often easier for individuals to be compassionate with others rather than themselves, although this can often lead to burnout (Germer, 2009; Jinpa, 2015; Neff, 2003a). However, Buddhism emphasises the importance of compassion not only for others but also for oneself (Neff, 2003a). The Tibetan word for compassion, ‘tsewa’, is understood to point out the way in which one would relate to the self and others. The primary motivation of compassion is that the object of compassion could be set free from suffering (Davidson & Harrington, 2002). The Dalai Lama has been quoted as saying, “[that, compassion] is the state of wishing that
the object of our compassion be free of suffering….yourself first, then in a more advanced way the aspiration will embrace others.” (Davidson & Harrington, 2002; Germer, 2009; Neff, 2003a). Consequently, with the increased interest in Buddhist philosophy, self-compassion is gaining increasing research attention in the field of psychology.

2.3.2. Defining and Conceptualizing Self-Compassion

Following the Buddhist understanding of compassion, self-compassion therefore involves being open, kind, tolerant, patient and sympathetic to our own suffering (Neff, 2003b). The conceptualisation of self-compassion has been credited to Kristin Neff, an associate professor at the University of Texas (Barnard & Curry, 2011; Germer, 2009; Neff 2003b; Neff & Lamb, 2009), who defined self-compassion as having three interrelated aspects: first, self-kindness – being kind and understanding to oneself as opposed to being self-critical and judgemental of oneself during times of perceived failure or inadequacy. The second is the recognition of common humanity, in that what one is feeling or experiencing is part of the greater human experience. This is opposed to a sense of isolation, feeling alone and self-pitying. Third, is a sense of mindfulness; keeping one’s difficult thoughts and feelings in balanced mindful acceptance rather than over-identifying with negative thoughts or feelings (Neff, 2003a, 2003b, 2011b).

A related concept, self-reassurance, has been proposed by Professor Paul Gilbert of the Compassionate Mind Foundation. He describes self-reassurance as a genuine concern for our own wellbeing, being sensitive, sympathetic and tolerant of our distress and non-judgmental towards ourselves (Gilbert & Proctor, 2006; Irons et al., 2006). Gilbert proposes what he refers to as two psychologies: the first being the approach of ‘engagement’, which is the ability to turn to our own and others’ suffering. This can be likened to Neff’s (2003a) mindfulness attitude. Then Gilbert suggests ‘alleviation’, that is, the ability to ease the
sources of suffering, which may be compared to Neff’s (2003a) self-kindness component. For the purposes of this study, Neff’s (2003a, 2003b, 2011a) conceptualization of self-compassion will be followed. The three interrelated aspects of self-compassion as proposed by Neff (2003a, 2003b, 2001b) which are self-kindness versus self-judgment, common humanity versus isolation and mindfulness versus over-identification, will be discussed below.

2.3.2.1. Self-kindness versus self-judgment.

Self-compassion is simply showing oneself the same kindness and compassion one would to a dear friend (Neff, 2003a, 2003b, 2011a, 2011b). It is important to note that self-compassion is extended to oneself during difficult times. This includes instances when individuals experience feelings and perceptions of failure, inadequacy, doubt and self-criticism. Self-compassion is also extended to oneself when one may be facing a difficult or challenging situation, for example, if a loved one is ill or suffering. Self-kindness therefore entails being forgiving, compassionate, empathetic, patient, understanding and warmly accepting of oneself during these moments. It is more than a resignation or grudging acceptance of what is happening, but is rather, a warm regard and kindness to the person (oneself) who is suffering. Self-compassion is extended specifically because one is suffering. One is viewing oneself as deserving of unconditional acceptance and regard during difficult times (Germer, 2009; Neff, 2003b; Neff, 2008; Neff & Lamb, 2009).

In contrast to self-kindness, self-judgement involves being overly harsh towards oneself, being demeaning, critical and disparaging of oneself. For many individuals, in times of failure and inadequacy, self-judgement or self-criticism is a typical response (Neff, 2003b). Ruminating on one’s failings and human weaknesses can lead to guilt, shame and ultimately depression. Suffering is thus amplified beyond the situation initially inciting pain (Beck,
Self-compassion is therefore holding a positive view of oneself, rather than a ruminative, pessimistic view (Neff, 2011a).

2.3.2.2 Common humanity versus isolation.

Second, self-compassion concerns acknowledging our common humanity and the fact that others share our experiences of failure, weakness and difficulty. During times of suffering, many people tend to feel isolated and alone. Feelings of shame resulting from harsh judgements of the self and self-criticism can cause one to withdraw from others. However, isolation is highly associated with negative outcomes like depression (Beck, 1963; Gilbert, Baldwin, Irons, & Palmer, 2006).

By practising self-compassion one acknowledges that experiences of suffering are part of the common human experience. It is the ability to recognise that one is connected to others who share similar experiences of pain, suffering, failings and human weaknesses. It is therefore allowing oneself to be human, an imperfect and flawed condition (Neff, 2003b). Compassion, by definition, means to suffer together (Goetz, et al., 2010), so self-compassion does not invite self-absorption, but rather implies being connected to and comforting others who share similar suffering (Neff, 2011a).

2.3.2.3. Mindfulness versus over-identification.

Mindfulness refers to paying attention in a non-judgmental way and being fully present within the current experience (Brach, 2003; Gilbert & Choden, 2014; Kabat-Zinn, 2011). In a self-compassionate context, mindfulness refers to the ability to maintain a balanced view of negative experiences, thoughts and feelings. Being mindful in this way, is recognition and acceptance of what is currently being experienced. It is the ability to avoid being
overwhelmed and over identifying with negative thoughts and emotions, while neither denying nor supressing them. People who over identify with painful thoughts and feelings can exaggerate their importance and may create a pessimistic explanatory style (Seligman, 2006). Germer (2009) posits that avoiding or denying negative thoughts or emotions increases suffering over and above the initial painful experience. Creating mindful awareness may provide a psychological resource needed to decrease the negative impact a painful experience may have (Fredrickson, 2001). Mindful awareness of thoughts and feelings allows one to be curious and non-judgmental about what one is feeling or thinking; and moreover, to be kind and tender to oneself during difficult times (Germer, 2009).

These components do not operate independently of one another and should not be viewed in isolation. Rather there is increased evidence that they interact with each other (Neff, 2003a, 2003b).

2.3.2.4. The interrelationship between the components of self-compassion.

While the three aspects of self-compassion have been conceptualized separately, they interact in order to produce an integral experience (Neff, 2003b). However, there is scant empirical research on the interrelationship between the components. Neff (2003b) provides the most complete explanation of the relationship between the components.

Mindfulness interacts with the other two components (self-kindness and common humanity) specifically, in that taking a non-judgemental stance relating to oneself allows one to be more curious about one’s thoughts and feelings and less self-critical. Furthermore, practising a mindful approach allows one to recognise more readily that one is not alone in suffering but that this is a common, shared human experience (Elkind, 1967; Neff, 2003b). Correspondingly, self-kindness and feeling more connected to others (common humanity) allows one to be more mindful and aware of the present moment without being overwhelmed...
and distracted by thoughts and feelings (Kok et al., 2013; Fredrickson, 2001; Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008). Self-kindness may promote connection with others, in that rather than withdrawing in isolation, seeking social support and connection with others, i.e. common humanity, is practising self-kindness. In addition, self-kindness and recognising one’s common humanity enhances mindfulness and compassion for others (Davidson & Harrington, 2002).

However, more empirical research is needed to examine the theoretical relationship among the dimensions of self-compassion. For example, Muris, Otgaar and Petrocchi (2016), as well as Muris and Petrocchi (2016), agree that self-compassion has been proposed as a protective measure against psychopathology. However, a meta-analysis conducted by these writers found that mindfulness and self-kindness were significant predictors of mental health but that common-humanity was not related to mental health. Furthermore, the negative items of self-judgement, isolation and over-identification in the Self-Compassion Scale (Neff, 2003a), displayed greater predictive power relating to psychopathology. They therefore suggest that the three components do not equally display an inverse relationship with one another (Muris & Petrocchi, 2016). Neff (2015) responded to this argument by explaining that a bi-factor analysis provided evidence of the relationship between the components and the balance between the compassionate and uncompassionate ways in which people respond to pain and failure.

Self-compassion ought to be further considered in its relationship with other psychological themes which will be examined in the section that follows.

2.3.3. Self-Compassion and Other Psychological Themes

In conceptualizing self-compassion it is important to note that this is similar to certain themes of the self that have been explored in other psychological fields, like empathy and self-
actualisation. However, it is distinct from aspects such as self-esteem, self-pity and self-indulgence (Neff, 2003b, 2011b, 2008; Neff & Germer, 2013, Neff & Vonk, 2009). The similarities and differences will be explained below.

2.3.3.1 Self-empathy.

Neff (2003b) maintains that self-compassion is most closely related to the concept of self-empathy, proposed by Judith Jordan (1990). Jordan describes empathy as a cognitive and affective process comprising different components. She defines self-empathy as the ‘observing self [who] extends empathetic attunement to the experiencing [] self’ (Jordan, 1991, p.287), implying that the self be accepted with openness and caring presence (Jordan, 1990). She encapsulates all three dimensions of self-compassion namely, self-kindness, common humanity and mindfulness in her approach.

2.3.3.2 Humanism.

Self-compassion is consistent with many themes in humanism (For example: Ellis, 1973; Maslow, 1968; Rogers, 1961). Maslow’s (1968) self-actualisation theory was underpinned by self-acceptance and unconditional acceptance of others. He asserted that this encouraged the development of B-values, which are the growth motivations, which function at the highest level of the need hierarchy (Maslow, 1968). Rogers’ (1961) concept of unconditional positive regard for oneself can be compared with self-compassion. He asserted that individuals should view both positive and negative attributes of themselves as they are in order to achieve their full potential. He also suggested that an unconditionally caring approach to oneself would be the goal of therapy if someone was to realise their full potential (Rogers, 1961). Ellis’ (1973) unconditional self-acceptance is precisely what self-compassion offers. Ellis believed that unconditional self-acceptance was a healthy psychological state in order to attain wellbeing and that accepting difficulties was the key to overcoming them (Ellis, 1973).
Humanistic psychology has been criticised for being too individualistic. However, self-compassion is not based on a separate self, but rather is common humanity, which fosters compassion and connection to others, not isolation or individualism (Neff, 2003a).

2.3.3.3. Positive psychology.

Self-compassion is well situated within the field of positive psychology as a protective factor which promotes wellbeing and resilience (Neff & Lamb, 2009). For example, Seligman’s (2006) “learned optimism” explanatory style can be likened to a self-compassionate stance of positive evaluations of the self and others. Learned optimism is seeing negative situations as transient, not personal or global/pervasive. Being self-kind, is taking a more optimistic view of oneself, while being mindful rather than over-identifying with negative feelings is to avoid a ruminative and pessimistic thinking style. Further, believing that one is not alone but is rather part of a shared human experience is also a more optimistic than pessimistic way of thinking (Seligman, 2006). Fredrickson’s (1998, 2001) broaden and build theory also espouses self-compassion. The broaden and build theory asserts that positive emotions experienced daily compound over time and serve to build a variety of psychological, social and intellectual resources. This promotes wellbeing and resilience (Fredrickson, 2001). Self-compassion enables one to build such resources and serves as a protective factor which promotes wellbeing (Fredrickson et al., 2008; Neff & Lamb, 2009).

2.3.3.4. Self-compassion versus self-esteem.

Self-esteem can be simply described as a global evaluation of oneself (Baumeister, Smart & Boden, 1996). It involves judgements and comparisons to a set standard as well as social comparison with others in various domains (Deci & Ryan, 1995). While the benefits of high self-esteem have been well founded, some psychologists have argued that there are certain negative aspects to promoting self-esteem such as narcissism, self-absorption, self-
centredness and lack of concern for others (Damon, 1995; Seligman, 1995). While studies show there is a significant relationship between self-compassion and self-esteem (Leary, Tate, Adams, Batts Allen, & Hancock, 2007; Neff, 2003a; Neff & Vonk, 2009), there is evidence that they seem to be distinct constructs (Barnard & Curry, 2011; Neff, 2011b). Neff (2011b) concurs with Baumeister, Campbell, Krueger, and Vohs (2003), who suggest that self-esteem is the result of doing well or is a positive comparison rather than the cause of those things (Baumeister, Campbell, Krueger, & Vohs, 2003; Neff, 2011b). Self-esteem therefore, fluctuates according to one’s performance or the comparisons one makes. Whereas self-compassion is extended when one is suffering from feelings of failure or personal inadequacy or if circumstances are particularly difficult. It is not a form of self evaluation but rather is a way of relating to oneself. It is thus more stable than self-esteem, as it is not based on personal success or external circumstances (Neff, 2003b; 2011b; Neff & Vonk, 2009). Further, Marshall et al., (2015) in a longitudinal study, conducted among adolescents, found that the long-term effects of self-esteem depended on self-compassion (Marshall, et al., 2015). It therefore appears that self-compassion has many of the benefits associated with self-esteem but has fewer drawbacks (Neff 2003a, 2003b).

2.3.3.5. Self-compassion versus self-pity and self-centeredness.

Self-compassion is distinct from self-pity, in that when individuals feel self-pity they tend to become immersed in their problems and feel separated and disconnected from others. In this way, self-pity accentuates egocentric feelings. Research shows that self-compassion fosters social connectedness and compassion for others as opposed to self-centeredness (Neff 2003a). Self-compassion therefore allows one to see that suffering and difficulty are integral to human experience i.e. common humanity. Further, self-compassion allows one to step back from one’s current situation and adopt a more balanced perspective, i.e. being mindful. This
is in contrast with over identifying with and being absorbed by negative feelings or trying to disassociate from experiences (Leary et al., 2007; Neff, 2003b, 2008).

In addition, some may fear that self-compassion leads to passivity or weakness. However, having compassion for oneself means that one desires wellbeing, optimal functioning and health. Failings are consequently not ignored but rather, self-compassion allows one to rectify faults and mistakes without self-condemnation (Barnard & Curry, 2011; Brach, 2003; Neff, 2003b).

To conclude, self-compassion involves being kind to oneself as opposed to being critical and judgemental during difficult circumstances and when facing feelings of failure or inadequacy. It also entails being mindful of difficult emotions while not over identifying with them and recognising that what one experiences is shared by others, so one is not alone in suffering. In this study, self-compassion will be operationalized using Neff’s (2003a, 2003b, 2011b) framework, and measured by the Self-Compassion Scale (Neff, 2003a, 2015). Empirical research will be examined in the following sections.

2.3.4. Empirical Research on Correlates of Self-Compassion

Research on self-compassion has expanded rapidly during the last decade. Until very recently, there has been scant research on self-compassion among adolescents. However this has begun to change.

Self-compassion has been linked to various positive outcomes within a number of domains. A discussion on self-compassion within specific domains follows. Where research pertains to adolescents specifically, this will be highlighted.
2.3.4.1. The relationship between self-compassion and depression and anxiety.

Self-compassion has been shown to have a negative correlation with psychopathology, specifically anxiety and depression. It has therefore been recognised as an important protective factor in reducing symptoms of psychopathology, over and above factors such as self-esteem (Leary et al., 2007; MacBeth & Gumley, 2012; Muris & Petrocchi, 2016; Neff, 2011b).

From the evolutionary perspective, Gilbert (2009a, 2009b, 2014) postulates that self-compassion taps the soothing and affiliation emotional system in the brain. This is the mammalian system associated with care-giving and attachment and the release of oxytocin (Gilbert, 2009a, 2009b 2014; Panksepp, 2011). This system is activated by loving and secure relationships with early caregivers. In contrast, self-criticism activates the threat/protection system in the brain, associated with insecure attachment, defensiveness and autonomic arousal (Gilbert, 2009a, 2009b 2014; Gilbert & Choden, 2014; Panksepp, 2011).

2.3.4.1.1. Self-compassion, self-criticism and the link with depression.

Self-compassion is the opposite of self-criticism. Highly self-critical people are vulnerable to depression and this negative self-view serves to maintain their depression. (Beck, 1963; Ehret et al., 2015; Gilbert & Irons, 2009; Irons et al., 2006). Thompson and Zuroff (2004) conceptualised self-criticism on two levels; comparative self-criticism and internalised self-criticism. Comparative self-criticism is a relational cognitive distortion, whereby others are seen as superior and critical of oneself. This drives the feeling of inferiority when one sees oneself in comparison with others (Thompson & Zuroff, 2004). Internalised self-criticism on the other hand, is a negative view of the self, which results from perfectionism by setting and trying to achieve unrealistically high self-imposed standards. In this instance success is not often enjoyed, but rather redefined as failure; and failure is responded to with increased self-
punity and a further sense of worthlessness (Hewitt & Flett, 1991; Thompson & Zuroff, 2004). Yamaguchi et al. (2014) found that both types of self-criticism negatively affected self-compassion, resulting in symptoms of depression (Yamaguchi, et al., 2014).

Self-compassion is therefore considered to be a more adaptive approach to perceived failure. The ability to be self-kind rather than self-critical is key here. It must also be recognised that one is not alone during instances of perceived inadequacies or failure. In addition, creating a more mindful approach allows one to avoid becoming caught up in the negative emotions engendered by self-criticism (Gilbert & Proctor, 2006). Self-compassion significantly negatively correlates with self-criticism, social comparison, anger, anxiety, depression, neuroticism and negative affect (Galla, 2016; Edwards, Adams, Waldo, Hadfield, & Biegel, 2014; Neff, 2003a; Neff et al., 2005; Neff & Vonk 2009; MacBeth & Gumley, 2012; Terry, Leary, & Mehta, 2012).

Research also shows that self-compassion is a healthier alternative to rumination than is distraction when coping with depression. It is equally as effective as cognitive reappraisal and acceptance (Diedrich, Grant, Hofmann, Hiller, & Berking, 2014; Odou & Brinkler, 2015; Raes, 2010). Mills, Gilbert, Bellew, McEwan and Gale (2007) found the factors opposite to self-compassion that is, self-judgement, isolation and over-identification correlated highly correlated with depression (Mills et al., 2007). Similarly, Hall et al. (2013) found that the components of self-judgment and isolation had the most significant relationship with symptoms of depression and anxiety. Specifically, individuals who engaged in ruminative thoughts self-judgment and who isolated themselves were more likely to indicate depressive symptomology (Hall et al., 2013; Neff, 2003a). However, Muris, Meesters, Pierik and de Kock (2015) found that of all three components of self-compassion, mindfulness was seen to be the most significant factor related to lowered levels of depression and anxiety, specifically in adolescents (Muris, Meesters, Pierik, & de Kock, 2015). Similarly, Ying (2009) found
over-identification to be the most significantly related to depression in a student sample. It thus seems that the ability to be self-compassionate is an important protective factor against the development of psychopathology, specifically depression and anxiety.

2.3.4.2. The relationship between self-compassion and wellbeing.

Self-compassion has been consistently linked with several indicators of wellbeing and positive functioning. This includes positive associations with happiness, optimism, positive affect, wisdom, personal initiative, curiosity and exploration; as well as greater gratitude, forgiveness and satisfaction with life (Breen, Kashdan, Lenser, & Fincham, 2010; Neff et al., 2007; Neff & Vonk, 2009; Wei et al., 2011).

In studies conducted among undergraduate students adjusting to university life, self-compassion has also been found to be associated with less homesickness and is a stronger predictor of wellbeing in students than is goal reengagement and availability of support (Neely, Schallert, Mohammed, Roberts, & Chen, 2009; Terry et al., 2012). With regards to psychological adjustment and wellbeing following negative life events, Leary et al. (2007) found that self-compassionate individuals try to be kinder to themselves and made themselves feel better following negative life events. Furthermore, they show less catastrophizing and personalising following such an event and show greater equanimity. Self-compassionate individuals were better able to acknowledge their responsibility in negative events without over-identifying and being overcome by the negative feelings associated with this, as well as reporting generally lower negative affect (Leary et al., 2007).

2.3.4.2.1. The relationship between self-compassion and affect.

In terms of the relationship between self-compassion and positive and negative affect, the findings are mixed. Most studies have found that self-compassion seemed to have a greater
association with negative affect (i.e. reducing it) than with positive affect (Bluth & Blanton, 2013; Galla, 2016; Hope, Koestner, & Milyavskaya, 2014; Zessin, Dickhäuser, & Garbade, 2015). In a meta-analysis of the relationship between self-compassion and wellbeing, Zessin, Dickhäuser, and Garbade (2015) found that the strongest correlation was between self-compassion and psychological wellbeing, followed by negative affect and cognitive wellbeing. The relationship to positive affect had the weakest correlation (Zessin et al., 2015). Similarly, in an adolescent sample, Bluth and Blanton (2014) found that self-compassion was associated with all the dimensions of wellbeing except for positive affect (Bluth & Blanton, 2014). However, Odou and Brinker (2015) found that both self-compassion and distraction reduced negative affect, but by inducing self-compassion in a written exercise, the participants increased in positive affect as well. This was corroborated in a study by Galla (2016), in which, following a meditation retreat for adolescents, increases in self-compassion predicted positive affect and life satisfaction. This was maintained after three months, but reductions in negative affect at baseline were greater (Galla, 2016). In line with positive psychology’s assertion that negative feelings are part of the spectrum of human experience, self-compassion provides the resources to hold negative feelings in warmth and self-acceptance. While self-compassion is linked to positive affect, it is primarily aimed at reducing negative feelings associated with negative events and feelings of inadequacy (Neff & Davidson, 2016; Neff & Tirch, 2013; Neff & Vonk, 2009). Just as self-compassion appears to be related to different aspects of wellbeing, the different components of self-compassion seem to interact differently with wellbeing.

2.3.4.2.2. The relationship between the components of self-compassion and wellbeing.

Research into the relationship between the different components of self-compassion and wellbeing is still emerging. However, Hollis-Walker and Colosimo (2011) found that common humanity and mindfulness specifically, were predictors of wellbeing (Hollis-Walker
Similarly, Bluth and Blanton (2014) found in an adolescent sample, that isolation and over-identification were most strongly associated with negative mood; and mindfulness was strongly associated with life satisfaction (Bluth & Blanton, 2014). These studies both found non-significant associations with the self-kindness/self-judgement subscale and wellbeing. This differs somewhat from what Van Dam, Sheppard, Forsyth and Earleywine (2011) found, in that the components of self-judgement and isolation were the most significant predictors of psychological health and wellbeing (Van Dam, Sheppard, Forsyth, & Earleywine, 2011). It is evident that further research is needed to clarify how specific aspects of self-compassion interact with wellbeing.

2.3.4.2.3. Self-compassion interventions and wellbeing outcomes.

Interventions based on self-compassion have also yielded promising results. In two Mindful Self-Compassion intervention pilot studies, the participants reported an increase in both self-compassion and mindfulness. They also reported higher levels of life satisfaction, as well as lower levels of anxiety and depression. Furthermore these increases were maintained at six month and one year intervals, post intervention (Bluth, Gaylord, Campo, Mullarkey, & Hobbs, 2015; Neff & Germer, 2013). When it came to adolescents specifically, increases in mindfulness and self-compassion significantly contributed to decreases in anxiety following the intervention (Bluth, Gaylord et al., 2015).

It is evident that self-compassion has significant positive outcomes related to wellbeing. Further, interventions in this regard, like the Mindful Self-Compassion program (Germer & Neff, 2013; Neff & Germer, 2013) may be a valuable support in therapeutic approaches to helping participants develop a greater sense of wellbeing. Of particular importance are the emerging positive findings among adolescent samples. This has long-term implications for developing programs and interventions specifically aimed at adolescents in order to cultivate
positive psychological adjustment. Self-compassion and its relationship to coping with stress as well as achievement strategies will now be discussed.

2.3.4.3. The relationship between self-compassion and stress, coping and achievement strategies.

Self-compassion has been found to be associated with decreases in perceived stress among a diversity of samples (Bluth & Blanton, 2013, 2014; Bluth, Roberson, & Gaylord 2015; Bluth, Roberson, Gaylord, Faurot et al., 2015; Edwards et al., 2014; Galla, 2016; Hall et al., 2013; Neff & Germer, 2013). Batts Allen and Leary (2010), found self-compassionate people cope with stressful events primarily by cognitive restructuring (Batts Allen & Leary, 2010); while Neff et al. (2005) found that those high in self-compassion use emotion-focused coping strategies rather than avoidance strategies to cope with stressful events (Neff et al., 2005). In one study, the components of self-compassion specifically predictive of managing stress were self-judgement/self-kindness and over-identification/mindfulness (Hall et al., 2013). The finding on the association between perceived stress and the mindfulness component specifically, has been confirmed in other studies (Bluth, Roberson, & Gaylord 2015; Edwards et al., 2014; Galla, 2016) which lends support to the interaction between mindfulness and self-compassion overall (Gilbert & Choden, 2014; Neff, 2003a, 2011a; Neff & Davidson, 2016; Siegel, 2007). However, Bluth and Blanton (2014), found that isolation had the strongest association with perceived stress, followed by mindfulness and over-identification (inversely) in an adolescent sample (Bluth & Blanton, 2014). Similarly, Barnett and Flores (2016) found that isolation and over-identification accounted for academic burnout and stress in students. It seems evident that self-compassion provides a protective function when one is faced with stressful events and leads to the employment of positive coping strategies.
Research into specific domains related to stress and coping that may be noteworthy for adolescents will be discussed below.

2.3.4.3.1. The relationship between self-compassion and recovery from trauma and PTSD (post traumatic stress disorder).

In terms of recovery from trauma and PTSD, self-compassion has been evidenced as providing a protective function and is positively associated with resilience following recovery (Scoglio et al., 2015; Zeller, Yuval, Nitzan-Assayag, & Bernstein, 2014). Following negative events or failure or being faced with personal weakness, self-compassionate people show better coping qualities by being more likely to learn and grow, as well as taking responsibility for their role in negative events without being overwhelmed. Furthermore, they are motivated to change their behaviour and perform better (Breines & Chen, 2012; Leary et al., 2007; Shepherd & Cardon, 2009).

2.3.4.3.2. The relationship between self-compassion and with coping with transition to university.

For students adapting to and coping with transition to college, those high in self-compassion adapt better and report less homesickness, academic anxiety and procrastination tendencies. They also report greater satisfaction with their decision to attend college, less perceived stress, as well as greater self-efficacy and belief in their abilities to produce a positive outcome. Self-compassion also moderates the relationship between academic burnout and wellbeing for students (Iskender, 2009; Neff et al., 2005; Terry et al., 2012; Williams, Stark & Foster, 2008; Woo Kyeong, 2013).
2.3.4.3.3. The relationship between self-compassion and academic goals.

Williams et al. (2008) found self-compassion to be unrelated to academic goal measures i.e. performance approach/avoidance and mastery approach/avoidance goals (Williams et al., 2008). However, Neff et al., (2005) found self-compassion to be positively associated with mastery goals and negatively associated with students’ performance goals. Hope et al. (2014) found self-compassion to be a protective factor against negative affect when goal progress fluctuated. Furthermore, students high in self-compassion tended to pursue more autonomous goals, i.e. goals that were more meaningful and personally valuable to them, as well as reengage in goal pursuit quicker than those lower in self-compassion (Hope et al., 2014; Neely et al., 2009; Neff et al., 2005).

The above findings contain important implications for adolescents particularly in terms of coping with academic pressure, managing goals and transitioning to tertiary education, which are some of the most difficult stressors adolescents deal with. Self-compassion therefore provides an understanding of how positive functioning may be promoted, specifically, if adolescents are to become more resilient and self-efficacious.

2.3.4.4. Other correlates related to self-compassion.

The other relevant studies discussed here are those related to possible outcomes which may be of specific consequence to adolescents. The studies cited below were implemented mainly among adults. However in some instances adolescent samples were employed. Where this is the case it will be indicated.

In this regard, self-compassion has been positively associated with social connection (Akin & Akin, 2015; Brodar, Barnard, Crosskey, & Thompson, 2015; Neff, 2003a). It also serves as a protective factor against eating disorders in both adults and adolescents and less body
Self-compassion also seems to be related to positive outcomes for LBG (lesbian, bisexual and gay) adolescents. Crews and Crawford (2015) found that those persons openly identifying as LBG, had an increased sense of self-compassion. Further, Greene and Britton (2015) found that self-compassion experiences in childhood predicted wellbeing in adult LGBTQ (lesbian, gay, bisexual, transgender and queer) persons (Crews & Crawford, 2015; Greene & Britton, 2015).

Marshall et al. (2015) found that self-compassion protected adolescents against the negative effects of low self-esteem, delineated as self-doubt, negative self-evaluations and adversity. In this manner, self-compassion has also been proposed as a healthier alternative to self-esteem as self-compassionate people are less concerned with social comparisons, feeling superior to others, self-absorption and defending their self-concept (Neff, 2003b; Neff & Davidson, 2016; Neff & Vonk, 2009).

In terms of health behaviours, self-compassion has been associated with self-care, seeking and adhering to medical treatment, improved health promoting behaviours and reduced daily smoking though self-regulation (Friis, Consedine, & Johnson, 2015; Kelly, Zuroff, Foa, & Gilbert, 2010; Sirois, Kitner, & Hirsch, 2014; Terry & Leary, 2011; Terry, Leary, Mehta, & Henderson, 2013). While most studies on health behaviours have been conducted on adult samples, they show promising results for adolescents in terms of positive health promotion.

An emerging area of research seeks to address the concern regarding factors which may contribute to the development of self-compassion in individuals. Indeed, the focus of this study is founded upon the exploration of the possible origins of self-compassion and how early life experiences may contribute to individual differences in self-compassion. It has been
suggested that early care-giving relationships play an important role in the development of self-compassion (Gilbert & Proctor, 2006; Neff & McGehee, 2010, Pepping et al., 2015). Further, studies have found differences in self-compassion to be associated with group variables, including, personality factors, culture, gender and age. Research findings in this regard will be examined below.

2.3.5. Individual and Group differences related to Self-Compassion.

When considering individual and group differences regarding self-compassion, differences have been found to be associated with personality factors, culture, gender and age. Possible differences in the origins of self-compassion in terms of early caregiving relationships are also examined.

2.3.5.1. Personality.

In terms of the ‘Big Five’ personality traits, self-compassion has been found to have the largest negative association with neuroticism and a significant positive association with agreeableness, extraversion and conscientiousness. However, self-compassion has little or no association with openness to experience (Hollis-Walker & Colosimo, 2011; Neff et al., 2007; Thurackal et al., 2016). The only other personality construct examined thus far is narcissism, which has been found to have a negative association with self-compassion in both adult and adolescent samples (Barnett & Flores, 2016; Barry, Loflin, & Doucette, 2015; Neff & Vonk, 2009).

2.3.5.2. Culture.

Cross-cultural research on self-compassion remains scant and most research in cultural differences has been conducted with Asian and American samples. Asian cultures have been described as being more self-critical, and interdependent than Western cultures (Kitayama &
Markus, 2000; Kitayama, Markus, Matsumoto, & Norasakkunkit, 1997; Markus & Kitayama, 1991) suggesting lower self-compassion (Neff, 2003b). However, some research suggests that Western cultures have higher levels of internalised self-criticism, while Asian cultures have higher levels of comparative self-criticism. Both negatively affect the development of self-compassion and suggest a greater risk for the development of depression (Yamaguchi et al., 2014). In addition, in a comparative study between the United States, Thailand and Taiwan, it was found that self-compassion was highest in Thailand and lowest in Taiwan, with the United States in between (Neff et al., 2008). This interplay between self-compassion and culture is more complicated than previously thought. It does, however, appear that self-compassion may be influenced by other socio-demographic factors like minority status, gender and age (Neff et al., 2008; Yarnell et al., 2015).

2.3.5.3. Gender.

In a meta-analysis of gender differences in self-compassion, Yarnell et al. (2015) found that females tend to have slightly lower levels of self-compassion than males do, and in samples of higher American minority groups this difference was more significant (Yarnell et al., 2015). Neff and Vonk (2009) suggest that females have lower self-compassion as they tend to be more self-critical and display more negative rumination than males do (Leadbetter, Kuperminc, Blatt, & Hertzog, 1999; Neff, 2003a; Neff & Vonk, 2009; Nolen-Hoeksema, Larson, & Grayson, 1999). However, a number of studies have found no significant gender differences in self-compassion; for example in Turkish students (Iskender, 2009), Thai and Taiwanese students (Neff et al., 2008) and US students (Neff & McGehee, 2010; Neff et al., 2007). Similarly Bluth and Blanton (2014), found no gender differences in self-compassion in younger adolescents but found that older female adolescents had lower self-compassion than older males, suggesting that other factors may explain gender differences during adolescence (Barnard & Curry, 2011; Yarnell et al., 2015).
2.3.5.4. Age.

When it comes to age, self-compassion is associated with subjective wellbeing, perceived quality of life and successful aging in older adults. Self-compassion has also been found to be higher in older adults than in student samples; and research suggests that self-compassion increases with age (Batts Allen, Goldwasser, & Leary, 2012; Homan, 2016; Hwang et al., 2016; Neff & Vonk, 2009). The literature is unclear regarding how or why older adults are higher in self-compassion. However, Neff et al. (2007) suggest it is owing to reflective wisdom, which is the ability to accept life as it is (Neff et al., 2007). Similarly Homan (2016), suggests it is the accumulation of life experience which allows one to have a more self-compassionate perspective on one’s failures and negative experiences (Homan, 2016). Hwang et al. (2016) propose that it may be due to middle age, which is characterised by general acceptance and adjustment to inevitable changes which may also be influenced by cultural context (Hwang et al., 2016).

In terms of adolescents, older female adolescents report lower self-compassion than that of older males and younger adolescents and subsequently lower wellbeing (Bluth & Blanton, 2014). Neff (2003b) asserts that adolescence is most likely the time when self-compassion is at its lowest. Gilbert and Irons (2009) propose that adolescents are particularly at risk of being highly self-critical owing to social comparisons and self-evaluations that may accompany the formation of an identity. This, according to Erikson (1977) is the task unique to this life stage (Erikson, 1977; Gilbert & Irons, 2009; Neff, 2003b).

When considering these group and individual differences in self-compassion, it seems prudent to also explore early primary care-giving relationships. These relationships may influence individuals’ ability to develop self-compassion.
2.3.5.5. The development of self-compassion – early caregiving relationships.

Concerning the possible origins of self-compassion, some researchers have proposed that self-compassion may originate in early childhood relationships with primary caregivers (Germer, 2009; Irons et al., 2006; Kelly & Dupasquier, 2016; Neff & McGehee, 2010; Pepping et al., 2015; Potter et al., 2014). Adolescents who have experienced childhood maltreatment in the form of emotional abuse, emotional neglect, physical abuse and sexual abuse have significantly lower self-compassion (Tanaka, Wekerle, Schmuck, & Paglia-Boak, 2011; Vettese, Dyer, Li, & Wekerle, 2011). Although, research has also found that developing self-compassion reduced negative outcomes, such as depression, anxiety, poor school performance and overall maladjustment associated with childhood maltreatment. Therefore self-compassion serves as a potentially protective factor in reducing the effects from adverse situations though adaptive coping and positive emotion regulation strategies (Jativa & Cerezo, 2014; Neff et al., 2005).

Considering early parental relationships and self-compassion, studies which have examined parental warmth versus parental criticism and attachment outcomes have found that parental criticism and parents being rejecting and over-protecting is significantly linked to self-criticism and lower self-compassion (Irons et al., 2006; Neff & McGehee, 2010; Pepping et al., 2015; Potter et al., 2014). Consequently, parental support and warmth have been found to be related to self-compassion (Irons et al., 2006; Kelly & Dupasquier, 2016; Neff & McGehee, 2010; Pepping et al., 2015). A secure attachment style is also related to high self-compassion (Neff & McGehee, 2010; Pepping et al., 2015) with attachment anxiety being negatively related to self-compassion (Germer, 2009; Neff & McGehee, 2010; Pepping et al., 2015; Wei et al., 2011). However, attachment avoidance has been shown to have no significant relationship with self-compassion (Pepping, et al., 2015; Wei et al., 2011). It has been suggested that when children are exposed to threat, neglect and rejection they are more
likely to internalise this by becoming self-critical and developing negative self-views which leads to lower self-compassion (Germer, 2009; Irons et al., 2006; Neff, 2011a; Pepping et al., 2015).

It would seem that early caregiving relationships, specifically the parent-child relationship may be important in understanding the development of self-compassion.

2.3.6. Conclusion

The ability to be self-compassionate has many beneficial and positive outcomes. Both theory and research support the notion that self-compassion provides a protective and resilient way of thinking and relating to oneself when faced with failure, negative life events and feelings of inadequacy. Consequently, the development of self-compassion has significant relevance for adolescent mental health as they navigate various aspects of their identity formation. Adolescents’ perceptions of their parents’ interactions with them conceptualised as parenting style, may have implications for the development of self-compassion. It is therefore important to consider the interaction between parenting style and self-compassion. Accordingly, the following section discusses parenting style, specifically in the context of adolescence.

2.4. Parenting Style

2.4.1. Context and Historical Overview

The socialization of the child is considered a major outcome of child and adolescent development (Erikson, 1977; Maccoby, 1992). Socialization refers to the child’s characteristics, skills and competence necessary to successfully adapt to and integrate within a culture or society (Baumrind & Thompson, 2002; Parke & Buriel, 2008). Harris (1995, 2009), in her proposed group socialization theory, suggests that parents have no effect on the
socialization of the child and this is determined by processes outside the home, like peer influences. She suggests that the child behavioural outcomes found in correlational studies are due to hereditary and child-to-parent factors and not to parent-to-child factors as has been widely accepted (Harris, 1995, 2009). However, it is generally accepted, both theoretically and empirically, that parents are the primary agent for socialization in children (Erikson, 1977; Grusec, 2002; Maccoby, 1992; Schaefer, 1965; Shaffer, 2005; Steinberg et al., 1992).

Both behaviourist and psychodynamic theorists were interested in the influence of parental behaviour on childhood development and socialization (Grusec, 2002; Maccoby, 1992; Darling & Steinberg, 1993). Researchers who have examined parenting behaviours from a behaviourist or social learning perspective were interested in the practices that parents might employ, by means of rewards and punishments, which could serve to direct children’s behaviour. Psychodynamic researchers, however, were interested in the attitudes and emotional processes behind parental behaviours (Grusec, 2002; Maccoby, 1992; Darling & Steinberg, 1993). Most researchers realised that it was not possible to separate parent behaviours and attitudes, as many behaviours were expressed in an emotional climate (Baldwin, 1948; Schaefer, 1965; Symonds, 1939). Pioneering work in this field by Diana Baumrind (1966), practising parent-child observations and holding interviews with parents gave rise to three parenting typologies: authoritative, authoritarian and permissive. Maccoby and Martin (1983) extended this work to include a fourth type, uninvolved. A discussion of these typologies follows.

2.4.2. Definition and Conceptualization of Parenting Style

Parenting style refers to behaviours or practices by parents directed at the child in various situations in a specific emotional climate (Berk, 2013; Darling & Steinberg, 1993). Many researchers use the terms ‘parenting styles’ and ‘parenting practices’ interchangeably.
However, Darling and Steinberg (1993) make a distinction between the two concepts. They propose that the goal of parenting is the socialization of the child, so parenting style is the emotional climate within which socialization is effected; parenting practices are behaviours the parents employ to help the child become socialized (Darling & Steinberg, 1993). Most researchers agree that Baumrind’s (1966) typologies and Maccoby and Martin’s (1983) two-dimensional model of these parenting typologies is an acceptable operationalization of parenting style (Berk, 2013; Carr, 2005; Darling & Steinberg, 1993; Shaffer, 2005). This theoretical model has been widely adopted as it incorporates both the behavioural and the emotional processes underlying children’s socialization.

2.4.2.1 The two dimensions of responsiveness and demandingness.

The two elements on which parenting style typologies are operationalised are parental responsiveness, also referred to as parental acceptance, warmth and supportiveness; and parental demandingness, also referred to as parental control, restrictiveness or permissiveness (Baumrind, 1991; Darling, 1999; Darling & Steinberg, 1993; Shaffer 2005; Spera, 2005).

Parental responsiveness refers to the extent to which the parent responds to the child in a warm, loving, accepting and supportive manner. The parent is emotionally available and attentive to the child’s needs. This is not merely unconditional, positive regard for the child (Maccoby & Martin, 1983), but is rather the type of environment created by the parent who positively reinforces the child by developing a reciprocal, loving, mutually respectful relationship with the child. The opposite approach to responsiveness occurs when the parent is cold, rejecting and emotionally unavailable to the child. This type of attitude is expressed in criticisms, disapproval, harshness and even outright hostility towards the child. The parent-child relationship is characterised by negativity, irritability and explosive conflict (Skinner, Johnson, & Snyder, 2005; Slicker, Picklesimer, Guzak, & Fuller, 2005).
Parental demandingness refers to the nature of the expectations the parent has of the child. It refers to the limits, structure and discipline required of the child. Further, demandingness involves the manner in which the parent exerts behavioural control and monitors the child. Within the continuum of demandingness, complete demandingness implies an inflexible and rigid approach by the parents, with limited freedom and independence for the child. Complete control of the child and the child’s consequent conformity result in the enmeshment of the parent and the child (Baumrind, 1991). The opposite would constitute absolute freedom, with no structure or limits required of the child, which in many cases would constitute parental neglect (Skinner et al., 2005; Slicker et al., 2005).

Using the dimensions of parental responsiveness and parental demandingness, four parenting styles have been identified: authoritative, which refers to high parental responsiveness and high parental demandingness; authoritarian, which is low parental responsiveness and high parental demandingness; permissive (sometimes called indulgent), which is high parental responsiveness and low parental demandingness; and uninvolved (sometimes called neglectful), which is low parental responsiveness and low parental demandingness (Baumrind, 1966; Maccoby & Martin, 1983). Figure 1 provides a visual illustration of this model. In this study, parenting style will be conceptualised according to this model and will be measured by the Parenting Style Inventory – II (Darling & Toyokawa, 1997).
2.4.2.2. The Authoritative parenting style.

Authoritative parents are warm but demanding. They are supportive, sensitive and attentive to their child, with whom they seek to establish a close connection. They have clear rules and standards for behaviour but are not intrusive or controlling of the child. Their approach to discipline is fair, reasonable and flexible, with much discussion tolerated in this regard. Autonomy and assertiveness, within limits is valued and supported and an open two-way communication style is encouraged. The relationship is reciprocal in nature (Baumrind, 1966; Berger, 2014; Berk, 2013; Darling, 1999; Kopko, 2007; Shaffer, 2005).
2.4.2.3. The Authoritarian parenting style.

Authoritarian parents are highly directive and controlling. They display little warmth and sensitivity to the child and may appear emotionally distant and rejecting. They set clear rules and standards for behaviour and expect these to be followed without discussion or explanation. These parents provide strict structure and monitor the child’s behaviour closely, with little regard for the child’s individuality or opinions. The parents’ word is law. Any failure of the child to comply with the rules results in punishment. The relationship is ‘power-over’ in nature (Baumrind, 1966; Berger, 2014; Berk, 2013; Darling, 1999; Kopko, 2007; Shaffer, 2005).

2.4.2.4. The Permissive parenting style.

Permissive or indulgent parents are warm and supportive of their children, with few or no demands placed upon them. These parents typically see themselves as their child’s friend. Discipline is lenient with highly flexible boundaries and structure in place. The child is allowed to make their own decisions, regardless of whether these are age-appropriate or not. The child is encouraged to express him/herself freely, even this is profane or critical of the parent. Activities are not closely monitored. Furthermore there are few consequences for unacceptable behaviour and the parent generally avoids confrontation with the child. The relationship is *laissez faire* in nature (Baumrind, 1966; Berger, 2014; Berk, 2013; Darling, 1999; Kopko, 2007; Shaffer, 2005).

2.4.2.5. The Uninvolved parenting style.

Uninvolved or neglectful parents have very few rules and make few demands on their children. This style is not to be confused with the permissive parenting style, as permissive parents care deeply for their children. However, in contrast, the uninvolved or neglectful
parent is insensitive and inattentive to their child’s needs, demonstrating very little warmth and affection for the child. They spend little time and energy on the child, with their focus being elsewhere, for example on work, substance use or other relationships. In extreme cases this parenting style may constitute abuse in its neglect. However, the intention in depicting parenting style along the two dimensions of demand and responsiveness is to measure a typology and normal range of behaviour, not pathology. The uninvolved style is therefore still within the “normal” limits of behaviour. The relationship is hands-off in nature (Baumrind, 1966; Berk, 2013; Darling, 1999; Kopko, 2007; Shaffer, 2005).

2.4.3. Empirical Findings Related to Parenting Style during Adolescence

Parenting style has been linked to various outcomes in adolescent development. Direct causal links are difficult to demonstrate. However, much evidence suggests that parental style has a significant impact on child development outcomes. Research suggests that an authoritative parenting style is most consistently linked to positive developmental outcomes; for example, child wellbeing, emotion regulation, social skills and academic ability (Barber, Maughan, & Olsen, 2005; Baumrind, 1966, 1967, 1991; Berk, 2013; Hancock Hoskins, 2014; Maccoby & Martin, 1983). Further, there is less empirical research regarding differences in mothers’ as opposed to fathers’ parenting styles and their distinct outcomes. The main findings are discussed in the following sections.

2.4.3.1. Differences in mothers’ and fathers’ parenting style

While most studies examine only maternal influence, other studies combine mother and father reports under a single dimension of parenting style. Few studies control for mothers’ parenting style to examine the outcomes of fathers’ parenting style specifically. The unique contribution that mothers’ versus fathers’ parenting styles exert on child and adolescent outcomes has been less researched. Older research findings maintain that mothers overall are
more involved with child rearing than fathers (Grodnick & Ryan, 1989; Paulson & Sputa, 1996). However more recent research suggests that mothers and fathers are more equally but somewhat distinctively involved with child rearing, indicating a possible shift in parenting influences upon child outcomes. Research has found that divorced parents appear to employ opposing parenting styles as a possible compensation measure (Bastaits, Ponnet, Van Peer, & Mortelmans, 2015). Further, evidence suggests that mothers and fathers tend to employ different parenting styles for sons and daughters (McKinney & Renk, 2008). Parenting combinations constituting at least one authoritative parent have been found to be associated with many positive outcomes and serve as a protective factor during adolescence (McKinney & Renk, 2008; Simmons & Conger, 2007). For instance, when considering delinquent behaviour in adolescents, Simmons and Conger (2007) found that the combination of one authoritative and one permissive parent demonstrated the lowest level of delinquency.

Some studies examined fathers’ parenting style and the outcomes thereof exclusively. Specifically, Bronte-Tinkew, Moore and Carrano (2006) examined the father-child relationship and its relationship with the risk of adolescents’ delinquency and substance use. They found that a positive father-child relationship reduced this risk. In addition an authoritarian father’s parenting style was associated with increased risk of delinquency and substance use in adolescents. Further, this influence was stronger in male adolescents than in females. Similarly, fathers who are characterised as being involved have been associated with lower levels of externalizing behaviours in sons, while adolescents with fathers who are highly controlling are found to demonstrate increased relational aggression (Gryczkowski, Jordan, & Mercer, 2010; Kawabata, Alink, Tseng, van IJzendoorn, & Crick, 2011). However, Rothbaum and Weisz (1994) found that the quality of mothers’ caregiving, characterised by acceptance and responsiveness was more significantly associated with the absence of externalizing behaviours than with the quality of fathers’ caregiving.
2.4.3.2. The relationship between parenting style and academic achievement.

Much research has focused on parenting style and academic outcomes in children. Authoritative parenting, characterised by support, encouragement, guidance and involvement in school work is most consistently associated with higher academic achievement, motivation and school engagement (Aunola, Stattin, & Nurmi, 2000; Baumrind, 1967, Dornbusch, Ritter, Leiderman, Roberts, & Fraleigh, 1987; Khan, Ahmad, Hamdan, & Mustaffa, 2014; Spera, 2005, 2006; Steinberg et al., 1992). However, this positive association between authoritative parenting and academic achievement differs across ethnicity and socio economic status. Studies show that an authoritarian style is more predominant, with positive outcomes, in African American, Asian and Hispanic families (Dornbusch, et al., 1987; Khan, et al., 2014; Kopko, 2007; Spera, 2005).

2.4.3.3. The relationship between parenting style and child self-esteem.

Many theorists propose that there is a significant link between parenting style and child self-esteem (Baumrind, 1975; Beebe & Masterson, 1986; Robin & Foster, 1989). However, evidence of the relationship between parenting style and child self-esteem is mixed. In some studies, no relationship between parenting style and self-esteem has been found (Alsheikh, Parameswaran, & Elhoweris, 2010; Lanza-Kaduce & Webb, 1992). Other studies have found a relationship between warm, authoritative parenting and high self-esteem, and between over-protection and low self-esteem in adolescents (DeHart, Pelham, & Tennen, 2006; Milevsky, Schlechter, Netter, & Keehn, 2007). The inconsistency in the findings is unlikely to be due to possible cultural differences, as Herz and Gullone (1999) found a relationship between adolescents’ self-esteem and parenting style in a cross cultural sample of Australian and Vietnamese adolescents (Herz & Gullone, 1999). Furthermore, Milevsky, Schlechter, Netter and Keehm (2007) found that differences in self-esteem outcomes were related more to a
maternal parenting style and less to the father’s (Milevsky, et al., 2007). Further research is needed to clarify cross-cultural outcomes and maternal versus paternal influences on adolescent self-esteem.

2.4.3.4. The relationship between parenting style and coping skills.

Children with authoritative and permissive parents display healthier and more effective coping strategies than those children with authoritarian or uninvolved parents (Nijhof & Engels, 2007; Wolfradt, Hempel, & Miles, 2003). Furthermore, university students with authoritative and permissive parents experience more homesickness but cope better than those with authoritarian and uninvolved parents (Nijhof & Engels, 2007). However, consistent with literature on parenting style outcomes in ethnic groups, it was found in an Indian sample, that authoritarian parenting style in fathers predicted healthy coping skills in adolescents (Bhattacharyya & Pradhan, 2015). Slicker, Picklesimer, Guzak and Fuller (2005) found that demandingness had no significant relationship with life-skills development but responsive parenting correlated strongly with life-skills development in adolescents. They proposed that a climate of acceptance, evident in both authoritative and permissive parents, rather than control enables competence to be developed in children (Slicker et al., 2005). Baumrind (1966), however, proposes that authoritative parenting, i.e. high in both warmth and demand, enables the development of a well-socialised and competent child (Baumrind, 1966, 1991) and that permissive parents foster a lack of confidence in children (Baumrind, 1975). It seems evident that further research is needed in order to clarify which particular coping strategies are employed specifically in cross cultural samples.

2.4.3.5. The relationship between parenting style and health behaviours.

In terms of health behaviours among adolescents, having authoritative parents provides a significant protective factor against the problem use of substances (Baumrind, 1991,
Radziszewska, Richardson, Dent, & Flay, 1996). The daughters of authoritarian and authoritative mothers are more physically active than girls with permissive mothers (Benar, Hemmatinezhad, Behrozi, Andam, & Yousefi, 2012; Sleddens, Gerards, Thijs, de Vries, & Kremers, 2011). Furthermore, indulgent parenting is related to unhealthy eating habits in adolescents, while authoritative parenting is associated with healthy eating (Coccia, Darling, Rehm, Cui, & Sathe, 2012; Sleddens, et al., 2011). High parental support and nurture, characterised by both indulgent and authoritative parenting has been found to be associated with lower stress levels and greater life satisfaction in adolescents (Coccia et al., 2012; Park, 2004). It would therefore appear that parents have significant influence in adolescent health behaviours which has long-term implications for individuals.

2.4.3.6. The relationship between parenting style and adolescent wellbeing.

Parenting style has been linked to many wellbeing outcomes in adolescence. When it comes to anxiety both trait anxiety and anxiety sensitivity are associated with an authoritarian parenting style (Erozkan, 2012; Wolfradt et al., 2003). Children who experience a more negative parenting style, characterised by violence, lack of warmth and support, punishments and neglect, are at greater risk of psychological difficulties (Richie & Buchanan, 2010); while authoritative parenting, characterised by warmth, support and discipline, is associated with positive psychological adjustment in adolescence (McKinney, Donnelly, & Renk, 2008).

2.4.3.7. The relationship between parenting style and the development of depression.

Various studies have examined parenting style as a predictor of depression and depressive symptomology. Research shows that there is a relationship between high levels of depression and an authoritarian parenting style characterised by low warmth and overprotectiveness, experienced in childhood. Permissive parenting is associated with lower levels of depression (Betts, Gullone, Sabura Allen, 2009; Sharma, Sharma, & Yadava, 2011). A number of studies
have found that authoritative parenting is associated with lower depression levels in adolescents (Aunola, et al., 2000; O’Byrne, Haddock, & Poston, 2002; Radziszewska, et al., 1996). However, in an Indian sample, Sharma et al. (2011) found no relationship between authoritative parenting and symptoms of depression. The authors propose that adolescents favour less involvement by parents. Parents therefore being highly demanding, and what they deem as interfering, as characterised by an authoritative parenting style, would lead to greater depression among adolescents (Sharma, et al., 2011). However, this should be researched further in order to understand whether separate dimensions of parenting style are associated with depressive symptoms.

2.4.3.8. Other parenting concepts and their links to adolescent mental health.

Considering research on the role of parenting style its relationship to adolescent mental health, various studies show significant findings. Parenting style is not always operationalised along the two dimensions of warmth and demand as depicted in the four parenting style typologies as delineated in the current study; however, findings from these studies are relevant to the content of this study. In research on the role of parent-child relationships in the development of depression, Blatt and Homann (1992) suggest that adolescents develop depression later in life when they evaluate themselves in terms of how they believe their parents perceived them. They do not refer to parenting style in terms of the 4 typologies. However, they posit that experiences of lack of parental care, support or warmth, along with excessive demand and criticism for failing to meet standards and expectations are associated with the development of depression in adulthood. They propose that the child internalises an impaired mental model of the self which creates a vulnerability to depression (Blatt & Homann, 1992). This is in line with Thompson and Zuroff’s (2004) conceptualisation of self-criticism, which may be based on unrealistically high standards set by parents with the child’s feelings of failure and worthlessness when these standards are not reached or adhered to.
Studies show that this negatively affects the ability to develop self-compassion (Yamaguchi, et al., 2014). Whiffen and Sasseville (1991) concur with Thompson and Zuroff’s (2004) findings, in that they found a maternal emphasis on achievement and high paternal control are significant predictors of self-criticism (Whiffen & Sasseville, 1991). Parker (1993) also found that anomalous parenting, defined as lack of care, characterised as rejecting and critical of the child, in addition to overprotection, create a vulnerability to depression. He suggests this is owing to the development of a dysfunctional cognitive style in the child (Parker, 1993). Similarly, Seligman et al. (1984) found in a study of adolescents, that a pessimistic explanatory style predicted depressive symptoms and this was positively linked to the mother’s explanatory style and depressive symptoms. They propose that this negative interpersonal dynamic may serve to maintain a pessimistic explanatory style and in turn maintain depression in both mother and child (Seligman et al., 1984).

It would seem that parenting style is important in the development of the adolescent self-concept. Moreover, the development of self-compassion or self-criticism based on an internalised mental model of the self has important implications for adolescent mental health.

2.4.4. Conclusion

Research clearly demonstrates that parenting style accounts for many outcomes in adolescence. The influence of the parent-child relationship has significant long-term implications for the adolescent’s identity formation and psychological adjustment. It is also widely acknowledged that the dimensions of responsiveness and demand are acceptable constructs of the parenting style model. Studies have consistently found that authoritative parenting, characterised by high responsiveness and high demand, is related to many positive outcomes in adolescents. However, the extent to which the styles are influenced by the
child’s personality and behaviour is unclear in the literature (Parke & Buriel, 2008). In addition, the generalizability of the parenting style typologies has been questioned, so further research into cross-cultural samples is needed to clarify discrepancies found in the literature in this regard (Hancock-Hoskins, 2014; Kopko, 2007; Parke & Buriel, 2008).

2.5 Evaluative Summary

Self-compassion, which has its origins in Buddhist philosophy, has recently begun to gain attention in Western psychology. Being self-compassionate is the ability to be kind and open to one’s own suffering when faced with perceived failure, negative life events or inadequacies in oneself. The concept of self-compassion encompasses self-kindness, mindfulness and common humanity. This is the ability to be aware of one’s feelings without being overwhelmed by them, being kind to oneself in that moment and recognising that what one is experiencing is shared by others. Individual and group differences in self-compassion can be attributed to personality, age, gender and culture. In terms of the possible origins of self-compassion, research suggests that early caregiving relationships may play a role in this regard.

During adolescence, a young person experiences rapid transition into adulthood. This transformation can be challenging, so self-compassion provides a way of thinking and relating to oneself that is supportive during this time. The successful conclusion to this stage is the ability to develop an identity separate from one’s parents. It is during this time that the parent child relationship undergoes significant changes as the adolescent seeks to establish an identity and gain independence from the parent. Parenting behaviours and attitudes conceptualised as parenting style, have important implications for adolescent outcomes, including possibly the ability to develop self-compassion.
Parenting style is operationalised along two dimensions, namely, responsiveness and demandingness. Consequently, four parenting styles have been identified: authoritative (high responsiveness and high demand), authoritarian (low responsiveness and high demand), permissive (high responsiveness and low demand) and uninvolved (low responsiveness and low demand). Parenting style has been associated with many significant outcomes during adolescence, for example, wellbeing, stress and coping strategies, academic achievement and health behaviours. It therefore appears that parenting style may have consequences for the development of self-compassion during adolescence.

A review of the literature yielded very little research on parenting style and self-compassion. Most research studies examine retrospective reports on the experiences of parenting in childhood. These types of studies are limited as far as their methods are concerned, depending as they do, mostly on the accuracy of autobiographical memories (Brewin, Andrews, & Gotlib, 1993). However, some studies have maintained that it is the perceptions of the experiences that are relevant, not the accuracy of the experience (for example, Pepping, et al., 2015). In order to eliminate that possible limitation, this study considers the current perceptions by the adolescent sample of their parents’ parenting style. Further, most studies have focused on either the maternal or the paternal parenting style (Hancock -Hoskins, 2014). This study evaluates and compares both styles as perceived by the adolescent.

In terms of the research on early childhood experiences and the development of self-compassion, after extensive repository searches, to the best of the author’s knowledge no studies have examined parenting style as operationalised by the four typologies of authoritative, authoritarian, permissive and uninvolved parenting styles. Most have only considered single dimensions, e.g. maternal warmth and criticism (Kelly & Dupasquier, 2016; Neff & McGehee, 2010) and, rejection and overprotection (Irons et al., 2006; Pepping et al., 2015; Potter et al., 2014).
This study seeks to extend current research by examining the influence of both maternal and paternal parenting styles, operationalised by the four typologies, on self-compassion outcomes in an adolescent sample.

The next chapter will delineate the methods employed in order to fulfil the research aims.
CHAPTER 3 – RESEARCH METHOD

3.1. Introduction

This chapter explicates the research methods employed in this study. The research aims are outlined. Thereafter, the research design is explained, followed by the sampling technique employed and the biographical characteristics of the participants. The procedure applied in implementing the study is discussed as well as a description of the measuring instruments employed. The method of statistical techniques used to analyse the collected data is described. Ethical considerations concerning the study are also set out.

3.2. Research Aims

The broad aim of the study was to examine the relationship between self-compassion and parenting style. The researcher was particularly interested in whether adolescents’ perceptions of their parents’ parenting style could predict self-compassion. These broad aims were therefore accomplished by the following specific objectives:

- To determine levels of self-compassion among a group of adolescents.
- To determine the prevalence of the four parenting styles: authoritarian, authoritative, permissive and uninvolved among a group of adolescents.
- To determine gender differences in self-compassion, i.e. scores for boys and girls.
- To determine gender differences in adolescents’ perceptions of parenting styles, i.e. scores for boys and girls.
- To determine maternal/paternal differences in adolescents’ perceptions of parenting styles, i.e. scores for mothers’ parenting style and fathers’ parenting style.
- To determine the relationship between parenting style and self-compassion.
➢ To determine how much variance in self-compassion scores was explained by parenting style.
➢ To determine the degree to which adolescents’ experiences of mothers’ parenting style and fathers’ parenting style respectively predict self-compassion.

The following sections below delineate the research design and the procedures employed to fulfil these aims.

3.3. Research Design

This was a quantitative study following a cross-sectional, survey design (Heppner & Heppner, 2004). Measures of self-compassion, the dependant variable, and parenting style, the independent variable, were collected by means of questionnaires. The questionnaires were self-report collected from a group of adolescents at one time point.

3.4. Sampling

Non-probability convenience sampling (Huck, 2012) was employed to select the school in which to conduct the study. The school was selected based on availability and agreement by the headmaster to participate in the research. The school was a private school based in Johannesburg, Gauteng.

Purposive sampling (Huck, 2012) was employed to obtain participants within the school. All the learners in grades 8 and 9 were invited to complete questionnaires for the research. The participants completed questionnaires in a single group setting. Particularly because adolescence is a period marked by significant cognitive and emotional changes, younger adolescents differ significantly in cognitive and emotional maturity from older adolescents (Berk, 2013; Siegel, 2013). Therefore, in order to avoid any possible confounding variables
influencing the outcomes, these students were chosen to ensure homogeneity in age to best accomplish the aims of the study.

3.5 Participants

A total of 271 learners were invited to participate in the research. The final sample consisted of 188 participants. This constitutes a response rate of 69.4%, which is considered acceptable for the nature of this study (Heppner & Heppner, 2004; Nulty, 2008).

The ages of the participants ranged from 13 to 16 years of age ($M = 14.44; SD = .630$). The sample comprised 54.8% ($n = 103$) females and 45.2% ($n = 85$) males. In terms of population groups, the majority of the sample were White 67% ($n = 126$), followed by Black participants, 20.7% ($n = 39$). The remainder of the sample consisted of Coloured 4.3% ($n = 8$), Indian 6.4% ($n = 12$) and Asian 0.5% ($n = 1$) participants. Two participants did not state their population group.

Table 3.1 details the demographic characteristics of the participants.
Table 3.1

*Demographic Characteristics of Participants*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Frequency</th>
<th>Percentage</th>
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<tbody>
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<tr>
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<td>11</td>
<td>5.9</td>
</tr>
<tr>
<td>14</td>
<td>87</td>
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<tr>
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<td>3</td>
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<tr>
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</tr>
<tr>
<td><strong>Gender</strong></td>
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<tr>
<td>Female</td>
<td>103</td>
<td>54.8</td>
</tr>
<tr>
<td><strong>Population Group</strong></td>
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<tr>
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<td>39</td>
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</tr>
<tr>
<td>White</td>
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</tr>
<tr>
<td>Coloured</td>
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<tr>
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<tr>
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</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>5.7</td>
</tr>
</tbody>
</table>
3.6. Procedure

Prior to the study the researcher obtained approval for the research proposal from the Higher Degrees Committee of the Department of Psychology at the University of Johannesburg. Ethical permission was obtained at the same time. Ethical considerations will be discussed in section 3.8 below.

The researcher approached the school and obtained permission from the Headmaster to conduct the research. Permission from the Gauteng Department of Education was not needed due to the school being a private, rather than public, school. Upon written approval by the headmaster, the researcher was put in contact with the school psychologist, the head of Life Orientation. The researcher worked in conjunction with this teacher, who facilitated the administrative procedures relating to the research process. All the grade 8 and 9 students were invited to participate in the research, totalling 271 students.

Parental consent forms (see Appendix 1) were sent home with the students, explaining the nature of the research and how data would be collected. The parents were invited to contact the researcher should they have any questions or be interested in receiving the results of the study. Two parents indicated they were interested in receiving the results and contacted the researcher, which was duly noted.

Parental consent forms were collected by the relevant class teachers. Questionnaires were then administered by the researcher to those whom had obtained parental consent after an assembly in a group setting. The administration of the questionnaires did not impinge on any class time. The researcher again explained the nature of the research and invited those present to participate. All those present completed the participant assent forms (see Appendix 2). These were then collected and collated next to the parental consent forms. Questionnaires were then distributed and completed anonymously by the participants. The questionnaires
took approximately 15 – 20 minutes to complete. The researcher was available for any questions regarding the study. The instruments used in the research will be discussed below.

3.7. Measuring Instruments

Self-report questionnaires, incorporating a biographical section were used to collect data. The Self-Compassion Scale (SCS) (Neff, 2003a, 2015) was employed to measure self-compassion. The Parenting Style Inventory-II (PSI-II) (Darling & Toyokawa, 1997) was used to measure the participants’ perceptions of their parents’ parenting style. The SCS and the PSI-II were available in the public domain online. These instruments will be described in the following sections.

3.7.1 Biographical Data

The biographical section was constructed in order to obtain information on the participants’ age, home language, population group and gender.

3.7.2 The Self-Compassion Scale (SCS) (Neff, 2003a, 2015)

3.7.2.1. Rationale for use.

The Self-Compassion Scale is the most widely-used measure for self-compassion, which is the primary construct in which the researcher is interested in. Furthermore, the operationalisation of self-compassion into the three components, as operationalised by Neff (2003a, 2003b, 2008, 2011), provides an in-depth understanding of the construct of self-compassion. The SCS has also shown promising emerging results with adolescent samples which the researcher was interested in exploring further (Bluth & Blanton, 2013, 2014; Neff & McGehee, 2010) Hence, the SCS was used to measure self-compassion.
3.7.2.2. Nature and administration.

The Self Compassion Scale (SCS) is a 26 item scale tapping all three aspects of self-compassion: self-kindness, common humanity and mindfulness. The SCS comprises six subscales: Self-Kindness (5 items, e.g., “I’m kind to myself when I’m experiencing suffering”); Self-Judgment (5 items, e.g., “I’m disapproving and judgemental about my own flaws and inadequacies”); Common Humanity (4 items, e.g., “I try to see my failings as part of the human condition”); Isolation (4 items, e.g., “When I fail at something that’s important to me, I tend to feel alone in my failure”); Mindfulness (4 items, e.g., “When something upsets me I try to keep my emotions in balance”); and Over-Identification (4 items, e.g., “When something painful happens I tend to blow the incident out of proportion”). Using a 5-point Likert scale, the participants indicate how often they behave in the stated manner.

3.7.2.3 Scoring and interpretation.

The items are scored on a 5-point Likert scale ranging from 1 = ‘almost never’ to 5 = ‘almost always’. The six subscales can be calculated separately by calculating the means of subscale responses. For the purposes of this study, only total self-compassion scores were employed. In order to determine a total self-compassion score, negative subscale items (Self-Judgement, Isolation and Over-Identification) need to be reverse-scored before calculating subscale means, then all six subscale means can be calculated to determine a total mean score. Higher scores mean a higher level of self-compassion (Neff, 2003a). For the purposes of this study, a score of higher than 3 was set to determine a higher level of self-compassion.

3.7.2.4. Reliability and validity.

Cross-validation of the scale’s factor structure has been confirmed by confirmatory factor analysis, which explains the inter-correlations between the six subscales.
(NNFI = 0.90; CFI =0.92). Internal consistency overall for the 26 item SCS is 0.92 and test-retest reliability for the SCS overall is $r=0.93$ (Neff, 2003a).

The SCS is reported to demonstrate strong construct validity when compared with similar established measures. Thus a significant negative correlation with self-criticism has been found, as measured by the Depression Experience Scale (Blatt, D’Afflitti, & Quinlan, 1976). Furthermore, a positive association with social connectedness as measured by the Social Connectedness Scale (Lee & Robbins, 1995), as well as positive associations with Attention, Repair and Clarity, as measured by the Trait Meta-Mood Scale has been reported (Salovey, Mayer, Goldman, Turvey, & Palfai, 1995).

Research indicates that the SCS demonstrates good convergent validity, e.g. significant correlation with Buddhist ratings of self-compassion, and discriminative validity, e.g. no correlation with narcissism or depression (Neff, 2003a, 2015; Neff & McGee, 2010; Vettese et al., 2011). Furthermore, the SCS has been demonstrated to show significant predictive validity in terms of mental health outcomes. The SCS has been found to have a significant negative correlation with the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and the Spielberger Trait Anxiety Inventory (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1968) as well as a significant positive association with the Life Satisfaction Scale (Diener, Emmons, Larson, & Griffin, 1985).

The SCS has not yet been validated for use in South African populations. However, one study in South Africa has been conducted using the SCS and it seemed to be psychometrically acceptable, with Cronbach alphas for Self-Kindness = 0.80, Common Humanity = 0.76, for Mindfulness = 0.88 and for the SCS as a whole, 0.88 (Swanepoel, 2009).
3.7.3 *The Parenting Style Inventory-II (PSI-II)* (Darling & Toyokawa, 1997)

3.7.3.1. Rationale for use.

This scale was chosen by the researcher, as it measures adolescents’ perceptions of their parents’ parenting styles, independently of the parents’ parenting practice (Darling & Toyokawa, 1997). Many other parenting style scales require the parents to complete the questionnaire, for example, PAQ-R (Reitman, Hupp, Rhode, & Altobello, 2002). For the purposes of this study, the researcher was interested in the participants’ perceptions of their parents’ parenting style, irrespective of the actual style employed by the parents. The participants completed separate questionnaires for their perceptions of both mother and father respectively.

3.7.3.2. Nature and administration.

The Parenting Style Inventory-II (PSI-II) is a 15 item adolescent-report scale measuring adolescents’ perceptions of their experiences with their parents. The PSI-II is a revision of the PSI-I scale (Lamborn, Mounts, Steinberg, & Dornbusch, 1991), which was designed to measure parenting style independently of parenting practice (Darling & Steinberg, 1993). The PSI-II comprises of three subscales: emotional responsiveness (5 items, e.g., “My mother spends time just talking to me”); demandingness (5 items, e.g., “My mother really expects me to follow family rules”); and autonomy-granting (5 items, e.g., “My mother gives me a lot of freedom”). The autonomy granting subscale was not used in this study as the four parenting styles from Baumrind’s (1966) model only combine the dimensions of emotional responsiveness and demandingness to infer parenting style. Using a 5-point Likert scale (1 = ‘strongly disagree’ to 5 = ‘strongly agree’) the participants were asked to indicate which response best described their attitude towards various aspects of their parents’ behaviour.
3.7.3.3. Scoring and interpretation.

For the purposes of this study, a score of above three was considered ‘high’ and a score of below three was considered ‘low’. High scores indicate stronger agreement regarding a specific dimension, with the exception of four items (e.g. “My mother hardly ever praises me”), which have to be reversed scored in order to calculate the scores. High scores on both subscales denote an authoritative style, high scores on demandingness and low scores on emotional responsiveness indicate an authoritarian style. Low scores on demandingness and high scores on emotional responsiveness refer to a permissive style. Low scores on both subscales indicate uninvolved parenting.

3.7.3.4. Reliability and validity.

The reliability indices for emotional responsiveness and demandingness are reported to be 0.74 and 0.72 respectively. Emotional responsiveness and demandingness show a moderate inter-correlation of 0.34. The scale has been found to show adequate variability and internal consistency, as, for example in a Dutch study by Nijhof and Engels (2007), and a Belgium study by Bastaits et al., (2015). The PSI-II also demonstrates predictive validity of other outcome variables, for example, coping skills and school grades (Darling & Toyokawa, 1997; Nijof & Engels, 2007). Item 7 of the Mother Scale, “My mother points out ways I can do better” was found to not demonstrate adequate reliability for this study and was therefore excluded from the analysis. This item was also excluded from the Father Scale in order to maintain consistency. No studies were found using the scale in the South African populations. However, international studies indicate psychometric acceptability (Bastaits, et al., 2015; Bhattacharyya & Pradhan, 2015).
3.8. Ethical Considerations

Ethical clearance was obtained from the Faculty of Humanities Research Ethics Committee at the University of Johannesburg (REC 01-046-2016 – see Appendix 3).

Permission was obtained from the headmaster of the school to administer measures during an acceptable school period. In accordance with World Health Organisation guidelines, informed assent (Appendix 2) was obtained from the participants and informed consent (Appendix 1) from their parents/guardians (WHO, 2016). Detailed information as to the nature of the study was made available to both the participants and their parents. The participants were invited to participate in the study on a voluntary basis. All reasonable steps were taken to ensure anonymity and confidentiality. There were no identifying details on any of the questionnaires. Each participant’s rights and dignity were respected and no bias, discrimination or prejudice was shown to any participant on any basis.

The researcher was the primary person gathering the data. Teachers were available to assist the researcher with handing out and collecting the questionnaires. The participants placed their questionnaires face down in a box, which the researcher oversaw, while the teachers marked off the participants next to their class lists and parental consent forms. The questionnaires were stored in a locked safe in the researcher’s office (Medical Research Council of South Africa, 2015; Schenk & Williamson, 2005).

3.9. Data Analysis

Data analyses were conducted using the Statistical Package for the Social Sciences (SPSS), version 23. Data was captured by the researcher and analysed by staff at STATKON at the University of Johannesburg. Descriptive statistics were first performed to examine means, standard variations and correlations among the variables. Parametric assumptions were tested
in order to determine the appropriate tests to be employed, which is discussed in the results chapter.

T-tests were employed in order to determine differences between groups. In order to determine how much of the variance in self-compassion (DV) was explained by parenting style (IV), a standard multiple regression analysis was implemented (Dancey & Reidy, 2011; Tredoux, 2009).

3.10. Summary

This chapter explained the method employed in this study. The research aims were specified, after which the research design, sampling method employed and participants were described. The procedure for data collection and measuring instruments were explained. Finally ethical considerations were discussed and the method of data analysis was presented. The results of the statistical analysis will be delineated in the following chapter.
CHAPTER 4 - RESULTS

4.1. Introduction

This chapter presents the findings from the statistical analyses conducted. The findings from the preliminary analyses are provided by means of reliability indices and descriptive statistics for the scales implemented in the study. In order to describe the general relationship among the variables, findings from inter-correlations among the variables are also presented. Thereafter, the statistics relating to the specific aims of the study are presented.

4.2. Preliminary Analyses

Preliminary analyses were performed in order to examine the characteristics of the data. This included: (a) reliability indices for the Self-Compassion Scale (SCS) and Parenting Style Inventory – II (PSI-II) and (b) determining means, standard deviations, percentages, skewness and kurtosis for variables. The preliminary analyses are presented below. The preliminary analysis thus addresses the first two aims of the study, namely:

To determine levels of self-compassion among a group of adolescents.

To determine the prevalence of the four parenting styles: authoritarian, authoritative, permissive and uninvolved among a group of adolescents.

4.2.1. Reliability Indices of Measuring Instruments

Table 4.1 reflects the Cronbach’s alpha (α) reliability coefficients for the scales. Most of the scales were above .70 which indicates adequate internal consistency, particularly for self-report measures used for research purposes (Pallant, 2011).

The SCS overall demonstrates very good internal consistency (α = .91). As indicated, self-kindness, self-judgment and common humanity all demonstrate good internal consistency,
yielding coefficients above .7. The items measuring isolation, mindfulness and over-identification yield Cronbach’s alpha values of just below .7. Inter-item correlation is examined if the item demonstrates low reliability consistency and if there are less than 10 items in the subscale. Therefore, when the inter-item correlation means are examined, each subscale meets acceptable reliability levels, as inter-item correlation means for a set of items should be between .20 and .40 in order to suggest reasonable item homogeneity as well as sufficient variance between items (Piedmont, 2014).

The PSI-II shows adequate internal consistency on all the items, except for the subscale measuring demandingness of the mother (α = .56). Inter-item correlations for this subscale were further examined and a mean of .20 was found. This value does not meet acceptable reliability indices. Upon examination of the item total statistics, it was found that item 7, “My mother points out ways I can do better”, demonstrated a statistic of .090, indicating a very low correlation with the other items in the subscale. When item 7 was excluded from the reliability analysis the Cronbach’s alpha was a value of .62. However, the inter-item correlation mean was then found to be $M = .29$, which suggests adequate item reliability.

Item 7 was therefore omitted from the analysis in both the Father and the Mother scales to ensure consistency in the analysis. Two other studies, Bastaits, et al. (2015), and Nijhof and Engels (2007), also reported inadequate reliability indices for the demandingness subscale. Bastaits et al. (2015) excluded two items from the demandingness subscale; although they did not specify which items were omitted (Bastaits, et al., 2015; Nijohf & Engels, 2007).

Upon examination of item 7, the researcher posited that the possible reason for this finding was that it was possibly ambiguous, specifically that it was not clear in which domains the mother may point out ways in which the child could do better, e.g. academically, socially, in
sport, chores or any other way. The reliability values are therefore reported separately in order to underscore this finding.

Table 4.1

_Cronbach’s Alpha Reliability Coefficients for Measuring Instruments_

<table>
<thead>
<tr>
<th>Scale</th>
<th>Number of Items</th>
<th>α</th>
<th>*Inter-Item Correlation M</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S-K</td>
<td>5</td>
<td>.76</td>
<td></td>
</tr>
<tr>
<td>S-J</td>
<td>5</td>
<td>.79</td>
<td></td>
</tr>
<tr>
<td>C-H</td>
<td>4</td>
<td>.72</td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>4</td>
<td>.70</td>
<td>.37</td>
</tr>
<tr>
<td>M</td>
<td>4</td>
<td>.60</td>
<td>.28</td>
</tr>
<tr>
<td>O-I</td>
<td>4</td>
<td>.69</td>
<td>.36</td>
</tr>
<tr>
<td>SCS (Tot)</td>
<td>26</td>
<td>.91</td>
<td></td>
</tr>
<tr>
<td>PSI-II (M)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MResp</td>
<td>5</td>
<td>.79</td>
<td></td>
</tr>
<tr>
<td>MDeman</td>
<td>5</td>
<td>.56</td>
<td></td>
</tr>
<tr>
<td>MDeman (Excl. item 7)</td>
<td>4</td>
<td>.62</td>
<td>.29</td>
</tr>
<tr>
<td>PSI-II (F)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FResp</td>
<td>5</td>
<td>.83</td>
<td></td>
</tr>
<tr>
<td>FDeman</td>
<td>5</td>
<td>.70</td>
<td></td>
</tr>
<tr>
<td>FDeman (Excl. Item 7)</td>
<td>4</td>
<td>.71</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* *Less than 10 items in subscale and not reliable, therefore Inter-Item Correlation Mean used.

SCS = Self-Compassion Scale; S-K = Self-Kindness; S-J = Self-Judgment; C-H = Common Humanity; I = Isolation; M = Mindfulness; O-I = Over-Identification; SCS Tot = Self-Compassion Total; PSI-II (M) = Parenting Style Inventory-II (Mother); MResp = Mother
Responsiveness; MDeman = Mother Demandingness; PSI-II (F) = Parenting Style Inventory-II (Father); FResp = Father Responsiveness; FDeman = Father Demandingness.

4.2.2. Means, Standard Deviations, Skewness and Kurtosis of Measuring Instruments

Means, standard deviations, skewness, kurtosis and $p$-values from the Kolmogorov-Smirnov test for normality scores are presented in Table 4.2. Males scored slightly higher on self-compassion ($M = 3.12$, $SD = .58$) than females ($M = 2.88$, $SD = .72$). Gender differences on all scores will be discussed in more detail in section 4.3.1. Overall, the mean self-compassion score for the group was $M = 2.99$; $SD = .67$.

The data were tested for normality before further analyses were conducted using the Kolmogorov–Smirnov test, setting the significance level at $\alpha = 0.05$. The Kolmogorov-Smirnov test has the advantage of being non-parametric and distribution free. It is also very well-suited to larger ($\geq 50$) sample sizes (Dodge, 2008). It was therefore chosen owing to the sample size of this study (males = 85; females = 103). Under the null hypothesis ($H_0$: $p \geq .05$), a non-significant result indicates that the data is normally distributed; and the alternate hypothesis ($H_1$: $p \leq .05$) would indicate that the data is not normally distributed. The Kolmogorov-Smirnov test indicated that self-kindness, self-judgement and fathers’ demandingness subscales as well as the self-compassion scale total for males showed normally distributed scores. The remainder of the subscales and self-compassion total scores for females were not normally distributed.

The skewness and kurtosis values were also calculated in order to ascertain the distribution of the scores. Skewness indicates the symmetry of the distribution, while kurtosis demonstrates the ‘peakedness’ of the distribution. Normally-distributed scores display skewness and kurtosis values of zero (Pallant, 2011). No firm guidelines exist for acceptable values of skewness and kurtosis. However, Heppner and Heppner (2004) propose that values less than...
the absolute value of two are considered acceptable in order to meet the criteria of normal distribution. In terms of skewness and kurtosis all the scores reported in Table 4.2 indicated acceptable normality. Male scores for Mother Responsiveness was the only score that showed negative skewness of higher than one but it fell below the modulus of two (-1.09), indicating normality of distribution.
Table 4.2

*Means, Standard Deviations, Skewness, Kurtosis and Normality of all Measures*

<table>
<thead>
<tr>
<th>Scale</th>
<th>Gender</th>
<th>Mean</th>
<th>SD</th>
<th>Skewness</th>
<th>Kurtosis</th>
<th>Kolmogorov-Smirnov</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCS:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S-K</td>
<td>Male</td>
<td>2.85</td>
<td>.84</td>
<td>.12</td>
<td>-.25</td>
<td>.170*</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>2.77</td>
<td>.89</td>
<td>.35</td>
<td>-.44</td>
<td>.021</td>
</tr>
<tr>
<td>S-J</td>
<td>Male</td>
<td>2.57</td>
<td>.89</td>
<td>.29</td>
<td>-.33</td>
<td>.072*</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>3.06</td>
<td>.98</td>
<td>-.17</td>
<td>-.89</td>
<td>.027</td>
</tr>
<tr>
<td>C-H</td>
<td>Male</td>
<td>2.69</td>
<td>.87</td>
<td>.16</td>
<td>-.89</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>2.77</td>
<td>.91</td>
<td>.28</td>
<td>-.41</td>
<td>.013</td>
</tr>
<tr>
<td>I</td>
<td>Male</td>
<td>2.62</td>
<td>.90</td>
<td>.29</td>
<td>-.70</td>
<td>.001</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>3.09</td>
<td>1.00</td>
<td>-.19</td>
<td>-.61</td>
<td>.022</td>
</tr>
<tr>
<td>M</td>
<td>Male</td>
<td>3.00</td>
<td>.79</td>
<td>-.12</td>
<td>-.30</td>
<td>.034</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>2.94</td>
<td>.79</td>
<td>.11</td>
<td>-.25</td>
<td>.009</td>
</tr>
<tr>
<td>O-I</td>
<td>Male</td>
<td>2.63</td>
<td>.99</td>
<td>-.15</td>
<td>-.94</td>
<td>.043</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>3.04</td>
<td>.93</td>
<td>-.23</td>
<td>-.85</td>
<td>.017</td>
</tr>
<tr>
<td>S-C Tot</td>
<td>Male</td>
<td>3.12</td>
<td>.58</td>
<td>-.18</td>
<td>.19</td>
<td>.200*</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>2.88</td>
<td>.72</td>
<td>.35</td>
<td>-.80</td>
<td>.027</td>
</tr>
<tr>
<td>PSI-II (M)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MResp</td>
<td>Male</td>
<td>4.05</td>
<td>.83</td>
<td>-1.09</td>
<td>.45</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>4.18</td>
<td>.84</td>
<td>-.94</td>
<td>-.17</td>
<td>.000</td>
</tr>
<tr>
<td>MDeman</td>
<td>Male</td>
<td>3.60</td>
<td>.79</td>
<td>-.46</td>
<td>.47</td>
<td>.027</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>3.88</td>
<td>.72</td>
<td>-.12</td>
<td>-1.13</td>
<td>.000</td>
</tr>
<tr>
<td>PSI-II (F)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FResp</td>
<td>Male</td>
<td>3.84</td>
<td>.97</td>
<td>-.84</td>
<td>-.06</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>3.68</td>
<td>.99</td>
<td>-.69</td>
<td>.05</td>
<td>.001</td>
</tr>
<tr>
<td>FDeman</td>
<td>Male</td>
<td>3.82</td>
<td>.81</td>
<td>-.29</td>
<td>-.57</td>
<td>.200*</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>3.75</td>
<td>.92</td>
<td>-.39</td>
<td>-.52</td>
<td>.007</td>
</tr>
</tbody>
</table>

Note. *p-value ≥ 0.05

SCS = Self-Compassion Scale; S-K = Self-Kindness; S-J = Self-Judgment; C-H = Common Humanity; I = Isolation; M = Mindfulness; O-I = Over-Identification; S-C Tot = Self-Compassion Total; PSI-II (M) = Parenting Style Inventory-II (Mother); MResp = Mother Responsiveness; MDeman = Mother Demandingness; PSI-II (F) = Parenting Style Inventory-II (Father); FResp = Father Responsiveness; FDeman = Father Demandingness.
4.2.3. Prevalence of the Four Parenting Style Groupings

The frequencies and percentages of scores for parenting style groupings are presented below. Table 4.3 and Table 4.4 provide scores for the mothers’ parenting style and the fathers’ parenting style respectively. As expected, adolescents perceived both mothers and fathers as predominately displaying the authoritative parenting style.

Table 4.3

Parenting Style Groupings of Mother

<table>
<thead>
<tr>
<th>Parenting Style</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permissive</td>
<td>20</td>
<td>10.6</td>
</tr>
<tr>
<td>Authoritative</td>
<td>122</td>
<td>64.9</td>
</tr>
<tr>
<td>Uninvolved</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>Authoritarian</td>
<td>15</td>
<td>8.0</td>
</tr>
<tr>
<td>*Missing data</td>
<td>29</td>
<td>15.4</td>
</tr>
<tr>
<td>Total</td>
<td>188</td>
<td>100</td>
</tr>
</tbody>
</table>

*Note: *Missing data = those who responded with a value of 3 or who did not complete Mother questionnaire.

Table 4.4

Parenting Style Groupings of Father

<table>
<thead>
<tr>
<th>Parenting Style</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permissive</td>
<td>17</td>
<td>9.0</td>
</tr>
<tr>
<td>Authoritative</td>
<td>111</td>
<td>59.0</td>
</tr>
<tr>
<td>Uninvolved</td>
<td>6</td>
<td>3.2</td>
</tr>
<tr>
<td>Authoritarian</td>
<td>24</td>
<td>12.8</td>
</tr>
<tr>
<td>*Missing data</td>
<td>30</td>
<td>16.0</td>
</tr>
<tr>
<td>Total</td>
<td>188</td>
<td>100</td>
</tr>
</tbody>
</table>

*Note: *Missing data = those who responded with a value of 3 or those who did not complete Father questionnaire.
4.3. Inferential Statistics

The following section presents the findings of inferential data analyses conducted in order to answer the following research aims:

- To determine gender differences in self-compassion.
- To determine gender differences in adolescents’ perception of parenting styles.
- To determine maternal and paternal differences in adolescents’ perception of parenting styles.
- To determine the relationship between parenting style and self-compassion.
- To determine how much variance in self-compassion scores was explained by parenting style.
- The degree to which adolescents’ experiences of mothers’ parenting style and fathers’ parenting style respectively predict self-compassion.

Independent *t*-tests were conducted in order to examine the mean differences between males and females on self-compassion and perception of parenting styles. Paired-samples *t*-tests were performed to determine maternal and paternal comparisons in parenting style. A standard multiple regression analysis was conducted to examine the variance in self-compassion scores. These analyses are expanded below.

4.3.1. Gender Differences in Self-Compassion

Male and female scores were compared by means of independent sample *t*-tests. This parametric test was chosen because, while the data were not normally distributed, the group sizes were large enough to warrant an independent sample *t*-test (Dancy & Reidy, 2011). There were statistically significant differences in mean scores between males and females for self-judgment, isolation, over-identification and the self-compassion total score. There were
no statistically significant differences for the dimensions of self-kindness, common-
humanity and mindfulness.

Females exhibited statistically significantly higher scores for all three of the negative
dimensions of self-compassion than males did, so they scored higher on self-judgment, reported feeling more isolation and over-identified with their negative emotions. Males exhibited higher levels of self-compassion overall. Table 4.5 presents the results of the gender differences in this regard.

Table 4.5

<table>
<thead>
<tr>
<th>Gender Differences in Self-Compassion Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCS</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>S-K</td>
</tr>
<tr>
<td>S-J</td>
</tr>
<tr>
<td>C-H</td>
</tr>
<tr>
<td>I</td>
</tr>
<tr>
<td>M</td>
</tr>
<tr>
<td>O-I</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Note: *p-value ≤ .05 (2 Tailed)

SCS = Self-Compassion Scale; S-K = Self-Kindness; S-J = Self-Judgment; C-H = Common Humanity; I = Isolation; M = Mindfulness; O-I = Over-Identification; Total = Self-Compassion Total; M = Mean; SD = Standard Deviation; t = test statistic; p = p-value

4.3.2. Gender Differences in Adolescents’ Perception of Parenting Style

An independent \(t\)-test was employed to examine the mean gender differences relating to the parenting style scores. Table 4.6 shows there were no statistically significant differences in mean scores between males and females for mothers’ responsiveness, fathers’ responsiveness and fathers’ demandingness. However, there were statistically significant differences in
means scores between males and females for mothers’ demandingness. Females reported their mothers to be higher on demandingness than males did.

Table 4.6

*Gender Differences in Perception of Parenting Style*

<table>
<thead>
<tr>
<th>PSI-II</th>
<th>Males (n = 85)</th>
<th>Females (n = 103)</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>MResp</td>
<td>4.05</td>
<td>4.18</td>
<td>-1.09</td>
<td>.28</td>
</tr>
<tr>
<td>MDeman</td>
<td>3.60</td>
<td>3.88</td>
<td>-2.58</td>
<td>.011*</td>
</tr>
<tr>
<td>FResp</td>
<td>3.84</td>
<td>3.68</td>
<td>1.10</td>
<td>.275</td>
</tr>
<tr>
<td>FDeman</td>
<td>3.83</td>
<td>3.75</td>
<td>.556</td>
<td>.579</td>
</tr>
</tbody>
</table>

*Note. *p*-value ≤ .05 (2 Tailed)*

PSI-II = Parenting Style Inventory-II; MResp = Mother Responsiveness; MDeman = Mother Demandingness; FResp = Father Responsiveness; FDeman = Father Demandingness.

M = Mean; SD = Standard Deviation; t = test statistic; p = *p*-value

**4.3.3. Maternal and Paternal differences in Parenting Styles**

A paired-samples *t*-test was conducted to compare the mean differences between mothers’ and fathers’ responsiveness and demandingness respectively. There was a statistically significant difference in mean scores for mothers’ responsiveness (*M* = 4.13, *SD* = .825) and fathers’ responsiveness. There were no statistically significant differences found between mothers’ demandingness and fathers’ demandingness. Table 4.7 demonstrates these differences.
Table 4.7

*Significance of Difference between Mothers’ and Fathers’ Parenting Style*

<table>
<thead>
<tr>
<th>Pair 1</th>
<th>RM-RF</th>
<th>.373</th>
<th>1.036</th>
<th>.000*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 2</td>
<td>DM-DF</td>
<td>-.025</td>
<td>.850</td>
<td>.694</td>
</tr>
</tbody>
</table>

*Note.* *p*-value ≤ .05
RM – RF = Responsiveness Mother - Responsiveness Father; DM-DF = Demandingness Mother – Demandingness Father

### 4.3.4. Correlations between self-compassion and parenting style

A Pearson’s correlation coefficient was calculated to examine the relationships among the different dimensions of self-compassion and parenting style as reflected in Table 4.8. Gender was included as a control variable in the analysis.

The correlations between all the variables were statistically significant, with the exception of the relationship between the demandingness dimension of both mother and father respectively and self-compassion. Therefore it appears evident that there is no statistically significant relationship between parents’ demandingness and the adolescents’ ability to develop self-compassion. However, responsiveness, described as warmth, love and support for the adolescent appears to be related to self-compassion (*p* ≤ .01). In addition there was a statistically significant relationship between both mothers’ and fathers’ demandingness, as well as mothers’ and fathers’ responsiveness (*p* ≤ .01), indicating that mothers and fathers display similar parenting patterns.
Table 4.8

Correlation Matrix for all Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>S-C</th>
<th>Gender</th>
<th>MResp</th>
<th>MDeman</th>
<th>FResp</th>
<th>FDeman</th>
</tr>
</thead>
<tbody>
<tr>
<td>S-C</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>-.202</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>MResp</td>
<td>.180*</td>
<td>.090</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDeman</td>
<td>.020</td>
<td>.189</td>
<td>-.047</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FResp</td>
<td>.259*</td>
<td>-.072</td>
<td>.351*</td>
<td>.041</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>FDeman</td>
<td>.069</td>
<td>-.041</td>
<td>.081</td>
<td>.455*</td>
<td>-.054</td>
<td>1</td>
</tr>
</tbody>
</table>

Note. * p value ≤ .01 (1 tailed)
S-C = Self-Compassion; MResp = Mother Responsiveness; MDeman = Mother Demandingness; FResp = Father Responsiveness; FDeman = Father Demandingness

4.3.4.1. Relationships between the components of self-compassion and the four parenting styles

In order to determine which specific parenting style, namely authoritarian, authoritative, permissive or uninvolved is associated with self-compassion; it was not possible to implement comparative tests owing to the differences in group sizes, with some groups being too small. Mean scores were therefore examined in order to make tentative inferences about differences in self-compassion as associated with parenting style. Table 4.9 details these findings.

Observations of these tentative relationships elicited the following conclusions: adolescents with permissive and authoritative parents (both characteristic of high responsiveness/warmth) demonstrated high levels of self-kindness. Those adolescents who scored high in self-judgment experienced their mothers as being more authoritarian and their fathers as uninvolved, both styles characterised by low responsiveness and warmth. Uninvolved parenting by both the mother and the father was evidenced by adolescents who reported high
levels of isolation. This finding was particularly high for those with uninvolved fathers. Mindfulness scores were also low for those with uninvolved parents. However, the scores were lower when the mother was perceived to be uninvolved. Overall, authoritative parenting appeared to have the strongest relationship with self-compassion, followed by permissive parenting. It is important to note that both authoritative and permissive parenting are characterised by high responsiveness and warmth, which is the dimension which seems to have the most significant correlation with self-compassion. As expected, uninvolved parenting had the least association with self-compassion.
Table 4.9
*Parenting Style Associations with Self-Compassion*

<table>
<thead>
<tr>
<th>SCS</th>
<th>PS</th>
<th>Mother</th>
<th>Father</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>S-K</td>
<td>Permissive</td>
<td>20</td>
<td>2.77</td>
</tr>
<tr>
<td></td>
<td>Authoritative</td>
<td>122</td>
<td>2.94</td>
</tr>
<tr>
<td></td>
<td>Uninvolved</td>
<td>2</td>
<td>1.75</td>
</tr>
<tr>
<td></td>
<td>Authoritarian</td>
<td>15</td>
<td>2.12</td>
</tr>
<tr>
<td>S-J</td>
<td>Permissive</td>
<td>20</td>
<td>3.05</td>
</tr>
<tr>
<td></td>
<td>Authoritative</td>
<td>122</td>
<td>2.72</td>
</tr>
<tr>
<td></td>
<td>Uninvolved</td>
<td>2</td>
<td>2.20</td>
</tr>
<tr>
<td></td>
<td>Authoritarian</td>
<td>15</td>
<td>3.31</td>
</tr>
<tr>
<td>C-H</td>
<td>Permissive</td>
<td>20</td>
<td>2.47</td>
</tr>
<tr>
<td></td>
<td>Authoritative</td>
<td>122</td>
<td>2.85</td>
</tr>
<tr>
<td></td>
<td>Uninvolved</td>
<td>2</td>
<td>1.75</td>
</tr>
<tr>
<td></td>
<td>Authoritarian</td>
<td>15</td>
<td>2.43</td>
</tr>
<tr>
<td>I</td>
<td>Permissive</td>
<td>20</td>
<td>2.97</td>
</tr>
<tr>
<td></td>
<td>Authoritative</td>
<td>122</td>
<td>2.77</td>
</tr>
<tr>
<td></td>
<td>Uninvolved</td>
<td>2</td>
<td>3.63</td>
</tr>
<tr>
<td></td>
<td>Authoritarian</td>
<td>15</td>
<td>3.33</td>
</tr>
<tr>
<td>M</td>
<td>Permissive</td>
<td>20</td>
<td>2.98</td>
</tr>
<tr>
<td></td>
<td>Authoritative</td>
<td>122</td>
<td>3.04</td>
</tr>
<tr>
<td></td>
<td>Uninvolved</td>
<td>2</td>
<td>1.88</td>
</tr>
<tr>
<td></td>
<td>Authoritarian</td>
<td>15</td>
<td>2.70</td>
</tr>
<tr>
<td>O-I</td>
<td>Permissive</td>
<td>20</td>
<td>3.15</td>
</tr>
<tr>
<td></td>
<td>Authoritative</td>
<td>122</td>
<td>2.81</td>
</tr>
<tr>
<td></td>
<td>Uninvolved</td>
<td>2</td>
<td>3.25</td>
</tr>
<tr>
<td></td>
<td>Authoritarian</td>
<td>15</td>
<td>2.81</td>
</tr>
<tr>
<td>S-C Tot</td>
<td>Permissive</td>
<td>20</td>
<td>2.85</td>
</tr>
<tr>
<td></td>
<td>Authoritative</td>
<td>122</td>
<td>3.09</td>
</tr>
<tr>
<td></td>
<td>Uninvolved</td>
<td>2</td>
<td>2.35</td>
</tr>
<tr>
<td></td>
<td>Authoritarian</td>
<td>15</td>
<td>2.61</td>
</tr>
</tbody>
</table>

*Note.* SCS = Self-Compassion Scale; PS = Parenting Style; S-K = Self-Kindness; S-J = Self-Judgment; C-H = Common Humanity; I = Isolation; M = Mindfulness; O-I = Over-Identification; S-C Tot = Self-Compassion Total
4.3.5  Parenting Style as a Predictor of Self-Compassion

The correlational analysis (Table 4.8) revealed that the demandingness dimension of parenting style had no statistically significant relationship with self-compassion (Mother’s Demandingness $r = .020$; Father’s Demandingness $r = .069$, $p \geq .01$). However, the responsiveness dimension had a statistically significant correlation with self-compassion (Mother’s Responsiveness $r = .180$; Father’s Responsiveness $r = .259$, $p \leq .01$). A standard multiple regression analysis was performed to examine the unique variance of each predictor on the dependent variable. The demandingness subscale was therefore excluded from the analysis, while the responsiveness of mother and father scales was included. The researcher also controlled for gender, as it was also found to have a correlation with self-compassion ($r = -.202$, $p \leq .01$). Table 4.10 reports the model summary of the predictor variables.

Table 4.10

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>R Square</th>
<th>Adjusted R Square</th>
<th>Std. Error of Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.339*</td>
<td>.115</td>
<td>.100</td>
<td>.628</td>
</tr>
</tbody>
</table>

* Predictors: Gender, Mother Responsiveness, Father Responsiveness
**Dependent Variable: Self-Compassion

$R^2 = .115$, therefore 11.5% of the variance in self-compassion experienced by adolescents can be explained by the gender of the respondent and the responsiveness of the mother and father respectively.

A two-way analysis of variance (ANOVA) was performed to determine whether there were statistically significant differences between mothers’ responsiveness, fathers’ responsiveness and gender on self-compassion scores. Table 4.11 reports the findings of this analysis,
showing that all three variables are jointly statistically significant in predicting self-compassion.

Table 4.11

*Analysis of Variance for Self-Compassion*

<table>
<thead>
<tr>
<th></th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>9.055</td>
<td>3</td>
<td>3.018</td>
<td>7.660</td>
<td>.000*</td>
</tr>
<tr>
<td>Residual</td>
<td>69.744</td>
<td>177</td>
<td>.394</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>78.799</td>
<td>180</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.*

* Predictors: Gender, Mother Responsiveness, Father Responsiveness
**Dependent Variable: Self-Compassion

Collinearity statistics revealed that there was no multi-collinearity between the variables.

As can be seen in Table 4.12, while all the predictor variables correlate with self-compassion, gender, with higher Beta value ($\beta = -.198, \ p \leq .01$) and responsiveness of the father ($\beta = .199, \ p \leq .01$) have a stronger relationship with self-compassion than the responsiveness of mothers ($\beta = .127, \ p \geq .01$). Thus the strongest predictor of self-compassion is the fathers’ responsiveness, which can be explained by the unstandardized coefficient (B). This indicates that for every unit of increase in the fathers’ responsiveness, self-compassion increases by .133 units. This is followed by gender, which, if one is female, self-compassion decreases by -.262 units.
Table 4.12

*Multiple Regression Table*

<table>
<thead>
<tr>
<th>Model</th>
<th>R²</th>
<th>β</th>
<th>B</th>
<th>SE</th>
<th>CI 99% (B)</th>
<th>Lower Bound</th>
<th>Upper Bound</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.115</td>
<td>-.198*</td>
<td>-.262</td>
<td>.095</td>
<td>-.449</td>
<td>-.075</td>
<td></td>
</tr>
<tr>
<td>MResp</td>
<td>.127</td>
<td>.102</td>
<td>.061</td>
<td>.018</td>
<td>.223</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FResp</td>
<td>.199*</td>
<td>.133</td>
<td>.051</td>
<td>.032</td>
<td>.234</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* *p* ≤ .01

R² = variance explained by independent variables; β = standardised coefficients; B = unstandardized coefficients; CI = confidence interval; MResp = Mothers’ responsiveness; FResp = Fathers’ responsiveness

4.4 Summary of the Results

This chapter presented the findings of the study. Preliminary analyses were conducted in order to examine the characteristics of the data. Reliability indices were calculated for the SCS and PSI-II respectively and descriptive statistics were performed. Preliminary analyses therefore addressed the first two aims of the study. Item 7 from the PSI-II, was omitted in the analyses as it was found not to be reliable and thereafter both the SCS and PSI-II demonstrated adequate internal consistency.

Means scores revealed an overall self-compassion score of *M* = 2.99; *SD* = .67, and the authoritative parenting style was the most prominently perceived parenting style among adolescents.

Inferential analyses were performed to answer the remaining research aims, which were aimed specifically at examining gender differences in self-compassion and parenting styles, correlation among variables and variance in self-compassion scores. Statistically significant differences in mean scores were found between males and females for self-compassion in
total, with males scoring higher self-compassion scores than those of females. Females scored higher on the negatively-worded items of the SCS, i.e. the components of self-judgment, isolation and over-identification. However, no significant gender differences were found for the positively-worded items of self-kindness, common humanity and mindfulness.

The findings revealed no statistically significant gender differences in perceptions of mothers’ responsiveness, fathers’ responsiveness and fathers’ demandingness. However, females reported their mothers to be higher on demandingness than males did. Significant differences were found in the mean scores for responsiveness of mothers and fathers respectively. Conversely, no significant differences were found between mothers’ and fathers’ demandingness.

Correlational analyses were performed between self-compassion and the independent variables, of mothers’ and fathers’ responsiveness, mothers’ and fathers’ demandingness, as well as gender, which was included as a control variable. All the variables demonstrated a statistically significant relationship with self-compassion, with the exception of the demandingness dimension for both mothers and fathers. Mean scores were further examined in order to determine the relationships between the specific components of self-compassion and the four parenting styles. Overall authoritative parenting appeared to have the strongest relationship with self-compassion, followed by permissive parenting. Both authoritative and permissive parenting are characterised by high responsiveness and warmth. Uninvolved parenting had the least association with self-compassion.

The multiple regression analysis revealed that 11.5% of the variance in self-compassion experienced by adolescents could be explained by the respondent’s gender, as well the responsiveness of the mother and father respectively. An ANOVA indicated that while all three variables (gender, responsiveness of mother and father) were jointly significant in
predicting self-compassion, the best predictor of higher self-compassion was the father’s responsiveness followed by gender, which, if one is female, self-compassion was lower.

The following chapter will present a discussion of these results. Possible explanations and interpretations within the context of existing literature will be proposed.
CHAPTER 5 – DISCUSSION OF RESULTS

5.1 Introduction

The researcher in this study was interested in what contributes to individual differences in the development of self-compassion. Self-compassion was operationalised using Neff’s (2003a) framework comprising the components of self-compassion, that is, self-kindness, common humanity and mindfulness, and measured by the Self-Compassion Scale (Neff, 2003a). The main aim of this study was to examine parenting style as a possible predictor of self-compassion among a group of adolescents.

Parenting style was operationalised along the two dimensions of responsiveness and demandingness, which, when combined were comprised of four parenting styles. These were authoritative, authoritarian, permissive and indulgent. Parenting style was examined according to the adolescents’ perceptions of their parents’ parenting style. The researcher deemed this to be important, as she postulated that the adolescents’ perceptions informed the reality of their experience regardless of the parenting style the parents believed they employed. In fact, studies show that there is often a low level of agreement between parents and children on parenting styles; further, adolescents’ perceptions of parenting style is a better predictor of outcomes than parents’ perceptions of their own behaviour (Tein, Roosa, & Michaels, 1994; Spera, 2006; Steinberg, et al., 1992). The Parenting Style Inventory-II (Darling & Toyokawa, 1997) was therefore used, as it measures adolescents’ perceptions of their parents’ parenting style independently of the parents’ reports on their own parenting style. The PSI-II also measures the dimensions of responsiveness and demandingness separately.

The study was conducted among a group of adolescents as this unique developmental phase concerns the formation of an identity separate from that of one’s parents; the ability to be
self-compassionate versus self-critical or harsh and judging of oneself would therefore possibly be constructed during this time.

This chapter reviews the findings of the study pertaining to the specific aims which will be outlined. The findings will be interpreted and postulated within the context of existing literature. The limitations of the study will be discussed and recommendations for future research studies will be proposed. Thereafter, the implications of the study will be discussed. Finally, concluding comments on the study will be noted.

5.2 Discussion of Results related to Aims of the Study

5.2.1 Levels of Self-Compassion among a group of Adolescents

The first aim of the study was to simply determine the levels of self-compassion among a group of adolescents. The overall self-compassion score was a mean of \( M = 2.99; \ SD = .67 \).

The participants ranged in age from 13-16 years with a mean age of \( M_{\text{age}} = 14.4 \) years.

This finding is in line with other adolescent studies of subjects of similar ages (13-16). For example, Bluth and Blanton (2013) reported a mean score of \( M = 2.98; \ SD = .54 \) for a group of 14-18 year-old adolescents. Similarly, Neff and McGehee (2010) found a mean self-compassion score of \( M = 2.97; \ SD = .62 \) for a group of adolescents of \( M_{\text{age}} = 15.2 \) years (Bluth & Blanton, 2013; Neff & McGehee, 2010). Edwards et al. (2014), however, found slightly lower levels of self-compassion scores than found in these other studies (\( M = 2.75; \ SD = .45 \)) within a similarly-aged group of adolescents prior to a mindfulness intervention. However, the post intervention scores were more similar (\( M = 3.01; \ SD = .38 \)). They suggested this could possibly be explained by the characteristics of the schools sampled (low income areas and high levels of parental unemployment). But some studies have also reported lower levels of self-compassion scores from adolescents purportedly from higher income and professional...
families (Bluth, Gaylord et al., 2015; Galla, 2016). These differences in findings perhaps indicate that variables other than environmental factors, could also play a role in the development of self-compassion in adolescents.

The results from this study were akin to scores from the participants in other similar studies on self-compassion among adolescents with comparable demographic backgrounds, but further research is required into the contextual factors which may contribute to the development of self-compassion within adolescents.

The first aim of the study was thus achieved.

5.2.2 Prevalence of the four Parenting Styles: Authoritarian, Authoritative, Permissive and Uninvolved among a group of Adolescents.

The second aim of this study was to determine the prevalence of the four parenting styles for mothers and fathers among a group of adolescents. As was expected, the adolescents rated both mothers and fathers predominantly as authoritative (Mothers = 64.9%, Fathers = 59%), indicating that they perceived their parents to be warm, supportive and responsive to them as well as providing adequate structure and discipline. For fathers, this was followed by those who were perceived as being authoritarian (12.8%), then permissive (9%) and lastly a small number of respondents rated their fathers as uninvolved (3.2%). Perceptions of mothers differed slightly, in that the authoritative style was followed by those who perceived their mothers as permissive (10.2%), then authoritarian (8%) and finally a very small number perceived their mothers as being uninvolved (1.1%).

It would seem that these adolescents mostly perceive their parents as both warm and firm, with some considering their fathers as being more disciplinary than their mothers, and their mothers as more sensitive and warm than their fathers. Very few felt their parents were
lacking in both warmth and discipline. This finding is similar to those in other studies, for example, Nijhof and Engels (2007) and Bronte–Tinkew et al. (2006) respectively found that most of the students in their studies reported having authoritative parents, followed by permissive, authoritarian and uninvolved. The predominance of authoritative parenting is relatively typical of other studies carried out among mostly White, English-speaking families (the majority of the participants in this study were White and English-speaking). Authoritarian parenting appears to be more common among other ethnic groups (Kopko, 2007; Steinberg et al., 1992). In a study that differed surprisingly from the typical parenting style clusters as reported in this study, Wolfradt et al. (2003) found among high school students that while the authoritative style was prevalent (32.2%) this was followed by the uninvolved style (referred to in their study as indifferent) (30.2%). It is unclear why the prevalence of uninvolved parenting was so high in their study (Wolfradt et al., 2003).

Differences in findings may be related to methodological limitations in studies on parenting styles, i.e. how parenting style is defined and therefore measured (Barber et al., 2005; Skinner et al., 2005); inconsistencies may therefore occur in the literature. Many parenting style studies do not refer to the four parenting styles specifically, but instead refer to other parenting constructs, for example ‘parental involvement’ or ‘parental behaviour’.

The second aim of the study was thus achieved.

5.2.3 Gender Differences in Self-Compassion

The third aim of the study was to determine whether there were gender differences in levels of self-compassion. There were significant gender differences in total self-compassion scores. Males reported higher levels of self-compassion ($M = 3.12; SD = .58$) than females ($M = 2.88; SD = .72$). Regarding the different components of self-compassion, females exhibited significantly higher scores on all three of the negatively-worded dimensions of self-
compassion than those of males. Thus they were more critical and judgemental of themselves ($M = 3.06, SD = .98$). Females reported feeling more isolated from others ($M = 3.09, SD = 1.00$) and tended to over-identify with their negative emotions ($M = 3.04, SD = .93$). No statistically significant differences were found between genders for the positively worded dimensions of self-kindness, common humanity and mindfulness.

First, it appears evident in the literature that there are significant gender differences in self-compassion among adult samples (Neff, 2003a, Neff et al., 2005; Neff & Vonk, 2009; Yarnell et al., 2015). The meta-analysis by Yarnell et al. (2015) provides evidence that females report lower self-compassion than males do. However, among adolescent and young adult samples, some studies found no gender differences among Turkish (Iskender, 2009), Thai and Taiwanese students (Neff, et al., 2008) and a group of US students (Neff et al., 2007). What is noteworthy is the specific age of the participants and gender differences found in various adolescent studies. Neff and McGehee (2010) found no gender differences in self-compassion among 15 year-old adolescents but in a comparison group of 21 year-old young adults, they found significant differences. This differs from the findings in the current study. However, the current study corresponds with that of Bluth and Blanton (2014), who reported significant gender differences in the 14-18 years age group, and no gender differences in the 11-14 age group. Similarly, Bluth, Roberson, Gaylord, Faurot et al., (2015) found that males reported higher levels of self-compassion than females did in the 13-18 years age group.

A possible explanation as to the variations in gender difference findings among adolescent studies is that the term ‘adolescence’ has been delineated across a fairly widespread age span. Some theorists propose adolescence may start as young as age 10 and others propose that adolescence ends as late as 30 years old, depending on whether one adopts physical, cultural or social markers to define this period (Cohen et al., 2016; Graham, 2004; Steinberg, 2015).
However what remains clear is this period is marked by rapid transition and significant change. It therefore seems evident that gender differences in self-compassion begin to occur during adolescence, yet the exact age at which this may occur remains unclear.

Second, regarding the components of self-compassion and gender differences, the finding in this study is congruent with other studies investigating gender differences among the components of self-compassion (Bluth & Blanton, 2014; Neff 2003a). Compared with males in the current study, females were found to be more self-judging, reported feeling more isolated and found it more difficult to maintain a balanced view of challenges and thus they over-identified with negative emotions. Further, this study found these gender differences pertaining to the components of self-compassion within this specific age group similar to findings by Bluth and Blanton (2014) who also found gender differences within these negatively worded components in their older adolescent age group (14-18 years) but not within the younger adolescent age group (11-14 years).

This finding of females with higher scores on the negatively-worded items could be interpreted within the context of research on the development of depression in adolescence. Research suggests that depression during adolescence is more pronounced in females than in males, and, further, these differences begin to develop from the age of 13 and show the greatest difference between ages 15-18 (Hankin et al., 1998). This finding then could also possibly be elucidated in view of Muris and Petrocchi’s (2016) critique of the Self-Compassion Scale (Neff, 2003a), whereby they propose the scale displays greater predictive power into psychopathology and therefore the positively and negatively-worded items do not equally display an inverse relationship with one another (Muris & Petrocchi, 2016). It appears that there may be a relationship between gender, the development of depression and the components of self-compassion during adolescence which could be investigated further.
Thus the third aim of the study was achieved.

5.2.4  Gender Differences in adolescents’ perception of Parenting Style

The fourth aim of this study was to determine whether there were gender differences in adolescents’ perceptions of parenting styles. The majority of both males and females did not differ in their perception of having authoritative parents, which means most of them felt their parents were both warm and demanding. Each dimension of parenting style (i.e. responsiveness and demandingness for both mother and father) was further examined separately in order to ascertain whether there were gender differences along each dimension. The results indicated no differences in perceptions between males and females on the dimensions of mothers’ responsiveness, fathers’ responsiveness and fathers’ demandingness. However an interesting finding was that female respondents found their mothers to be more demanding than males did. The demandingness dimension is concerned with expectations of the child’s behaviour, monitoring of behaviour, structure and discipline. It appears that females perceive their mothers to be more restrictive and monitoring of their behaviours; perhaps having higher expectations of them and being stricter than what the males perceive their mothers to be. Shek (1998) reported similar findings in a Chinese sample of adolescents, where daughters perceived their mothers as more demanding than sons did. This may be explained by what Maccoby and Jacklin (1974) refer to as ‘cross-sex indulgent’ and ‘same-sex severity rule’; whereby parents are more demanding with their same sex children and more indulgent to their opposite sex children. Further, Maccoby and Jacklin (1974) propose that this rule applies more to fathers than to mothers, although this is not the case in the current study (Shek, 1998).

This finding may also be related to specific domains, for example academic achievement, peer relationships or sports. For instance, in relation to school performance, Dornbusch et al.
(1987) found that boys rated both their parents as more authoritarian than girls did and similarly, Alsheikh et al. (2010) found that girls perceived both their parents to be more responsive than boys did. When measuring self-worth and procrastination behaviours in adolescents, Pychyl, Coplan and Reid (2002) found that girls rated their parents as more authoritative than boys did. However, concerning the internalisation of moral values, Hardy, Padilla-Walker and Gustavo (2008) found no gender differences in adolescents’ perceptions of their parents’ parenting styles.

Kausar and Shafique (2008) suggested that gender differences in adolescents’ perception of parenting style may be explained by the psychodynamic perspective whereby they posit that boys are closer to their mothers than girls are, and girls are closer to their fathers than boys are. Therefore each gender views the opposite sex parent more favourably, which is similar to what Maccoby and Jacklin (1974) proposed. This may be feasible in this study, i.e. that mothers apply the ‘same-sex severity rule’ with their daughters and therefore daughters rated their mothers as more demanding (Kausar & Shafique, 2008; Maccoby & Jacklin, 1974).

However, Bastaits et al. (2015) offers a somewhat different view. They propose that parents have more in common with and identify better with same sex children, which would mean therefore that mothers would be less demanding of daughters. The finding in this study does not support this view, however. The researcher concurs with McKinney and Renk (2008), who suggest that parents employ different parenting strategies when parenting sons or daughters, which would explain the differing perceptions by the adolescents. It may be related to specific domains which may be particularly relevant to mothers and daughters (for example, dating), within which this occurs. However, why this occurred only for the females’ ratings of their mothers is unclear. Therefore, gender difference regarding perceptions of parenting styles is a finding which could be explored further.
The fourth aim of the study was thus achieved.

### 5.2.5 Differences in Mothers’ and Fathers’ Parenting Styles

The fifth aim of this study was to determine whether mothers and fathers differed in their parenting styles. This was determined by examining the responsiveness and demandingness dimensions separately. Both mothers and fathers were found to be equally strict, restrictive and disciplining of their children, therefore there were no differences between mothers and fathers within the demandingness dimension. However, mothers and fathers differed in their responsiveness towards their children. Overall, the adolescents in this study perceived their mothers to be warmer, more supportive and accepting than their fathers. Most existing studies suggest that mothers and fathers differ in their parenting style (Bastaits, et al., 2015; McKinney & Renk, 2008; McKinney et al., 2008; Milevsky et al., 2006; Paulson & Sputa, 1996; Simmons & Conger, 2007). It is rare that both parents employ the same parenting style, but Hardy et al. (2008) found no differences between mothers and fathers on all the parenting style dimensions measured, including, responsiveness, demandingness and autonomy-granting. Bastaits et al. (2015) propose that for divorced parents specifically, mothers and fathers tend to adopt opposing parenting styles, suggesting a compensatory mechanism. McKinney & Renk (2008) suggest that different combinations of maternal and paternal parenting style, with at least one parent being authoritative, is veritably better for adolescents and leads to positive emotional adjustment, although Simmons and Conger (2007) propose that having two authoritative parents is related to the most positive outcomes for adolescents (Bastaits et al., 2015; McKinney & Renk, 2008, Simmons & Conger, 2007). Milevsky et al. (2007) found that the combination of an authoritative mother and permissive father was evident for wellbeing among adolescents, indicating that a permissive father may not be as detrimental to the child as a permissive mother. As far as the development of self-compassion is concerned, it is unclear which combination is most optimal for adolescents. However, it is
interesting to note that both the authoritative and the permissive parenting style contains high levels of the ‘responsiveness’ dimension within the parenting style model, which as will be discussed below, has implications for the development of self-compassion. This will be discussed further in section 5.2.6.1.

The fifth aim of the study was thus achieved.

5.2.6 The relationship between Parenting Style and Self-Compassion

The sixth aim of the study was to determine the relationship between self-compassion and parenting style. The dimensions of responsiveness and demandingness were examined separately and correlated with self-compassion; thereafter, the relationship between self-compassion and the four parenting styles was examined.

5.2.6.1 Self-compassion correlations with dimensions of parental responsiveness and demandingness

The parenting style dimensions of responsiveness and demandingness were tested for correlation with self-compassion. The demandingness dimension for both parents was not significantly related to self-compassion (Mothers’ Demandingness $r = .02$; Fathers’ Demandingness $r = .07$ $p \geq 0.01$), demonstrating that discipline, structure, restrictiveness or any kind of rule setting and supervision is not related to self-compassion. However, the responsiveness dimension for both parents demonstrated a significant relationship to self-compassion (Mothers’ Responsiveness $r = .18$; Fathers’ Responsiveness $r = .26$ $p \leq 0.01$). Thus it is evident that the development of self-compassion in adolescence is related to being raised by parents who exhibit a parenting style high in responsiveness, warmth, nurturing and support. Several studies reported similar findings, i.e. that parental warmth and responsiveness was associated with self-compassion (Irons et al., 2006; Kelly & Dupasquier,
Parental warmth and responsiveness have also been found to be associated with other positive outcomes which may be related to self-compassion in adolescents, for example, active coping, social safeness, the development of life skills and empathy (Kawabata et al., 2011; Kelly & Dupasquier, 2016; Nijof & Engels, 2007; Slicker et al., 2005; Wolfradt et al., 2003). Self-compassion is a skill which entails being kind, nurturing and accepting to oneself. It could be considered a form of emotion regulation; a way of relating to oneself empathetically and activating the internal soothing and safety system (Gilbert, 2009a; Neff, 2003a). Therefore being self-compassionate is an internalizing behaviour which could be acquired based on the interactions from one’s parents when they are perceived as warm, accepting and nurturing.

5.2.6.2 Relationships between the Components of Self-Compassion and the Four Parenting Styles

Tentative relationships between the components of self-compassion and parenting style were observed by examining mean scores comparisons.

An authoritative parenting style, followed by a permissive parenting style by both mothers and fathers was found to have the strongest relationship with self-compassion. This finding concurs with other studies, as well as the pertinent theory, as to the positive outcomes associated with authoritative parenting (Baumrind, 1966, 1975; Darling, 1999; Darling & Steinberg, 1993; Hancock Hoskins, 2014; Kopko, 2007). Baumrind (1966, 1975) was particularly critical of the permissive parenting style, which she proposed led to increased aggression, aimlessness and irresponsibility in boys and resulted in girls being passive and
An assessment of the literature does provide evidence as to the deleterious effects of permissive parenting (Hancock Hoskins, 2014; Spera, 2005); however, certain research has found some positive outcomes associated with permissive parenting. For example, some adolescents who experience lower stress and higher life satisfaction (Coccia et al., 2012) and adaptive coping strategies and problem solving skills (Nijhof & Engels, 2006; Wolfradt et al., 2003). The finding on the positive relationship between authoritative and permissive parenting styles to self-compassion supports the finding on the relationship between parental warmth and self-compassion as both the authoritative and permissive parenting styles are characterised by high levels of parental responsiveness. Not surprisingly, uninvolved parenting, characterised by low responsiveness and demandingness, demonstrated the least association with self-compassion.

The components of self-compassion, that is, self-kindness as opposed to self-judgment, common humanity rather than isolation, and mindfulness rather than over-identification were examined separately to ascertain their unique relationship to each parenting style. Carrying out comparative tests was impossible owing to the differences in group sizes, so mean scores were examined to explore the relationships between the components of self-compassion and parenting style. While these were observed relationships rather than statistical relationships, the tentative conclusions drawn by the researcher nonetheless proved to be interesting. The most noteworthy observations will be discussed.

Adolescents who reported high levels of self-kindness, common humanity and mindfulness unsurprisingly had authoritative and permissive parents, both styles characteristic of high responsiveness and warmth. Those adolescents who were highly self-judging had authoritarian mothers and uninvolved fathers. Both the authoritarian and uninvolved parenting style is characterised by low responsiveness. Therefore, again, it is unsurprising that these adolescents were more critical and judgmental of themselves, as perhaps they had
internalised this rejection and lack of warmth. Those who felt more isolated reported having uninvolved parents. Perhaps feeling disconnected from one’s parents could exacerbate feelings of loneliness and isolation. In addition, feelings of isolation appeared to be particularly more evident for those adolescents with uninvolved fathers ($M = 4.21; SD .37$). Finally, adolescents who over-identified with difficult emotions and were unable to maintain a balanced view of their emotions and challenging situations were also more likely to have uninvolved parents, particularly an uninvolved father.

Few studies have examined the relationship of the components of self-compassion separately to other constructs. Two correlational studies found the negatively-worded components of self-judgment, isolation and over-identification all significantly correlated with depression (Mills et al., 2007; Ying, 2009). The components of self-judgment and isolation have been found to be predictive of depression, and, while over-identification with emotions does not appear to be predictive of depressive symptomology, it is related to depression (Hall et al., 2013; van Dam et al., 2011). Literature and theory support the link between self-criticism and depression (Beck, 1963; Gilbert et al., 2006; Gilbert & Irons, 2009). Although depression was not measured in this study, it appears that adolescents who experience their parents as uninvolved and authoritarian, the two parenting styles which are low in responsiveness, are likely to feel more isolated and lonely as well as to be more judgemental and critical of themselves; which may make them at risk of developing depression. Parental criticism, as well as childhood neglect and abuse, have been associated with lower self-compassion (Potter et al., 2014; Tanaka et al., 2011). Furthermore, literature supports the view that uninvolved and authoritarian parenting is associated with both internalising and externalising problems in adolescents (Kawabata et al., 2011; Kelly & Dupasquier, 2016; Nijof & Engels, 2007). It seems plausible that without a home environment of warmth and nurturance, adolescents feel more disconnected from others and are unable to give themselves the compassion and
kindness they need; this may be as a result of not receiving this care and compassion from their parents.

The sixth aim of the study was thus achieved.

5.2.7 Parenting Style as a predictor of Self-Compassion

The seventh aim of this study was to determine how much variance in self-compassion could be explained by parenting style. The eighth aim, which broadened the seventh aim, was to determine the degree to which mothers’ and fathers’ parenting style respectively predicted self-compassion. As the demandingness dimension of the parenting style typology revealed no statistical relationship with self-compassion, only the responsiveness dimension was assessed as a predictor. Gender was included as a control variable, as the results revealed that all three variables: mothers’ responsiveness, fathers’ responsiveness and gender (being female) were significant predictors of self-compassion, and accounted for 11.5% of the variance in self-compassion experienced by adolescents. Interestingly, the fathers’ responsiveness was found to be the strongest predictor of self-compassion among adolescents.

Firstly, when considering what may contribute to, and predict self-compassion, several other studies have found that the nature of early caregiving relationships may be related to the development of self-compassion (Neff, 2003a; Neff & McGehee, 2010; Pepping et al., 2015). For example, individuals who display insecure attachment are more likely to be self-critical, harsh and unkind to themselves, be unable to self-soothe in difficult situations and feel overwhelmed by negative emotions. These are individuals who experience their parents as rejecting, overprotective and critical and are thus more likely to be unable to experience self-compassion. Conversely, those individuals with a secure attachment style have been found to be more self-compassionate and self-reassuring (Gilbert, et al., 2006; Neff & McGehee,
The different dimensions of attachment are beyond the scope of this study. However, it would seem that those individuals who have been raised in an environment in which they can trust their parents to respond to them in a warm, accepting and nurturing way are able to be more self-compassionate. It appears that in accordance with Bowlby’s (1973, 1977, 1980) attachment theory, adolescents internalise their experiences with early caregiving to form a model of relating to themselves and others (Bartholomew & Horowitz, 1991; Karavasilis, Doyle, & Markiewicz, 2003). Neff and McGehee (2010) propose that self-compassion is an internal reflection of the parent-child relationship. Similarly, Gilbert et al. (2006) propose that experiences of early parenting become schemas that are a source of self-relating and Pepping et al. (2015) suggest that the critical parent becomes the internal critical voice of the child. Therefore the adolescent creates a model of self-relating that internalises a critical, rejecting and insensitive parent which results in the adolescent being more self-critical and less self-compassionate. In concurrence with this, studies have found that maternal criticism is associated with low self-compassion (Kelly & Dupasquier, 2016; Neff & McGehee, 2010).

Secondly, this study found that the father’s responsiveness was a stronger predictor of self-compassion than the mother’s responsiveness and gender. What would contribute to this unique finding? Most studies consolidate reports of mothers’ and fathers’ parenting styles under one parenting style variable. However, several studies have addressed this limitation, by measuring fathers’ influence on child outcomes separately to mothers’, demonstrating that fathers play a different role in child outcomes from the mothers. The stereotypical role of a father being a patriarchal breadwinner has changed dramatically in recent years (Lamb & Tamis-Lemonda, 2004; Parke & Buriel, 2008). It is now well recognised that fathers make a significant and unique contribution to the development of their children (Parke, 2004). Parke and Buriel (2008) suggest that a father’s role is one of fostering a sense of identity and
encouragement of autonomy within the child. While the father’s involvement is typically quantitatively less than the mother’s, their qualitative contribution is an important predictor in child development (Parke & Buriel, 2008; Pychyl et al., 2002). A father can be described as involved when his relationship with his child can be described as warm, supportive, close, affectionate and accepting (Allen & Daly, 2002).

For example, Gryczkowski et al. (2010) found higher levels of fathers’ involvement but not mothers’ involvement were related to lower levels of child externalizing behaviours. Similarly, Bronte-Tinkew et al. (2006) found that a positive father-child relationship reduced the risk of delinquent behaviour and substance use by adolescents. Children of involved fathers also display more cognitive competence and academic achievement, as well as being more self-accepting and employing an internal locus of control. Furthermore, the capacity for empathy in adolescents is strongly predicted by high levels of paternal involvement (Allen & Daly, 2002). The role of fathers in adolescent and child development requires further attention. However, it appears evident that the ability to develop an internal model of self-compassion, by being kind and accepting towards oneself, the ability to view failure and inadequacy within the self as part of the shared human experience as well the ability to not over-identify with and be overwhelmed by negative emotions may be related to the perception of one’s relationship with one’s father. It should also be considered that a lack of father involvement or a father who is perceived as being authoritarian could also be predictive of lower self-compassion within an adolescent. Therefore, the father’s responsiveness has the potential to both increase as well as decrease self-compassion within the adolescent.

The seventh and eighth aims of the study were thus achieved.
The main findings of the study were interpreted and discussed within the context of existing literature on self-compassion and parenting styles. The limitations to the study will now be discussed.

5.3 Limitations of the Study

Several limitations of this study should be considered. First, the researcher was unable to determine correlations between the four parenting styles and self-compassion owing to unequal group distribution. Thus the conclusions drawn regarding the relationships between the four parenting styles and self-compassion were tentative and were based on the researcher’s observations only.

Self-report measures were employed in this study, which can have some disadvantages. Questions can be misunderstood, so reducing the reliability of the scale; set responses force the participant to answer based on what is available, which does not capture the full range of possible thoughts, opinions and attitudes to the question; and the respondents may show a social desirability bias. The researcher attempted to mitigate these limitations by being present during the data collection to answer questions and explain anything that was unclear to the participants. In addition the survey was anonymous and confidential. Self-report measures were chosen above other possible information sources to investigate the adolescents’ perceptions, which were considered the most reliable indicators of the constructs being measured.

The measures chosen have not been validated for use in the South African context and therefore results should be interpreted as such.

The sample is this study could be considered fairly homogeneous, as only one school in one geographical location (Johannesburg, Gauteng) was employed and consequently the
demographics of the participants was probably very similar and thus not necessarily reflective of the demographics of the country. Care should therefore be taken when generalising these results to other dissimilar populations. Further, the school was chosen by means of convenience sampling. However, the participants were chosen based on their age, to ensure homogeneity in age to best accomplish the study outcomes.

Several limitations regarding empirical evidence on parenting style needs to be explained. First, in terms of measurement, most studies utilise parents’ reports of their own parenting styles, while some employ reports from children based on their perceptions of their parents’ parenting style. However, there is often a low level of agreement between parents and children on parenting style measures. Parents tend to rate themselves more favourably on all the dimensions of parenting than their children (Tein et al., 1994; Spera, 2006; Steinberg et al., 1992). Therefore, when assessing the literature, there should be caution when reviewing the literature, considering whether parenting style has been measured according to the child’s perception or the parent’s as this can have implications for the outcomes. Second, parenting style in the literature has been operationalised along several themes or dimensions (for example: involvement, acceptance, warmth, coercion, control) and therefore parenting style is not always examined specifically according to the four parenting style typologies proposed by Baumrind (1966, 1967, 1991) and Maccoby and Martin (1983). These two limitations engendered challenges for the researcher when like-for-like comparisons became necessary in the assessment of parenting style outcomes in adolescence. Regarding the current study, adolescents’ perceptions were measured to ensure more reliable data. In addition the dimensions of responsiveness and demandingness were measured separately to examine the unique contribution of each dimension to the parenting style taxonomy. The reduction of parenting style in this manner was to ensure that no bias or ambiguity existed in the current study.
This study yielded a predominant rating by adolescents of authoritative parenting, which was not unexpected given the demographic profile of the participants. However, it should be noted that in order to maintain ethical principles, information related to the study was provided upfront to the participants and their parents and participation in the study was entirely voluntary. It therefore remains unclear as to whether those learners who chose not to participate may have perceived their parents to be from the other groupings. Thus examining the relationship between particularly the uninvolved and authoritarian parenting styles and self-compassion was limited. Furthermore, the nature of the participants’ family compositions i.e., single parent, divorced families was not included in the biographical data as the emphasis of the study focused on the adolescents’ perception of their parents’ parenting style regardless of the composition of the family structure.

Another possible limitation is that no characteristics other than the gender and age of the adolescents were measured, so no other confounding variables relating to the child could be controlled for. Further, it has been found that the characteristics of the child may predict a parents’ parenting style (Bastaits, 2015; Kopko, 2007) but two-way effects were not examined in this study. It could also be considered that adolescents who are more self-compassionate have more positive interactions with their parents and may therefore perceive their parents more favourably. Another consideration is that adolescents may model their parents’ own self-compassion which could explain adolescent self-compassion. Parent’s own self-compassion was not measured in this study and therefore could not be controlled for.

This study was cross-sectional in nature and data was only collected at one time. Thus no specific causality can be concluded. Given the variability across adolescence and moreover that it appears that gender differences in self-compassion begin to occur during this time, a cross sectional study limits further exploration of this development. Further, a quantitative study impedes understanding of the processes related to the complexity of adolescence and
the development of self-compassion. Thus qualitative data would provide useful information to complement the statistical findings in this study.

In order to address some of the limitations delineated here, recommendations for future research will be examined below.

5.4 Recommendations for Future Research

The researcher acknowledges that, while perceptions of parenting during adolescence are an important factor in the development of self-compassion, experiences of parenting during adolescence are not the only factors relating to self-compassion. The model in this study found that gender and parenting style, specifically responsiveness, accounted for 11.5% of the variance in self-compassion. Therefore a variety of factors may predict differences in self-compassion. The relationship between early caregiving relationships and self-compassion particularly in the context of the rapid transition during adolescence is complex. Therefore future research should investigate various other processes which may predict self-compassion during adolescence.

Longitudinal research over the course of adolescence and young adulthood may provide further explanations of the dynamic nature of adolescence and how it may relate to self-compassion over time. Of particular relevance may be the gender differences in self-compassion that occur during adolescence. In addition, changes in parenting style may occur during adolescence and, this too, has implications for the development of self-compassion among adolescents. Therefore longitudinal research in this regard would be able to evaluate the changes that occur both in both parents’ parenting style and adolescents during this period and the consequent influences on the development of self-compassion.
In order to better understand the mechanisms related to fathers’ responsiveness being a stronger predictor of self-compassion than mothers’ responsiveness; qualitative data, in the form of adolescent interviews or observations may provide useful explanations in this regard. In addition, other measures of parenting may be employed to extrapolate these findings further. It was not clear from the data whether those adolescents who chose not to participate in the study or those who omitted either the mother or the father scale were from single-parent homes. Research into the development of self-compassion relating to having an absent parent may provide interesting insight into pathways of individual differences in self-compassion.

Future studies could also include more diverse populations in order to ascertain the generalizability of these results to other populations from differing socio-economic backgrounds, particularly in the South African context.

Lastly, research could be conducted to evaluate intervention and training programmes aimed at adolescents and their parents to increase self-compassion.

5.5 Implications of the Study

Based on the results found in this study, the following implications are put forward. Self-compassion may help adolescents relate to themselves in a kinder way. Therefore teaching self-compassion to adolescents may assist those experiencing difficulties in their home environments. As self-compassion can be developed and enhanced, programmes teaching adolescents self-compassion could be introduced into schools.

The importance of warm, supportive and responsive parenting has been demonstrated in this study and parents may benefit from psycho-education programmes highlighting the protective and positive outcomes relating to warm and responsive parenting. Further, parents may also
benefit from self-compassion education, as studies show that parents who are self-compassionate are less stressed and display authoritative parenting over other parenting styles (Gouveia, Carona, Canavarro, & Moreira, 2016).

Furthermore, the value of the father’s role in the development of self-compassion in the adolescent has been highlighted. Therefore, programmes could be explored in order to strengthen the father-child relationship. These programmes could include shared activities, for example, camping, sporting activities, cooking or board games, as well as psycho-education, where opportunities to build the relationship between father and child are facilitated. These programmes could be implemented through schools or other organisations (for example, churches). The importance here is not the specific activity, but rather creating an environment of connection based on warmth and acceptance of the child.

5.6 Conclusion

The researcher was interested in what contributes to individual differences in self-compassion. Factors such as age, gender, culture and personality traits have all been found to contribute to individual differences in self-compassion. Early caregiving relationships have also been found to be related to the development of individual differences in self-compassion. The researcher was specifically interested in the nature of early care-giving relationships and how these relationships may contribute to the development of self-compassion. Parenting style was examined in this regard, by combining the dimensions of responsiveness and demandingness to form a parenting style typology. Consequently, the four parenting styles examined were: authoritative, authoritarian, permissive and uninvolved. Further the researcher was interested in a cross sectional study in a group of adolescents in order to measure current perceptions of adolescents’ experiences of their parents interactions with them. This was done to avoid any potential biases associated with retrospective reports. Thus
the broad aim of the study was to examine the relationship between self-compassion and parenting styles. Moreover, the study was to determine whether parenting style could be a predictor of self-compassion among a group of adolescents.

A group of adolescents were chosen for the study as adolescence is a period marked by significant transformation and pronounced physical, emotional and psychosocial change. According to Erikson’s (1977) psychosocial theory, the developmental task during this time is that of developing an identity separate to one’s parents. Therefore the parent-child relationship is expected to encounter substantial changes during this time. As adolescents navigate these changes within themselves and their relationships, they are at risk of becoming self-critical. If the parent-child relationship is characterised by rejection, criticism and a lack of emotional support and care, the adolescent is likely to feel isolated, to internalise negative judgments about themselves, become self-critical and feel easily overwhelmed by negative emotions. Thus they will lack all the components of self-compassion; self-kindness, common humanity and mindfulness. Moreover there is a considerable risk that under these conditions, namely, parental rejection, self-criticism, isolation and negative social comparisons, the adolescent will develop depression. This is supported by both theory and research in this regard (Beck, 1963; Gilbert & Irons, 2009; Gilbert & Proctor, 2006; Neff & McGehee, 2010; Potter et al., 2014).

This study contributes to and augments previous research on self-compassion, particularly in adolescent samples. It confirms the relevance of early care-giving relationships in the development of individual differences in self-compassion. It also confirms Neff’s (2003a) claim that the Self-Compassion scale is reliable for research purposes with adolescents (Neff & McGehee, 2010). The levels of self-compassion within this group of adolescents, as well as gender differences, were similar to other studies of adolescents within the same age range.
Unsurprisingly, the majority of adolescents perceived their parents to be predominantly authoritative. With regards to the dimensions of responsiveness and demandingness, overall, mothers were perceived to be warmer and more responsive than fathers, and there were no differences reported within mothers’ and fathers’ demandingness dimension. The responsiveness dimension for both parents was found to be related to self-compassion, while demandingness for both parents was not related to self-compassion. Finally, mothers’ and fathers’ responsiveness, as well as being female, all predicted self-compassion, with fathers’ responsiveness being the strongest predictor of self-compassion among this group of adolescents.

The current study found that the nature of parenting experienced during adolescence is important in the development of self-compassion which may serve as a protective factor during this period of transition and change. It is worth noting that while adolescents’ are seeking to separate from their parents during this time, feeling the need to gain independence from them and establish an identity that espouses their own values and ideals, the role of the parent nonetheless remains important during adolescent development. A surprising finding was that the father’s responsiveness was the strongest predictor of self-compassion, thus indicating the unique contribution the father makes to the development of self-compassion during adolescence. In particular, the role of the father in adolescent development has changed significantly during the past few decades, and the stereotypical patriarch who is distant from his children and uninvolved with their emotional development, no longer holds true. As the current study reveals, fathers have a significant role to play in their children’s lives, particularly in relation to the development of self-compassion. The researcher acknowledges that the relationship between perceived parenting experienced by adolescents and the development of self-compassion is complex, and other factors may predict self-compassion; nonetheless, the findings in this study are significant enough to lend support to
emerging research in the relationship between early caregiving relationships and self-compassion. It is evident that responsive parenting, characterised by sensitivity, warmth, acceptance and nurturance is related to the ability to develop self-compassion in adolescence.

Finally, the researcher is heartened by the growth and promising findings within self-compassion research. Specifically, the researcher is encouraged by the positive findings from this study in that parents have an important and constructive role to play in their child’s development. Parents may underestimate the importance of providing a loving, accepting, warm and responsive influence in the adolescent’s life. This is particularly at a time when adolescents appear to want or need less involvement from the parent and shun any kind of emotional closeness. In particular, the researcher was surprised and excited to discover the finding regarding the relevance of a responsive, involved, warm father. It is the researcher’s opinion that strengthening the father-child relationship in this regard has promising outcomes for the development of self-compassion during adolescence. Further, this finding provides insight and understanding into what may contribute to individual differences in self-compassion in general, which augments the view that self-compassion most likely originates in early caregiving relationships.
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Boulder, CO: Sounds True.


Informed Consent Form for Parents

Informed Consent for Psychological Research Purposes – Department of Psychology University of Johannesburg

Dear Parent,

I am a Masters student currently doing research at the University of Johannesburg. My study is on self-compassion in adolescents. I am exploring whether their experiences of a particular parenting style can predict their ability to develop self-compassion or not. Simply stated, self-compassion is the ability to be kind to, and accepting of oneself, to know that one is not alone during times of perceived failure, and to be aware of one’s difficult emotions without being overwhelmed by them. Parenting style can simply be described as the way in which you engage with your child. I’m interested in your child’s perception of this, which may or may not reflect the actual style with which you engage your child.

Process:
This study would entail your child filling out three short questionnaires, during class time, as agreed to by the school. This should take no longer than approximately 15 minutes.

I would like to invite your child to participate in this research. Your decision to have your child participate in this study is entirely voluntary. If you do consent your child will be given an informed assent form in order that they may decide whether they would like to participate or not. They may withdraw at any time during the research with no consequences to this choice. Your child’s participation is strictly confidential and anonymous. Any information about your child will have a number allocated to it, not their name. Information collected will be secured in a locked office and no one but the researcher and supervisor will have access to this information. Please note neither you nor your child will be identified in any way in this study. There are no foreseeable risks to the study.

Please feel free to contact me, or my supervisor, should you have any queries in this regard. Should you wish to receive the results of this study, kindly advise me via email in order that I may liaise with you.

Name of Researcher: Jenny Dakers
Contact details: Tel: 083
Email: Jenny.dakers
Supervisor: Professor Tharina Guse
Tel: 011 559 3248
Email: tguse@uj.ac.za
Title of the Study: Parenting Style as a Predictor of Self-Compassion Among a Group of Adolescents.

Certificate of consent: Please sign and return to the school.
I have read the foregoing information. I have had opportunity to ask questions about this study. Any questions I have asked have been answered to my satisfaction. I consent voluntarily for my child to participate as a participant in this study.

Name of participant: ____________________

Grade: ____________________

Name of Parent/Guardian: ____________________

Signature: ____________________

Date: ____________________

This consent form, as well as your child’s assent form, WILL NOT be attached to their questionnaires. Their questionnaires remain anonymous.
Informed Assent Form for Participants

Informed Assent for Psychological Research Purposes – Department of Psychology University of Johannesburg

Dear Student,

I am currently doing research at the University of Johannesburg. My research is on self-compassion in adolescents. I am exploring whether or not experiences of a particular parenting style can predict your ability to develop self-compassion or not. Simply stated, self-compassion is the ability to be kind and accepting to yourself, to know that you are not alone during times of perceived failure, and to be aware of your difficult emotions without being overwhelmed by them. Parenting style can simply be described as the way you experience your parents’ interactions with you.

You can choose whether or not you want to participate. I have discussed this research with your parent(s)/guardian and they know I am also asking for your agreement to participate. Your parents have to agree to your participation. If you do not wish to take part you don’t have to, even if your parents have agreed. Your information will be completely confidential and will not be shared with anyone.

You may ask me any questions about this study at any time.

Name of Researcher: Jenny Dakers
Contact details: Tel: 083
Email: Jenny.dakers
Supervisor: Professor Tharina Guse
Tel: 011 559 3248
Email: tguse@uj.ac.za
Title of the Study: Parenting Style as a Predictor of Self-Compassion Among a Group of Adolescents.

Certificate of assent:

I have read the information about this study. I have had opportunity to ask questions about this study. Any questions I have asked have been answered to my satisfaction. I can ask questions later if I want to.

☐ I agree to take part in this research.

☐ I do not wish to participate in this research.

Name: ___________________________  Grade: ___________________________

Signature: ________________________  Date: _________________________

This assent form WILL NOT be attached to your questionnaire. Your questionnaire remains anonymous.