PERSONALITY PSYCHOPATHOLOGY AND THE ROLE OF SELF-COMPASSION

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ABSTRACT

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Previous research has examined the relationship between particular personality disorders (PDs) and self-compassion. However, this work has not extended to-the Alternative Model for Personality Disorders (AMPD), which was proposed in Section III of the DSM-5. The current study aimed to use self-compassion, synonymous with self-empathy, one of the elements of functional impairment in the AMPD, to support the idea that empathy is a multifaceted construct and highlight associations between self-compassion and personality psychopathology. The study used Neff's Self-Compassion Scale (SCS) in addition to Criterion A (elements of personality functioning) and Criterion B (pathological traits) of the AMPD in order to observe associations between PDs and self-compassion. The findings can help to establish working treatment methods for individuals with PDs as well as provide support for the hybrid dimensional-categorical model.

KEY WORDS: Self-compassion, Empathy, Personality psychopathology, Alternative model for personality disorders, DSM-5

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CHAPTER I

Introduction

The current study examined self-compassion, or self-empathy, and its relationship

with personality functioning and pathological traits in the Alternative Model for

Personality Disorders (AMPD) in the *Diagnostic and Statistical Manual of Mental*

Disorders- 5th Edition (DSM-5; American Psychiatric Association [APA], 2013).

Importantly, impairment in empathy is a common element of personality disorders (PDs;

Boland, Damnjanovic, & Anderson, 2018; McClure et al., 2013; Noren et al., 2007;

Skodol et al., 2005a). As defined in the DSM-5, empathy is an understanding and

appreciation for the experiences of others, a tolerance for the perspectives of others, and

an understanding of how one's actions can impact others (APA, 2013). However, some

researchers have suggested a difference between empathy towards others and empathy

towards oneself (Neff and Pommier, 2013). Therefore, the current study examined self-

compassion, the ability to empathize with one's own behaviors without criticism or

judgment, and its relationship with personality psychopathology.

CHAPTER II

Literature Review

PDs are widely defined as being configurations of maladaptive personality traits, and accompanying functional impairment. According to the National Institute of Mental Health (NIMH), approximately 9.1% of the population is diagnosed with a PD (NIMH, 2018). Importantly, personality psychopathology is associated with deficits in vocational functioning (McGurk et al., 2013), marital and parenting problems (Zanarini et al., 2015), and externalizing/criminal behavior (Miller and Lynam, 2001). However, with the emergence of a new model for PD diagnosis, more research on the impairment associated with personality psychopathology is needed.

Models of Personality Disorders

A strictly categorical approach to PD diagnosis is currently used in the DSM-5. However, due to numerous criticisms of this model, many have argued a dimensional approach should be implemented (Clark, 2007; Watson, Clark, & Chmielewski, 2008). Indeed, there is an absence of research supporting the clinical utility of the categorical model (Verheul, 2005) and substantial diagnostic overlap (Widiger & Mullins-Sweatt, 2010), resulting in extensive comorbidity and heterogeneity between and among PD diagnoses. In response to these limitations, the DSM-5 created an alternative model for the assessment and diagnosis of personality psychopathology. Section III of the manual includes an Alternative Model for Personality Disorders (AMPD), which takes a hybrid, dimensional-categorical approach. This hybrid model attempts to separate PD "severity" (*Criterion A*) from "style" (*Criterion B*), wherein Criterion A (Table 1) focuses on significant impairments of self (e.g., identity and self-direction) and interpersonal

functioning (e.g., empathy and intimacy) and Criterion B (Table 2) focuses on

pathological personality trait domains and facets. Criterion B consists of 25 pathological

personality trait facets subsumed under five pathological trait domains (i.e., Antagonism,

Detachment, Disinhibition, Negative Affect, and Psychoticism). In addition, the AMPD

maps "severity" and "style" across six categorical PDs from DSM-5 Section II, including

antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal PDs

(APA, 2013). Each of the six categorical PDs are composed of a profile including

elements of personality dysfunction (Criterion A), and a pathological trait profile

(Criterion B; Table 3) necessary for that PD.

Table 1. *Criterion A: Personality Functioning of AMPD DSM-5 (APA, 2013)*

Elements of Personality Functioning
Self:
1. *Identity:* Experience of oneself as unique, with clear boundaries between self and others; stability of self-esteem and accuracy of self-appraisal; capacity for, and ability to regulate, a range of emotional experience.
2. *Self-direction*: Pursuit of coherent and meaningful short-term and life goals; utilization of constructive and prosocial internal standards of behavior; ability to self-reflect productively.
Interpersonal
1. *Empathy*: Comprehension and appreciation of others' experiences and motivations; tolerance of differing perspectives; understanding the effects of one's own behavior on others.
2. *Intimacy*: Depth and duration of connection with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behavior.

Table 2. *Criterion B: Pathological Traits of AMPD DSM-5 (APA, 2013)*

Trait Domains	**Trait Facets**
1. Antagonism	Manipulativeness
	Deceitfulness
	Grandiosity
	Attention Seeking
	Callousness
2. Detachment	Withdrawal

	Intimacy Avoidance
	Anhedonia
	Depressivity
	Restricted Affectivity
	Suspiciousness
3. Disinhibition	Irresponsibility
	Impulsivity
	Distractibility
	Risk taking
	Rigid Perfectionism
4. Negative Affectivity	Emotional Lability
	Anxiousness
	Separation Insecurity
	Submissiveness
	Hostility
	Perseverance
5. Psychoticism	Unusual Beliefs & Experiences
	Eccentricity
	Perceptual Dysregulation

Table 3. *Pathological Traits for AMPD Personality Disorders (APA, 2013)*

Personality Disorder	Pathological Trait
1. Antisocial Personality Disorder	Manipulativeness (Antagonism)
	Callousness (Antagonism)
	Deceitfulness (Antagonism)
	Hostility (Antagonism)
	Risk Taking (Disinhibition)
	Impulsivity (Disinhibition)
	Irresponsibility (Disinhibition)
2. Avoidant Personality Disorder	Anxiousness (Negative Affectivity)
	Withdrawal (Detachment)
	Anhedonia (Detachment)
	Intimacy Avoidance (Detachment)
3. Borderline Personality Disorder	Emotional Lability (Negative Affectivity)
	Anxiousness (Negative Affectivity)
	Separation Insecurity (Negative Affectivity)
	Depressivity (Negative Affectivity)
	Impulsivity (Disinhibition)
	Risk Taking (Disinhibition)
	Hostility (Antagonism)
4. Narcissistic Personality Disorder	Grandiosity (Antagonism)
	Attention Seeking (Antagonism)
	Anxiousness (Negative Affect)*
	Emotional Lability (Negative Affect)*
	Depressivity (Detachment)*

5. Obsessive-Compulsive Personality Disorder	Rigid Perfectionism (opposite of Detachment)
	Perseveration (Negative Affectivity)
	Intimacy Avoidance (Detachment)
	Restricted Affectivity (Detachment)
6. Schizotypal Personality Disorder	Cognitive & Perceptual Dysregulation (Psychoticism)
	Unusual Beliefs & Experiences (Psychoticism)
	Eccentricity (Psychoticism)
	Restricted Affectivity (Detachment)
	Withdrawal (Detachment)
	Suspiciousness (Detachment)

*Trait domains and facets included in the current study to measure vulnerable narcissism

Numerous studies have provided findings in support of the AMPD and the validity of its measures (Few et al., 2013; Morey, Krueger, & Skodol, 2013; Morey et al., 2015; Wright et al., 2012). Given that the model is relatively new and not yet routinely used for diagnosing personality psychopathology, research surrounding the model is still somewhat limited. However, research studying personality psychopathology using the categorical model is abundant. Therefore, as research on PDs moves in a dimensional direction, it is important to replicate categorical findings using the new model. Furthermore, the model makes it possible to examine self-compassion directly with the empathy, as it is presently defined in the AMPD, along with examining associations between self-compassion and PD trait conceptualizations.

Functional Impairment in Personality Disorders

Important to the AMPD conceptualization of personality psychopathology, PDs are characterized by impairment in functioning. Indeed, numerous studies have shown associations between personality psychopathology and impairment in functioning (e.g., Boland, Damnjanovic, & Anderson, 2018; McClure et al., 2013; Noren et al., 2007; Skodol et al., 2005a). For instance, individuals with PDs have been shown to demonstrate

high levels of comorbid substance abuse, anxiety, and mood disorders (Tomko et al., 2014). Furthermore, certain PDs are likely to demonstrate high levels of shame and emotional dysregulation (Gramzow & Tangney, 1992; Gratz, Rosenthal, Tull, Lejeuz, & Gunderson, 2006; Schoenleber & Berenbaum, 2010). Interpersonal dysfunction is also highly prevalent (e.g., Wilson, Stroud, & Durbin, 2017), with research showing individuals with PDs exhibit greater levels of intimate partner violence (Weinstein, Gleason, & Oltmanns, 2012), and have lower quality intimate relationships due to a lack of empathy (Jeung & Herpertz, 2013; Rutan, Alonso, & Groves, 1988).

Personality Disorders & Empathy/Compassion

Most relevant to the current study, is impairment in empathy. Indeed, impairment in empathy has been demonstrated across several PDs (APA, 2013). For instance, research using the categorical approach has found both Narcissistic PD (NPD) and Antisocial PD (ASPD) are associated with a lack of emotional empathy, or the vicarious sharing of emotion (Ritter et al., 2011; Smith, 2006). A DSM-IV field study found a significant lack of empathy across inmates with personality psychopathology (Widiger et al., 1996). Additionally, numerous studies supported a lack of empathy, or alteration in empathy, in individuals with Borderline personality Disorder (BPD), which was predicted to impact the level impairment in interpersonal relationships of those individuals (Dziobek et al., 2011; Jeung & Herpertz, 2013; Niedtfeld, 2017).

Furthermore, within the AMPD, Criterion A includes empathy as a facet of impairment in personality functioning. Therefore, each of the six PDs assessed in the AMPD are given an explicit profile for impairment in empathy. For example, BPD empathy impairment is classified by a compromised ability to recognize other's feelings

or needs, mainly due to an interpersonal hypersensitivity (APA, 2013). In addition, antagonism, one of the five trait domains in Criterion B, is associated with a lack of empathy (Graziano, Habashi, Sheese, & Tobin, 2007). Of additional import, numerous studies have come to the conclusion that empathy is almost interchangeable with compassion (Black, 2004; Goetz et al., 2010; Wispe, 1986). Therefore, compassion focused research, including self-compassion, may be relevant to understanding personality psychopathology both in the categorical and hybrid model.

Self-Compassion

Self-compassion is an ability to understand one's own emotions without judgment or blame. Self-compassion includes three main principles: self-kindness, common humanity, and mindfulness (Neff, 2016a). Self-kindness encompasses an understanding for oneself rather than holding onto judgments of shortcomings; common humanity is the understanding that no one is perfect and all humans are flawed; and mindfulness is one's ability to have a clear understanding of one's own suffering (Neff, 2016a). Much of the literature on self-compassion supports the idea that individuals with high levels of self-compassion have better emotional coping skills (Neff, Hseih, & Dejitthirat, 2005). On the other hand, individuals with low levels of self-compassion tend to judge themselves more harshly than they do others (Neff, 2003a). Not surprisingly, previous work has shown links between self-compassion and the constructs of anxiety and depression. Numerous studies have suggested that self-compassion moderates the relationship between symptoms of depression and anxiety in the presence of psychological stressors (Chu et al., 2018; Jiang et al., 2016; Keng & Liew, 2017; Kyeong, 2013; Leary et al., 2007). Cumulatively, these studies suggest that higher levels of self-compassion reduce the

severity of anxious and depressive symptoms, suggesting that self-compassion is beneficial in times of adversity (Neff, 2003b)

Most of the research regarding self-compassion and PDs has specifically focused on BPD with limited research also examining NPD. For example, Rivera (2014) found evidence supporting the idea that reduced levels of self-compassion increase symptoms of BPD. Relatedly, another study found that Compassion Focused Therapy (CFT), which involved promoting self-compassion, reduced BPD patients' self-loathing symptoms over time (Lucre & Corten, 2010). However, the same study found that many individuals with BPD associate self-compassion with self-destructive behaviors, which can lead to a developed fear of self-compassion (Lucre & Corten, 2010). Other work has examined shame in NPD populations, where the authors found that shame could potentially be resolved by having patients access their underlying self-compassion in psychotherapy (Kramer, Pascual-Leone, Rohde, & Sachse 2017). However, additional work has shown non-significant associations between NPD traits and self-compassion (Neff 2003a). Notably, previous work has suggested two types of narcissism, including both grandiose and vulnerable components of the syndrome (Miller & Campbell, 2008; Pincus & Lukowitsky, 2010; Russ, Shedler, Bradley, & Weston, 2008; Wink, 1991). Therefore, inconsistent findings may also result from varying operationalizations of NPD.

Importantly, each of these studies also measured self-compassion using a different methodology. However, a validated measure of self-compassion exists. The Self-Compassion Scale (SCS; Neff, 2003a) was designed based on the three principle features of self-compassion, including self-kindness vs. self-judgment, common humanity vs. isolation, mindfulness, vs. over-identification. Furthermore, previous work examining

PDs and self-compassion used the categorical model for PD conceptualization, and has assessed only BPD and NPD. Therefore, work related to the AMPD and personality psychopathology on a broader scale is needed, as impairment in empathy is present in all PDs. The role of empathy and compassion is relevant across PDs, especially from the perspective of the AMPD, which includes impairment in empathy in its conceptualization of personality impairment. Although previous studies have provided some evidence linking self-compassion to PDs, the current study was designed to measure personality psychopathology from an AMPD perspective using a validated measure of self-compassion.

Current Study

The current study aimed to examine self-compassion and its relationship with functional impairment and pathological personality traits in the AMPD. Although some research has been conducted regarding the relationship between self-compassion, as measured by the Self-Compassion Scale (Neff, 2003a), and personality psychopathology (Kramer, Pascual-Leone, Rohde, & Sachse 2017; Lucre and Corten, 2010; Neff, 2003a; Rivera, 2014), this work has been limited and has utilized strictly categorical approaches. Therefore, this study examined personality psychopathology and its impairment using a hybrid categorical-dimensional approach. Furthermore, since the AMPD retained six categorical PDs (albeit with a different operationalization than DSM-5 Section II), this study also evaluated the relationship between self-compassion and specific PD trait and impairment conceptualizations. In other words, this study not only examined associations with the dimensional traits and broad areas of impairment from the AMPD, but examined the six categorical PD operationalizations as well.

Hypotheses

The following hypotheses outline the expected findings of this study.

(1) Although self-compassion and its facets are expected to show at least moderate associations with personality impairment (AMPD Criterion A) in both self and interpersonal functioning broadly, a particularly strong association is expected with impairment in empathy. Past research has supported the interchangeability between empathy and compassion (Black, 2004; Goetz et al., 2010; Wispe, 1986). Therefore, although Empathy in the AMPD model refers to empathy towards others, we expect Empathy to show strong associations with self-compassion.

(2) At least moderate relationships are expected between self-compassion and its facets and several dimensional personality traits (AMPD Criterion B). At the domain level, the strongest (negative) association is expected between self-compassion and Negative Affectivity. At the facet level, the strongest associations are expected between self-compassion and Anxiousness (-), Emotionality Lability (-), Submissiveness (-), Impulsivity (-) and Grandiosity (+).

(3) Finally, associations are expected between self-compassion and most PD trait conceptualizations and PD-specific impairment, including BPD, NPD, Avoidant PD (APD), and Antisocial PD (ASPD).

    a. Although Neff (2003a) found that narcissism had a weak correlation with self-compassion, narcissism was measured using a categorical conceptualization. Given research related to self-compassion in the treatment of NPD (Kramer, Pascual-Leone, Rohde, & Sachse, 2017), as well as research demonstrating the emotional vulnerability inherent in

individuals with NPD (Wink, 1991), it is expected that the trait

conceptualization and functional impairment of NPD will show strong

associations with self-compassion and its facets. In addition, a study

conducted on narcissism and the AMPD Criterion B found that grandiose

narcissism had a significant negative association with the trait facet

anxiousness. Of note, the AMPD conceptualization of NPD only assesses

the grandiose aspects of the disorder (Miller, Gentile, Wilson, &

Campbell, 2011); therefore, the current study will calculate a "vulnerable

NPD" variable as well. Vulnerable narcissism will be measured using the

trait facets associated with grandiose NPD (i.e., Grandiosity and Attention

seeking) as well as additional trait facets hypothesized to conceptualize

vulnerable narcissism (i.e., Emotional Lability Anxiousness, and

Depressivity) These traits were chosen using conceptual expectations of

vulnerable narcissism, as well as using previous research to suggest these

traits are important (Miller, Gentile, Wilson, & Campbell, 2011).

b. Given the previous work showing associations between categorical BPD

and self-compassion (Lucre & Corten, 2010; Rivera, 2014) as well as the

level of negative affectivity common in individuals with BPD (APA, 2013;

Hepp et al, 2017; Hepp, Lane, Wycoff, Carpenter, & Trull, 2018), it is

expected that self-compassion will show strong associations with trait-

based BPD and its associated impairment.

c. Similar to BPD, Avoidant PD is associated with negative affectivity

manifesting as anxiousness (APA, 2013). Given previous research on the

relationship between negative affect and self-compassion, it is expected that self-compassion will also show associations with trait based APD (Luo, Quiao, & Che, 2018).

d. Finally, ASPD is conceptualized by both impulsivity and a lack of emotional vulnerability. Given previous work showing negative associations between impulsivity and self-compassion (Morley, 2017) and the previous hypothesis that predicted a negative association between impulsivity and self-compassion, it is predicted that self-compassion will show negative associations with trait based ASPD and the associated impairment.

CHAPTER III

Methods

Participants and Procedures

The current study used both an undergraduate sample ($n = 155$) and an Amazon

Mechanical Turk (MTurk) sample ($n = 278$). G*Power analysis (Erdfelder, Faul, &

Buchner, 1996) suggested a sample between 125 and 289 to capture a small-medium to

medium effect; therefore, the anticipated sample was adequate for all proposed analyses.

All measures were administered online using Qualtrics software as part of a larger scale

data collection. An undergraduate sample was collected from the Sam Houston State

University online student recruitment system. Undergraduate students received course

credit for their participation. However, because previous work has shown that

undergraduates have lower self-compassion scores than community samples (Neff &

Pommier, 2013), it was important to include an additional sample with greater variability.

Therefore, data was also collected using Amazon MTurk. Individuals were compensated

$1.50 USD for their participation[1]. Groups were analyzed separately in order to focus on

findings that replicate across both samples.

Three hundred and twenty students were included in the undergraduate sample.

Using a built-in validity measure (described below), 165 participants were excluded from

the analyses, leaving a total of 155 participants. Of the remaining sample, participants

were 89.8% female, with a mean age of 20.48 years ($SD = 3.86$). Participants were

primarily Caucasian (47.8%), followed by Hispanic/Latino (24.8%), African American

(19.7%), Asian (3.2%), and Other race/ethnicities (3.2%; other included participants who

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[1] Funding for this project has been awarded from the Society for Personality Assessment.

identified as "mixed", "Caucasian/Native American" and "multi-ethnic"). The majority of participants identified themselves as being straight/heterosexual (80.3%), with the remainder identifying as bisexual (15.9%), lesbian (.6%), and gay (.6%). Of the sample, 55.4% of participants indicated that someone close to them had been diagnosed with a mental illness at some point in their life, while 25.5% reported having been previously diagnosed with a mental illness themselves.

One thousand responses were included in the MTurk sample, with 722 participants being removed after failing to pass the validity measure, leaving a total of 278 participants. Of the remaining sample, participants were 59.3% female, with a mean age of 36.70 ($SD = 12.08$). Participants were primarily Caucasian (68.9%), followed by Asian (10.4%), African American (10%), Hispanic/Latino (6.4%), Pacific Islander (.7%), Native American (.4%) and Other (2.5%; other included participants who identified as Middle Eastern, European, African European, and "mixed"). Approximately 38.2% of individuals reported a bachelor's degree as their highest level of education, while 23.9% reported high school as their highest level of education, 18.6% reported having an associate's or technical degree, 15% reported having a master's degree, and 3.6% reported having a doctorate. The majority of participants identified themselves as being straight/heterosexual (81.4%), with the remainder identifying as bisexual (10.7%), lesbian (3.2%), gay (2.5%), demisexual/polyamorous (.4%), and fluid (.4%). Of the sample, 56.4% of participants indicated that someone close to them had been diagnosed with a mental illness at some point in their life, while 25.4% reported having been previously diagnosed with a mental illness themselves.

Measures

Demographic Survey Participants completed a short survey created by the primary investigator, which asked participants demographic questions (e.g., race/ethnicity, gender, birthdate, etc.). In addition, this survey asked about mental health history (e.g., diagnosis, history of treatment, hospitalizations, etc.). Participants were asked to check "yes" or "no" to questions regarding a history of each of these experiences and then to further describe their history if present.

Self-Compassion Scale (SCS) The SCS (Neff, 2003a) is a 26-item self-report questionnaire designed to assess an individual's level of self-compassion as characterized within the three components of Self-Kindness, Common Humanity, and Mindfulness. Each of the 26 items is answered on a 5-point scale ranging from 1 (almost never) to 5 (almost always). The three components of the SCS are then integrated to identify a single higher-order self-compassion scale. For the undergraduate sample, internal consistencies for the SCS Total ($\alpha = .93$) and subscales ($\alpha = .76$ [Mindfulness] - .87 [Self-Kindness]) were acceptable. For the MTurk sample, internal consistencies for the SCS Total ($\alpha = .95$) and subscales ($\alpha = .83$ [Common Humanity] - .90 [Self-Kindness]) were acceptable.

Personality Inventory for DSM-5 (PID-5) The PID-5 (APA, 2013) is a 220-item self-report questionnaire developed to measure the pathological personality traits in Criterion B of the AMPD. Items are answered on a 4-point scale ranging from 0 (very false or often false) to 3 (very true or often true). It assesses five dimensional trait domains (Negative Affect, Disinhibition, Antagonism, Detachment, and Psychoticism), which are further divided into 25 facets. Previous research has supported the reliability, validity, and factor structure of this measurement of pathological traits (see Al Dajani et al., 2016 for a review). The current study will use the official PID-5 scoring algorithm to

score the pathological trait facets. The scores will be derived using the mean across all items on each domain or facet. PD variables will then be calculated by summing the trait facet scores making up each of the AMPD PDs, which has been done in previous studies (e.g., Boland et al., 2018). Because the conceptualization of NPD in the AMPD is focused on the grandiose components for narcissism, the current study will also calculate a vulnerable narcissism variable by adding the facets Anxiousness, Emotional Lability, and Depressivity to the NPD operationalization, which has been found to have strong associations with vulnerable narcissism in previous work (Miller, Gentile, Wilson, & Campbell, 2011; Miller & Maples, 2011). For the undergraduate sample, the internal consistencies were acceptable (Negative Affectivity α = .90; Disinhibition α = .88; Detachment α = .86; Antagonism α = .84; Psychoticism α = .84), as were the majority trait facets (α = .71 [Grandiosity] - .90 [Depressivity]) except for Suspiciousness (α = .67), Perceptual Dysregulation (α = .60), Unusual Beliefs and Experiences (α = .62), Deceitfulness (α = .67), and Irresponsibility (α = .63). For the MTurk sample, the internal consistencies were acceptable (Negative Affectivity α = .91; Disinhibition α = .90; Detachment α = .90; Antagonism α = .90; Psychoticism α = .90), as were all trait facets (α = .74 [Irresponsibility] - .90 [Anxiousness]).

Level of Personality Functioning Scale Self-Report (LPFS-SR). The LPFS-SR (Morey, 2017) is an 80-item self-report questionnaire designed to measure the severity of one's personality psychopathology across the four dimensions included in Criterion A of the AMPD. These four dimensions of personality functioning include identity, self-direction, empathy, and intimacy. Each item is measured on a 4-point scale ranging from 1 (totally false) to 4 (very true). Previous research supports the overall reliability and

validity of the measure (Morey, 2017). For the undergraduate sample, the internal

consistencies were acceptable (Identity α = .84; Self-direction α = .81; Intimacy α = .80;

Empathy α = .74). For the MTurk sample, the internal consistencies were acceptable

(Identity α = .87; Intimacy α = .86; Self-direction α = .83; Empathy α = .77).

Disorder-Specific Impairment Scale (DSI). The DSI (Anderson & Sellbom,

2018) is a 58-item scale developed to measure Criterion A of the AMPD using disorder-

specific impairment descriptions included in the DSM-5. For each PD sub-scale, items

ask participants to select one of five statements of increasing severity (ranging from 0 [no

impairment] to 4 [extreme impairment]), with items reflecting each explicit content area

within Criterion A for each respective disorder. For the undergraduate sample, the

internal consistencies were acceptable for some PDs (BPD α = .85; APD α = .84; SZPD α

= .81; NPD α = .73) and not acceptable for others (OCPD α = .63; ASPD α = .56). For

the MTurk sample, the internal consistencies were acceptable (APD α = .91; BPD α =

.89; SZPD α = .83; NPD α = .82; ASPD α = .72; OCPD α = .71).

Validity Indicator. Because the measures used in this study do not have built-in

validity scales, six validity items will be dispersed throughout to ensure participants are

responding appropriately to the item content. Validity indicator items were written as

statements that a majority of participants would disagree with, such as "I am only friends

with people born in August." Individuals who agree with two or more validity items will

be removed from analyses.

Statistical Analysis

Regarding the first hypothesis, Pearson correlation analyses were conducted in

order to determine the zero-order associations between LPFS total and subscale scores

and self-compassion as measured by the SCS. To address the second hypothesis, we used

Pearson correlations to evaluate the zero-order associations between domain and subscale

scores on the PID-5 and SCS scores. Finally, regarding the third hypothesis, Pearson

correlations were used to evaluate the zero-order associations between PD trait

conceptualizations (as measured by PID-5 trait PD trait combinations) and disorder

specific impairment (as measured by the DIS) and SCS scores. Grandiose and vulnerable

trait-conceptualizations of narcissism were analyzed separately.

CHAPTER IV

Results

Given the number of comparisons in the current study, there is an inflated

possibility for Type I error. Therefore, we used a Bonferroni corrected alpha of $p < .001$

to determine statistical significance. This was calculated by dividing the original alpha

value ($p < .05$) by the number of tests being conducted with each dependent variable ($n =$

48). In addition, we only interpreted moderate correlations ($r > .30$) as meaningful. All

moderate correlations were also statistically significant in the current study. Finally, we

calculated confidence intervals for all correlations (See Appendix B-1 through B-4).

First, we evaluated the zero-order associations between AMPD functional

impairment and self-compassion. These results are shown in Appendix A-1. All AMPD

functional impairment total and subscale scores were moderately or largely correlated

(r's = -.29 [LPFS Empathy & Self-Kindness]--.67 [LPFS Identity & SCS Total], Median

= -.47) with self-compassion total and subscale scores (i.e., Self-Kindness, Common

Humanity, Mindfulness, and SCS total) in both samples. However, the LPFS Identity

subscale and the LPFS Total scale were the only scales that showed strong correlations

across the majority of facets of self-compassion (r's = -.47 [LPFS Total & Self-

Kindness]--.67 [LPFS Identity & SCS Total]) in both samples. Additionally, although the

LPFS Empathy subscale was expected to have particularly strong correlations with self-

compassion, it showed the weakest correlations (r's = -.29 [Self-Kindness]--.41

[Mindfulness]) with all facets of self-compassion compared with the other total and

subscales of functional impairment.

Next, we evaluated the zero-order associations between AMPD pathological personality domains and trait facets and self-compassion. These results are shown in Appendix A-2. The majority of AMPD domains and traits facets were moderately correlated (Domain *r*'s = -.07 [Antagonism & Self-Kindness]--.73 [Negative Affectivity & Mindfulness], Median = -.42; Trait facet *r*'s = .00 [Perceptual Dysregulation & Self-Kindness]--.69 [Anxiousness & Mindfulness], Median = -.29) with self-compassion total and subscale scores (i.e., Self-Kindness, Common Humanity, Mindfulness, and SCS total) in both samples. The strongest negative association was found between the trait domains Negative Affectivity (*r*'s = -.45 [Common Humanity]--.73 [Mindfulness], Median = -.60), followed by Detachment (*r*'s = -.42 [Mindfulness]--.52 [SCS Total], Median = -.48) and Disinhibition (*r*'s = -.29 [Common Humanity]--.52 [Mindfulness], Median = -.43). The majority of Negative Affectivity trait facets had moderate negative correlations (*r*'s = -.26 [Submissiveness & Mindfulness]--.69 [Anxiousness & Mindfulness], Median = -.46), with the facets Anxiousness (*r*'s = -.45 [Common Humanity]--.69 [Mindfulness], Median = -.55) and Emotional Lability (*r*'s = -.37 [Common Humanity]--.64 [Mindfulness], Median = -.49) exhibiting the strongest correlations. Additionally, particular facets of Detachment (i.e., Withdrawal, Anhedonia, Depressivity, and Suspiciousness) and Disinhibition (i.e., Impulsivity and Distractibility), showed moderate associations with SCS total and subscale scores (*r*'s = -.22 [Impulsivity & Common Humanity]--.64 [Anhedonia & SCS Total]). However, no associations were found between the trait facet Grandiosity and self-compassion (*r*'s = .01 [Self-Kindness]--.08 [Mindfulness]) in either sample.

Finally, we evaluated zero-order associations between AMPD trait conceptualizations, disorder specific impairment, and self-compassion. These results are shown in Appendix A-3 and Appendix A-4. The majority of PDs according to trait conceptualizations and disorder specific impairment were moderately correlated (*r*'s = -.06 [Grandiose NPD & Self-Kindness]--.70 [Trait-based BPD & Mindfulness], Median = -.46) with self-compassion in both samples. NPD DSI showed moderate negative associations with all facets of self-compassion (*r*'s = -.31 [Common Humanity]--.48 [Mindfulness], Median = -.42). However, Grandiose and Vulnerable NPD showed differential patterns. Grandiose NPD showed weak or non-significant correlations (r's = -.06 [Self-Kindness] - -.19 [Mindfulness], Median = -.10) and Vulnerable NPD showed moderate to strong negative correlations (*r*'s = -.47 [Common Humanity] - -.66 [Mindfulness], Median = -.56) with SCS scores in both samples. Additionally, BPD and APD, according to trait conceptualizations and disorder specific impairment, showed strong negative correlations (BPD *r*'s = -.48 [Trait-based BPD & Common Humanity]--.70 [Trait-based BPD & Mindfulness], Median = -.59; APD *r*'s = -.50 [APD DSI & Mindfulness]--.63 [Trait-based APD & SCS Total], Median = -.57) with self-compassion and its facets. However, ASPD was moderately correlated with SCS scores according to trait conceptualizations (*r*'s = -.23 [Common Humanity]--.39 [Mindfulness], Median = -.30) and weakly correlated with SCS scores according to disorder specific impairment (*r*'s = -.08 [Self-Kindness]--.19 [Mindfulness/SCS Total], Median = -.13) across both samples.

CHAPTER V

Discussion

The primary purpose of the current study was to investigate the role of self-compassion in personality psychopathology, as measured in the DSM-5 AMPD. Two samples were examined in the study to examine the convergence of self-compassion and the AMPD scores across both samples. The utilization of two samples allowed for a replication of our findings with undergraduate and community populations, helping to strengthen the study. Indeed, we focused this discussion on findings that were consistent across both samples. We examined self-compassion and its associations with functional impairment, pathological personality domains and traits, and specific PD construct conceptualizations. More specifically, we wanted to investigate associations between self-compassion and empathy as measured in Criterion A for the purpose of determining the extent to which empathy pertains to both the self and others, and aid to supporting research of the hybrid dimensional- categorical model.

Our results showed a pattern of moderate to strong negative associations between functional impairment and the three facets of self-compassion. This was not surprising, given that PDs are defined by significant functional impairment and that previous research indicates self-compassion is associated with better emotional coping skills (APA, 2013; Neff, Hseih, & Dejitthirat, 2005). However, we predicted that functional impairment in empathy, specifically, would have the strongest association with self-compassion and its facets due to previous research suggesting that empathy and compassion are interchangeable terms (Black, 2004; Goetz et al., 2010; Wispe, 1986).

Despite our prediction, the results showed that although impairment in empathy had moderate negative associations with self-compassion and its facets (as expected), the associations were weaker compared with other total and subscales of the LPFS. Instead, Identity evidenced the strongest associations with self-compassion. This may be accounted for by previous research that indicated that individuals that judge themselves more harshly tend to have lower levels of self-compassion (Neff, 2003a), which may be better accounted for by the subscale of identity as defined by Criterion A. In addition, it is possible that although empathy and compassion may be interchangeable terms, that the operationalization of empathy in the AMPD may be quite different than empathy operationalized by self-empathy. Nonetheless, this finding extends beyond previous literature in regards to the relationship between self-compassion and functional impairment in personality psychopathology.

The second aim of the study was to investigate associations between self-compassion and its facets and specific domains and traits of Criterion B. The domain of Negative Affectivity was shown to have the strongest (negative) associations with self-compassion, followed by Detachment and Disinhibition. These findings are consistent with expectations. More specifically, moderate associations were found with Negative Affectivity's traits of Anxiousness, Emotional Lability, and Submissiveness, with the first two showing the strongest associations. Given previous research suggesting that low levels of self-compassion can impact and exacerbate BPD symptomology (Rivera, 2014), it is unsurprising that Negative Affectivity and its composite traits were found to have strong negative associations.

Furthermore, particular traits of the domains of Detachment (i.e., Withdrawal, Anhedonia, Depressivity, and Suspiciousness) and Disinhibition (i.e., Impulsivity and Distractibility) were found to have moderate negative associations. Although these were not hypothesized to be among the strongest associations, these findings may be accounted for by the amount of moderate associations found between all of Criterion B and self-compassion and its facets. Furthermore, the findings are not completely surprising as they too, along with Negative Affectivity and its composite traits, are included in a BPD diagnosis (APA, 2013). Additionally, given past findings on higher levels of self-compassion reducing both anxious and depressive symptoms (Chu et al., 2018; Jiang et al., 2016; Keng & Liew, 2017; Kyeong, 2013; Leary et al., 2007; Neff, 2003b), it is unsurprising that Negative Affectivity and Detachment would have moderate negative associations with self-compassion.

Another finding that did not support our hypotheses was that Grandiosity did not have a significant positive association with self-compassion and its facets, and, instead, the findings were non-significant. This is surprising as inflated self-esteem would theoretically be expected to have at least moderate associations compassion toward oneself. The current study anticipated that the utilization of a validated measure of self-compassion, the SCS, along with the utilization of the AMPD over the categorical model would yield significant findings for traits associated with NPD. However, the findings supported previous research that indicated the lack of significance between NPD traits and self-compassion (Neff, 2003a).

The third aim of the study was to investigate associations between PD trait conceptualizations and PD-specific impairment and self-compassion. Of particular

interest were BPD and NPD, which had been studied previously, along with APD and ASPD, which were lacking self-compassion research, but would be conceptually expected to show associations with self-compassion. Furthermore, given support for both grandiose and vulnerable components of narcissism (Miller & Campbell, 2008; Pincus & Lukowitsky, 2010; Russ, Shedler, Bradley, & Weston, 2008; Wink, 1991), NPD was examined as two separate variables for the trait-based conceptualizations (i.e., grandiose and vulnerable narcissism). The results showed that both NPD impairment and vulnerable NPD had moderate negative associations with self-compassion. However, as expected, given the lack of association between Grandiosity and self-compassion, Grandiose NPD did not have significant associations with self-compassion scores. The findings support previous work suggesting a distinction between two forms of narcissism (Miller & Campbell, 2008; Pincus & Lukowitsky, 2010; Russ, Shedler, Bradley, & Weston, 2008; Wink, 1991), and further suggests that these differing presentations of narcissism may lead to differential patterns of impairment. Indeed, those who show vulnerable narcissism may be at a greater likelihood to demonstrate difficulties in self-compassion. Importantly, the AMPD only includes grandiose NPD traits in the conceptualization of NPD (i.e., Grandiosity and Attention Seeking), but does not include traits reflective of vulnerability. Therefore, the results of the study have broader implications for the AMPD's operationalization of NPD, as individuals with vulnerable NPD are likely to present with different problems. Additionally, the lack of representation of vulnerable NPD has faced criticism in the past (Miller, Gentile, Wilson, & Campbell, 2011), and the current findings support the need to distinguish between vulnerable and grandiose NPD.

Furthermore, the results examining BPD trait conceptualization and disorder specific impairment showed that, similar to categorical research, there were strong negative associations between BPD and self-compassion (Lucre & Corten, 2010; Rivera, 2014). The findings were also supported by previous research (Hepp et al, 2017; Hepp, Lane, Wycoff, Carpenter, & Trull, 2018) that emphasized the role of Negative Affectivity in BPD, which was shown to have strong associations with self-compassion. The results from the second aim of the study supported that not only is Negative Affectivity, along with particular traits, moderately to strongly negatively associated with self-compassion; but additional trait facets (i.e., Impulsivity and Depressivity) included in a BPD trait-conceptualization were found to be significantly associated with self-compassion as well. Additionally, as predicted, APD had strong negative associations with self-compassion. The results were unsurprising as the domain (i.e., Detachment and Negative Affectivity) and traits (i.e., Anxiousness, Withdrawal, and Anhedonia) included in the Criterion B diagnosis of APD were each found to have strong associations with self-compassion. However, the strong associations between APD and self-compassion were initially predicted to be the result of the role the domain Negative Affectivity and its traits, but other traits included in the trait-conceptualization (i.e., Withdrawal and Anhedonia) were also found to have negative associations. This suggests that difficulties in self-compassion are associated with a fairly broad range of pathological personality traits.

Of notable importance, inconsistent findings were shown in the results investigating associations between trait conceptualization and disorder specific impairment of ASPD and self-compassion. More specifically, the ASPD trait conceptualization results indicated moderate negative associations with self-compassion

and its facets, as predicted in the hypothesis; however, the ASPD disorder specific impairment results indicated weak negative associations the self-compassion and its facets. It is possible that this is largely due to the conceptualization of ASPD impairment, which includes difficulties with others, more than internal difficulties in functioning. In other words, though the personality traits included in an ASPD diagnosis may be associated with low self-compassion, functional impairment resulting from ASPD as operationalized by the AMPD may be more focused on difficulties with others more than difficulties with oneself. However, the inconsistencies between the two measures suggest a need for further investigation.

Implications

Overall, our findings have implications for the role self-compassion plays in personality psychopathology by finding significant associations between these constructs. More specifically, given the lack of research on the relationship between self-compassion and personality psychopathology from the dimensional perspective, the current study examined, not only each PD conceptualization, but each element of functional impairment and pathological trait domains and facets. These associations helped to provide insight into other areas of impairment as well as highlighted additional areas of dysfunction associated with particular traits or specific PD operationalizations. For instance, the study found notably stronger associations between self-compassion and particular subscales of functional impairment (i.e., identity) than other subscales of (i.e., empathy). The identity subscale was found to have even stronger associations with self-compassion than empathy. These results can lead to further investigations into the relationship between identity and self-compassion. For instance, examining different

facets of identity and their associations with the facets of self-compassion may provide a deeper insight into what aspects of identity make it so strongly associated with the SCS. Additionally, the results can lead to future research regarding the interchangeability of self-empathy and self-compassion, as self-compassion may be more strongly associated identity than empathy.

Furthermore, treatment methods, such as Compassion-Focused Therapy (CFT), have been developed to increase compassion for the self and others (Lucre & Corten, 2010). Therefore, the strong negative associations found between PDs (i.e., BPD and APD) and self-compassion may help determine working treatment plans. For instance, PDs with strong negative associations with self-compassion would be more likely to benefit from therapy that targets that particular area of impairment. However, there has been limited work related to treatment efforts focused on the AMPD. Therefore, the study addresses a need for future research to help better understand treatment outcomes from particular treatments, such as CFT, and the AMPD.

In addition, the results indicated large differences between particular PD operationalizations (i.e., Grandiose NPD vs. Vulnerable NPD). Therefore, the role of self-compassion in distinguishing between particular PD operationalizations can contribute to previous research examining differences between the dimensional traits within and between PDs. Furthermore, the results lead to future research examining the commonalities that particular PDs share besides particular dimensional traits. For instance, APD and BPD were found to both have strong negative associations with self-compassion even though only some of their dimensional traits and facets overlap. Therefore, further investigations into the role self-compassion plays in the AMPD might

contribute to a better understanding of shared impairment, which could impact the way working treatment plans are approached and established. Finally, the current study will add to the growing literature of the AMPD in the DSM-5. More specifically, the study provides directions for further investigation by highlighting strong associations between self-compassion and particular elements of functional impairment, dimensional traits and facets, and PD conceptualizations.

Limitations and Future Directions

There are several limitations of the current study that should be noted. First, the number of statistical analyses leads to inflated error. Although we attempted to mitigate this by using two samples, using a Bonferroni corrected alpha, and focusing on findings with moderate effect sizes, the possibility for error should not be ignored.

Another limitation of the study was the validity of the DSI, which was used as one of the measures to examine PD operationalizations. Although these disorder-specific impairment scales have been used in previous work (Anderson & Sellbom, 2018), they have not been independently evaluated. The results of the current study indicated differences between associations of self-compassion with ASPD conceptualizations. More specifically, the PID-5, which examined at PD-trait conceptualizations, found moderate negative associations, whereas the DSI only found week negative associations. Furthermore, while the results of the current study indicated differences between ASPD and self-compassion using the two conceptualizations, other PDs did not appear to be impacted. In fact, all PDs, with the exception of NPD that was measured as a single or two distinct disorders, showed similar associations with self-compassion under the both conceptualizations. However, the validity of the PID-5 is widely supported (see Al Dajani

et al., 2016 for a review), while the validity of the DSI is limited due to the novelty of the measure. Therefore, the inconsistency between ASPD conceptualizations should prompt future research into investigating the validity of the DSI. Of note, the Cronbach's alphas for the particular trait facets of the PID-5-SF were found to have poor internal consistencies (i.e, Suspiciousness, Perceptual Dysregulation, Unusual Beliefs and Experiences, Deceitfulness, and Irresponsibility). However, none of the aforementioned traits were predicted to have a particularly strong association with self-compassion.

Furthermore, no clinical samples were utilized in the study. Therefore, the potential range restriction at the more pathological ends of the domains is another limitation. Future directions should include a possible replication of the study in clinical samples to account for the more extreme expressions of pathological trait domains. In addition, the utilization of self-report measures in the current study was another potential limitation. The use of multi-method assessments that include behavioral indicators and interview rated data, along with self-report, would be beneficial in understanding these relationships in the future and should be considered for future research. Lastly, despite past research suggesting interchangeability between empathy and compassion, the results found that self-compassion had stronger associations with the element of identity than empathy, suggesting self-empathy and self-compassion may not by synonymous. Therefore, future investigations can further explore the associations between self-compassion and empathy compared with self-compassion and identity.

REFERENCES

Al-Dajani, N., Gralnick, T. M., & Bagby, R. M. (2016). A psychometric review of the Personality Inventory for *DSM-5* (PID-5): Current status and future directions. *Journal of Personality Assessment, 98*(1), 62–81.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author

Bernstein, D. P., Iscan, C., & Maser, J. (2007). Opinions of Personality Disorder Experts Regarding TheDSM-IVPersonality Disorders Classification System. *Journal of Personality Disorders,21*(5), 536-551. doi:10.1521/pedi.2007.21.5.536

Black, D. M. (2004). Sympathy reconfigured: Some reflections on sympathy, empathy and the discovery of values. The International Journal of Psychoanalysis, 85(3), 579–596.

Boland, J. K., Damnjanovic, T., & Anderson, J. L. (2018). Evaluating the role of functional impairment in personality psychopathology. *Psychiatry Research.* doi:10.1016/j.psychres.2018.03.049

Clark, L. A. (2007). Assessment and diagnosis of personality disorder: Perennial issues and emerging conceptualization. *Annual Review of Psychology, 58,* 227–258.

Dziòbek, I., Preissler, S., Grozdanovic, Z., Heuser, I., Heekeren, H. R., & Roepke, S. (2011). Neuronal correlates of altered empathy and social cognition in borderline personality disorder. *NeuroImage, 57,* 539–548. http://dx.doi.org/10.1016/j.neuroimage.2011.05.005

Erdfelder, E., Faul, F., &Buchner, A. (1996). GPOWER: A general power analysis program.*Behavior Research Methods, Instruments, & Computers*,28, 1–11.

Goetz, J. L., Keltner, D., & Simon-Thomas, E. (2010). Compassion: An evolutionary

    analysis and empirical review. Psychological Bulletin, 136, 351–374.[SEP]

Gramzow, R., & Tangney, J. P. (1992). Proneness to shame and the narcissistic

    personality. *Personality and Social Psychology Bulletin*, *18*, 369–376.

    doi:10.1177/0146167292183014

Gratz, K. L., Rosenthal, M. Z., Tull, M. T., Lejeuz, C. W., & Gunderson, J. G. (2006). An

    experimental investigation of emotion dysregulation in borderline personality

    disorder. *Journal of Abnormal Psychology*, *115*, 850–855. doi:10.1037/0021-

    843X.115.4.850

    Graziano, W., Habashi, M., Sheese, B., & Tobin, R. (2007). Agreeableness,

    empathy, and helping: A person × situation perspective. *Journal of Personality*

    and Social Psychology, 93, 583-599.[SEP]

Hepp, J., Lane, S. P., Carpenter, R. W., Niedtfeld, I., Brown, W. C., & Trull, T. J. (2017).

    Interpersonal problems and negative affect in borderline personality and

    depressive disorders in daily life. *Clinical Psychological Science*, *5*, 470–484.

    10.1177/2167702616677312

 Hepp, Lane, Wycoff, Carpenter,Trull (2018) Interpersonal stressors and negative affect

    in individuals with borderline personality disorder and community adults in daily

    life: A replication and extension *Journal of Abnormal Psychology, 127* (2),

    pp. 183-189

Jeung, H., & Herpertz, S. C. (2014). Impairments of Interpersonal Functioning: Empathy

    and Intimacy in Borderline Personality Disorder. *Psychopathology,47*(4), 220-

    234. doi:10.1159/000357191

Kramer, U., Pascual-Leone, A., Rohde, K. B., & Sachse, R. (2017). The role of shame
and self-compassion in psychotherapy for narcissistic personality disorder: An
exploratory study. *Clinical Psychology & Psychotherapy,25*(2), 272-282.
doi:10.1002/cpp.2160

Krusemark, E. A., Campbell, W. K., Crowe, M. L., & Miller, J. D. (2018). Comparing
self-report measures of grandiose narcissism, vulnerable narcissism, and
narcissistic personality disorder in a male offender sample. *Psychological
Assessment, 30*(7), 984-990.

Levine, D., Marziali, E., & Hood, J. (1997). Emotional processing in borderline
personality disorder. *Journal of Nerv- ous and Mental Disease, 185*, 240– 246.

Lucre, K. M., & Corten, N. (2013). An exploration of group compassion-focused therapy
for personality disorder. Psychology and Psychotherapy, 86(4), 387–400.
doi:10.1111/j.2044-8341.2012.02068.x

Luo, X., Qiao, L., & Che, X. (2018). Self-compassion Modulates Heart Rate Variability
and Negative Affect to Experimentally Induced Stress. *Mindfulness,9*(5), 1522-
1528. doi:10.1007/s12671-018-0900-9

McClure, M.M., Harvey, P.D., Bowie, C.R., Iacoviello, B., Siever, L.J., 2013. Functional
outcomes, functional capacity, and cognitive impairment in schizotypal
personality disorder. Schizophr. Res. 144 (1), 146–150.

McGurk, S.R., Mueser, K.T., Mischel, R., Adams, R., Harvey, P.D., McClure, M.M., et
al., 2013. Vocational functioning in schizotypal and paranoid personality
disorders. Psychiatry Res 210 (2), 498–504.

Miller, J. D., & Campbell, W. K. (2008). Comparing clinical and social-personality conceptualizations of narcissism. *Journal of Personality*, *76*, 449–476. doi:10.1111/j.1467-6494.2008.00492

Miller, J. D., Gentile, B., Wilson, L., & Campbell, W. K. (2013). Grandiose and vulnerable narcissism and the *DSM-5* pathological personality trait model. *Journal of Personality Assessment*, *95*, 284–290. doi:10.1080/00223891.2012.685907

Miller, J. D., & Lynam, D. (2001). Structural models of personality and their relation to antisocial behavior: A meta-analytic review. *Criminol- ogy, 39,* 765–798.

Miller, J.D., Maples, J., 2011. Trait Personality Models of Narcissistic Personality Disorder, Grandiose Narcissism, and Vulnerable Narcissism, in the Handbook of Narcissism and Narcissistic Personality Disorder: Theoretical Approaches, Empirical Findings, and Treatments. In: Campbell, W.K., Miller, J.D. (Eds.), Hoboken, New Jersey. http://dx.doi.org/10.1002/9781118093108.ch7.

Morey, L. C. (2017). Development and initial evaluation of a self-report form of the DSM–5 Level of Personality Functioning Scale. *Psychological Assessment, 29*(10), 1302-1308.

Morley, R. H. (2017). The Impact of Mindfulness Meditation and Self-Compassion on Criminal Impulsivity in a Prisoner Sample. *Journal of Police and Criminal Psychology,33*(2), 118-122. doi:10.1007/s11896-017-9239-8

Mulay, A. L., Cain, N. M., Waugh, M. H., Hopwood, C. J., Adler, J. M., Garcia, D. J., ... Skadberg, R. (2018). Personality constructs and paradigms in the Alternative

DSM-5 Model of Personality Disorder. Journal of Personality Assessment, 100, 593–602.

Neff, K. D. (2003a). Development and validation of a scale to measure self-compassiom. Self and Identity, 2, 223–250.⌷

Neff, K. D., Hseih, Y., & Dejitthirat, K. (2005). Self-compassion, achievement goals, and coping with academic failure. Self and Identity, 4, 263–287.⌷

Neff, K. D., & Pommier, E. (2013). The Relationship between Self-compassion and Other-focused Concern among College Undergraduates, Community Adults, and Practicing Meditators. *Self and Identity,12*(2), 160-176.

Neff, K. D. (2016a). The Self-Compassion Scale is a valid and theoretically coherent measure of self-compassion. *Mindfulness, 7,* 264–274. http:// dx.doi.org/10.1007/s12671-015-0479-3 NIMH » Home. (2018). Retrieved from https://www.nimh.nih.gov/index.shtml

Niedtfeld, I. (2017). Experimental investigation of cognitive and affective empathy in borderline personality disorder: Effects of ambiguity in multimodal social information processing. *Psychiatry Research,253*, 58-63. doi:10.1016/j.psychres.2017.03.037

Norén, K., Lindgren, A., Hällström, T., Thormählen, B., Vinnars, B., Wennberg, P., et al., 2007. Psychological distress and functional impairment in patients with personality disorders. Nord. J. Psychiatry 61 (4), 260–270.⌷

Pincus, A. L., & Lukowitsky, M. R. (2010). Pathological narcissism and narcissistic personality disorder. *Annual Review of Clinical Psychology*, *6*, 421–446. doi:10.1146/annurev.clinpsy.121208.131215

Putnam, K. M., & Silk, K. R. (2005). Emotion dysregulation and the development of

    borderline personality disorder. *Devel- opment and Psychopathology, 17,* 899–

    925.

Ritter, K., Dziobek, I., Preißler, S., Rüter, A., Vater, A., Fydrich, T., Roepke, S. (2011).

    Lack of empathy in patients with narcissistic personality disorder. *Psychiatry*

    Research,187(1-2), 241-247. doi:10.1016/j.psychres.2010.09.013

Rivera, A. C. (2014). Mindfulness and self-compassion in relation to borderline

    personality disorder. *Dissertation Abstracts International,74*(12-B), e.

Russ, E., Shedler, J., Bradley, R., & Westen, D. (2008). Refining the construct of

    narcissistic personality disorder: Diagnostic criteria and subtypes. *American*

    Journal of Psychiatry, *165*, 1473–1481. doi:10.1176/appi.ajp.2008.07030376

    Rutan, J.S., Alonso, A., and Groves, J.F., (1988). Understanding defenses in

    group psychotherapy. *International Journal of Group Psychotherapy*, *38*, 4, 459-

    472

Schoenleber, M., & Berenbaum, H. (2010). Shame aversion and shame-proneness in

    Cluster C personality disorders. *Journal of Abnormal Psychology*, *119*, 197–205.

    doi:10.1037/a0017982

Skodol, A.E., Oldham, J.M., Bender, D.S., Dyck, I.R., Stout, R.L., Morey, L.C., et al.,

    2005a. Dimensional representations of DSM-IV personality disorders:

    relationships to functional impairment. Am. J. Psychiatry 162 (10), 1919–1925.

Smith, A. (2006). Cognitive Empathy and Emotional Empathy in Human Behavior and

    Evolution. *The Psychological Record,56*(1), 3-21. doi:10.1007/bf03395534

Tomko, R. L., Trull, T. J., Wood, P. K., & Sher, K. J. (2013). Characteristics of

    Borderline Personality Disorder in a Community Sample: Comorbidity,

    Treatment Utilization, and General Functioning. *Journal of Personality*

    *Disorders,*1-17. doi:10.1521/pedi_2013_27_093

Verheul, R. (2005). Clinical Utility of Dimensional Models for Personality

    Pathology. *Journal of Personality Disorders,19*(3), 283-302.

    doi:10.1521/pedi.2005.19.3.283

Watson, D., Clark, L. A., Chmielewski, M. (2008). Structures of personality and their

    relevance to psychopathology: II. Further articulation of a comprehensive uni ed

    trait structure. *Journal of Personality, 76*, 1545–1586.

Weinstein, Y., Gleason, M. E., & Oltmanns, T. F. (2012). Borderline but not antisocial

    personality disorder symptoms are related to self-reported partner aggression in

    late middle-age. *Journal of Abnormal Psychology, 121,* 692–698.

Widiger, T. A., Cadoret, R., Hare, R., Robins, L., Rutherford, M., Zanarini, M., . . .

    Frances, A. (1996). DSM—IV antisocial personality disorder field trial. *Journal*

    of Abnormal Psychology, 105(1), 3-16.

Widiger, T. A., & Mullins-Sweatt, S. N. (2010). Clinical utility of a dimensional model

    of personality. *Professional Psychology: Research and Practice, 41,* 488–494.

Wilson, S., Stroud, C. B., & Durbin, C. E. (2017). Interpersonal dysfunction in

    personality disorders: A meta-analytic review. *Psychological Bulletin, 143*(7),

    677-734.

Wink, P. (1991). Two faces of narcissism. *Journal of Personality and Social*

    Psychology, *61*, 590–597. doi:10.1037/0022-3514.61.4.590

Wispe, L. (1986). The distinction between sympathy and empathy: To call forth a

    concept, a word is needed. Journal of Personality and Social Psychology, 50(2),

    314–321.

Zanarini, M.C., Frankenburg, F.R., Reich, D.B., Wedig, M.M., Conkey, L.C.,

    Fitzmaurice, G.M., 2015. The course of marriage/sustained cohabitation and

    parenthood among borderline patients followed prospectively for 16 years. J.

    Pers. Disord. 29 (1), 62.

APPENDIX A

Appendix A-1

Pearson Correlations for SCS and AMPD Criterion A: LPFS

	SelfKind_SelfJ	ComHum_Isol	Mindf_Overid	SCS total
LPFS_Identity	**-.60*/-.56***	**-.60*/-.61***	**-.66*/-.58***	**-.67*/-.64***
LPFS_Self-direction	**-.48*/-.38***	**-.48*/-.38***	**-.54*/-.46***	**-.54*/-.44***
LPFS_Empathy	**-.34*/-.29***	**-.37*/-.33***	**-.41*/-.36***	**-.40*/-.36***
LPFS_Intimacy	**-.37*/-.32***	**-.45*/-.38***	**-.47*/-.46***	**-.46*/-.43***
LPFS_Total	**-.51*/-.47***	**-.56*/-.50***	**-.59*/-.57***	**-.59*/-.56***

Note: SelfKind_SelfJ = Self-kindness vs. Self-judgment; ComHum_Isol = Common humanity vs. Isolation; Mindf_Overid = Mindfulness vs. Overidentification); LPFS = Level of Personality Functioning The correlations prior to the slash represent the MTurk sample and the correlations following the slash represent the PerP sample. Significant values are presented in boldface font
* Represent the correlations that met the threshold for the Bonferroni correction

Appendix A-2

Pearson Correlations for SCS and AMPD Criterion B: PID-5-SF

	SelfKind_SelfJ	ComHum_Isol	Mindf_Overid	SCS total
Antagonism	-.07/-.10	-.09/-.10	**-.16/-.17**	**-.12/-.14**
Manipulative	-.01/-.09	-.01/-.03	-.06/-.11	-.04/-.09
Deceitfulness	**-.18/-.19**	**-.21*/-.18**	**-.27*/-.23**	**-.24*/-.22**
Grandiosity	.01/.06	-.02/-.01	-.08/-.08	-.03/-.01
AttentionSeeking	**-.14/-.10**	-.10/-.10	**-.23*/-.20**	**-.17/-.15**
Callousness	**-.12/-.10**	**-.12/-.08**	-.14/-.12	**-.14/-.10**
Detachment	**-.48*/-.51***	**-.46*/-.47***	**-.48*/-.42***	**-.51*/-.52***
Withdrawal	**-.40*/-.43***	**-.37*/-.46***	**-.38*/-.36***	**-.41*/-.46***
IntimacyAvoidance	-.18/-.22	-.17/-.15	-.16/-.14	**-.18/-.19**
Anhedonia	**-.60*/-.52***	**-.58*/-.48***	**-.61*/-.46***	**-.64*/-.54***
Depressivity	**-.53*/-.51***	**-.51*/-.53***	**-.54*/-.47***	**-.57*/-.56***
RestrictAffect	-.03/.18	-.02/.14	-.10/-.01	-.03/.12
Suspiciousness	**-.43*/-.36***	**-.45*/-.37***	**-.46*/-.46***	**-.48*/-.44***
Disinhibition	**-.48*/-.34***	**-.41*/-.29***	**-.52*/-.44***	**-.50*/-.39***
Irresponsibility	**-.31*/-.15**	**-.27*/-.12**	-.34*/-.27	**-.33*/-.19**
Impulsivity	**-.35*/-.26**	**-.28*/-.22**	**-.42*/-.34***	**-.37*/-.30***
Distractibility	**-.50*/-.34***	**-.44*/-.29***	**-.51*/-.41***	**-.52*/-.38***
RiskTaking	-.10/-.05	-.10/-.02	**-.15/-.13**	**-.12/-.07**
RigidPerfect	**.38*/.30***	**.28*/.34***	**.40*/.29***	**.39*/.36***
NegativeAffect	**-.63*/-.51***	**-.57*/-.45***	**-.73*/-.62***	**-.69*/-.58***
EmotionalLability	**-.50*/-.40***	**-.48*/-.37***	**-.64*/-.54***	**-.58*/-.48***
Anxiousness	**-.64*/-.47***	**-.58*/-.45***	**-.69*/-.50***	**-.68*/-.52***

SeparationInsecurity	-.42*/-.40*	-.36*/-.32*	-.50*/-.50*	-.46*/-.44*
Submissiveness	-.45*/-.29*	-.39*/-.27	-.47*/-.26	-.47*/-.31*
Hostility	-.46*/-.36*	-.41*/-.37*	-.57*/-.45*	-.52*/-.43*
Perseverence	-.49*/-.43*	-.48*/-.37*	-.59*/-.44*	-.57*/-.46*
Psychoticism	-.27*/-.15	-.26*/-.19	-.31*/-.12	-.30*/-.18
UnusualBeliefs&				
Experiences	-.14/-.06	-.13/-.09	-.19/-.04	-.17/-.08
Eccentricity	-.32*/-.21	-.30*/-.24	-.34*/-.16	-.34*/-.23
PerceptDysregation	-.21*/.00	-.21*/-.08	-.24*/-.07	-.24*/-.06

Note: SelfKind_SelfJ = Self-kindness vs. Self-judgment; ComHum_Isol = Common humanity vs. Isolation; Mindf_Overid = Mindfulness vs. Overidentification); PID-5-SF = Personality Inventory of DSM-5 Short Form. The correlations prior to the slash represent the MTurk sample and the correlations following the slash represent the PerP sample. Significant values are presented in boldface font
* Represent the correlations that met the threshold for the Bonferroni correction

Appendix A-3

Pearson Correlations for SCS and AMPD Criterion B: Trait Conceptualizations

	SelfKind_SelfJ	ComHum_Isol	Mindf_Overid	SCS total
Trait_ASPD	**-.31*/-.26**	**-.28*/-.23**	**-.39*/-.37***	**-.35*/-.32***
Trait_APD	**-.60*/-.56***	**-.56*/-.53***	**-.61*/-.51***	**-.63*/-.59***
Trait_BPD	**-.61*/-.52***	**-.54*/-.48***	**-.70*/-.62***	**-.66*/-.59***
Trait_GNPD	-.08/-.06	-.07/-.08	**-.19/-.18**	**-.12/-.12**
Trait_VNPD	**-.55*/-.48***	**-.51*/-.47***	**-.66*/-.58***	**-.62*/-.56***
Trait_OCPD	**-.17/-.08**	**-.25*/-.01**	**-.29*/-.16**	**-.25*/-.08**
Trait_SZPD	**-.41*/-.29***	**-.41*/-.34***	**-.47*/-34***	**-.46*/-.36***

Note: SelfKind_SelfJ = Self-kindness vs. Self-judgment; ComHum_Isol = Common humanity vs. Isolation; Mindf_Overid = Mindfulness vs. Overidentification); Trait = PID-5 trait conceptualizations; ASPD = Antisocial PD; APD = Avoidant PD; BPD = Borderline PD; GNPD = Grandiose Narcissistic PD; VNPD = Vulnerable Narcissistic PD; OCPD = Obsessive Compulsive PD; SZPD = Schizotypal PD. The correlations prior to the slash represent the MTurk sample and the correlations following the slash represent the PerP sample. Significant values are presented in boldface font
* Represent the correlations that met the threshold for the Bonferroni correction

Appendix A-4

Pearson Correlations for SCS and DSI

	SelfKind_SelfJ	ComHum_Isol	Mindf_Overid	SCS total
DSI_ASPD	**-.15**/-.08	**-.16**/-.10	**-.19**/-.09	**-.19**/-.10
DSI_APD	**-.55***/**-.57***	**-.54***/**-.52***	**-.57***/**-.50***	**-.59***/**-.58***
DSI_BPD	**-.63***/**-.57***	**-.59***/**-.49***	**-.66***/**-.56***	**-.67***/**-.59***
DSI_NPD	**-.42***/**-.40***	**-.40***/**-.31***	**-.48***/**-.45***	**-.47***/**-.42***
DSI_OCPD	**-.47***/**-.40***	**-.44***/**-.35***	**-.50***/**-.37***	**-.51***/**-.41***
DSI_SZPD	**-.56***/**-.43***	**-.52***/**-.39***	**-.59***/**-.45***	**-.60***/**-.46***

Note: SelfKind_SelfJ = Self-kindness vs. Self-judgment; ComHum_Isol = Common humanity vs. Isolation; Mindf_Overid = Mindfulness vs. Overidentification); DSI = Disorder Specific Impairment; ASPD = Antisocial PD; APD = Avoidant PD; BPD = Borderline PD; NPD = Narcissistic PD; OCPD = Obsessive Compulsive PD; SZPD = Schizotypal PD. The correlations prior to the slash represent the MTurk sample and the correlations following the slash represent the PerP sample. Significant values are presented in boldface font
* Represent the correlations that met the threshold for the Bonferroni correction

APPENDIX B

Appendix B-1

Confidence Intervals for SCS and AMPD Criterion A: LPFS

	SelfKind_SelfJ	ComHum_Isol	Mindf_Overid	SCS total
LPFS_Identity	**-.52--.67*/-.44--.66***	**-.52--.67*/-.50--.70***	**.59--.72*/-.46--.68***	**-.60--.73*/-.54--.72***
LPFS_Self-direction	**-.38--.57*/-.24--.51***	**-.38--.57*/-.24--.51***	**-.45--.62*/-.33--.58***	**-.45--.62*/-.30--.56***
LPFS_Empathy	**-.23--.44*/-.14--.43***	**-.26--.47*/-.18--.46***	**-.35--.50*/-.21--.49***	**-.30--.49*/-.21--.49***
LPFS_Intimacy	**-.23--.44*/-.17--.45***	**-.35--.54*/-.24--.51***	**-.37--.56*/-.33--.58***	**-.36--.55*/-.29--.55***
LPFS_Total	**-.42--.59*/-.34--.48***	**-.47--.64*/-.37--.61***	**-.51--.66*/-.45--.67***	**-.51--.66*/-.44--.66***

Note: SelfKind_SelfJ = Self-kindness vs. Self-judgment; ComHum_Isol = Common humanity vs.
Isolation; Mindf_Overid = Mindfulness vs. Overidentification); LPFS = Level of Personality Functioning
The correlations prior to the slash represent the MTurk sample and the correlations following the slash
represent the PerP sample. Significant values are presented in boldface font
* Represent the correlations that met the threshold for the Bonferroni correction

Appendix B-2

Confidence Intervals for SCS and AMPD Criterion B: PID-5

	SelfKind_SelfJ	ComHum_Isol	Mindf_Overid	SCS total
Antagonism	-.05--.19/.06--.25	.03--.21/.06--.25	**-.04--.27/-.01--.32**	**.00--.23/.02--.29**
Manipulative	.11--.13/.07--.24	.11--.13/.13--.19	.06--.18/.05--.26	.08--.16/.07--.24
Deceitfulness	**-.06--.29/-.03--.34**	**-.09--.32*/-.02--.33**	**-.16--.38*/-.07--.37**	**-.13--.35*/-.06--.36**
Grandiosity	-.11-.13/-.10-.22	.10--.14/.15--.17	.04--.20/.08--.23	.09-.15/.15--.17
AttentionSeek	**-.02--.25/-.06--.25**	.02--.22/.06--.25	**-.22--.34*/-.04--.35**	-.05--.28/.01--.30
Callousness	**.00--.23/.06--.25**	**.00--.23/.08-.23**	-.02--.25/.04--.27	-.02--.25/.06--.25
Detachment	**-.38--.57*/-.38--.62***	**-.36--.55*/-.34--.48***	**-.38--.57*/-.28--.54***	**-.42--.59*/-.39--.63***
Withdrawal	**-.30--.49*/-.29--.55***	**-.23--.44*/-.33--.58***	**-.27--.48*/-.21--.49***	**-.31--.50*/-.33--.58***
IntimacyAvoid	**-.06--.29/-.06--.36**	**-.05--.28/.01--.30**	-.27--.04/.02--.29	**-.06--.29/-.03--.34**
Anhedonia	**-.52--.67*/-.39--.63***	**-.50--.65*/-.35--.59***	**-.53--.68*/-.33--.58***	**-.56--.70*/-.42--.64***
Depressivity	**-.44--.61*/-.38--.62***	**-.42--.59*/-.41--.63***	**-.45--.62*/-.34--.48***	**-.48--.64*/-.44--.66***
RestrictAffect	.09--.15/**.02-.33**	.10--.14/-.02-.29	.02--.22/.15--.17	.09--.15/-.04-.27
Suspiciousness	**-.33--.52*/-.21--.49***	**-.35--.54*/-.23--.50***	**-.36--.55*/-.33--.58***	**-.38--.57*/-.30--.56***
Disinhibition	**-.38--.57*/-.19--.47***	**-.31--.50*/-.14--.43***	**-.43--.60*/-.30--.56***	**-.41--.58*/-.25--.52***
Irresponsibility	**-.20--.41*/.01--.30**	**-.16--.38*/.04--.27**	**-.23--.44*/-.12--.41**	**-.22--.43*/-.03--.34**
Impulsivity	**-.24--.45*/-.11--.40**	**-.17--.38*/-.06--.36**	**-.32--.51*/-.19--.47**	**-.23--.44*/-.15--.44***
Distractibility	**-.41--.58*/-.19--.47***	**-.34--.53*/-.14--.43***	**-.42--.59*/-.27--.53***	**-.43--.60*/-.24--.51***
RiskTaking	.02--.22/.11--.21	.02--.22/.14--.18	-.03--.26/.03--.28	**.00-.23/.09--.23**
RigidPerfect	**.27--.48*/.15-.44***	**.17-.38*/.19--.47***	**.30-.49*/.14-.43***	**-.29--.49*/.21-.49***
NegativeAffect	**-.55--.70*/-.38--.62***	**-.48--.64*/-.31--.57***	**-.67--.78*/-.51--.71***	**-.62--.75*/-.46--.68***
EmotionalLabil	**-.41--.58*/-.26--.52***	**-.38--.57*/-.23--.50***	**-.56--.70*/-.42--.64***	**-.50--.65*/-.35--.59***
Anxiousness	**-.56--.70*/-.38--.48***	**-.50--.65*/-.31--.57***	**-.62--.75*/-.37--.61***	**-.61--.74*/-.39--.63***

SeparInsecur	-.32--.51*/-.26--.52*	-.25--.46*/-.17--.45*	-.41--.58*/-.37--.61*	-.36--.55*/-.30--.56*
Submissiven	-.35--.54*/-.14--.43*	-.29--.49*/-.12--.41	-.37--.56*/-.11--.40	-.37--.56*/-.16--.45*
Hostility	-.36--.55*/-.21--.49*	-.31--.50*/-.23--.50*	-.48--.64*/-.31--.57*	-.43--.60*/-.29--.55*
Perseverence	-.39--.57*/-.29--.55*	-.38--.57*/-.23--.50*	-.51--.66*/-.30--.56*	-.48--.64*/-.33--.58*
Psychoticism	-.16--.38*/.01--.30	-.15--.37*/-.03--.34	-.20--.41*/.04--.27	-.19--.40*/-.02--.33
UnusBel&Exp	-.02--.25/.10--.22	-.01--.24/.07--.24	-.07--.30/.12--.20	-.05--.28/.08--.23
Eccentricity	-.21--.42*/-.05--.36	-.19--.40*/-.09--.38	-.23--.44*/.00--.31	-.23--.44*/-.07--.37
PerceptDysreg	-.09--.32*/-.16-.16	-.09--.32*/.08--.23	-.13--.35*/.09--.23	-.13--.35*/.10--.22

Note: SelfKind_SelfJ = Self-kindness vs. Self-judgment; ComHum_Isol = Common humanity vs.
Isolation; Mindf_Overid = Mindfulness vs. Overidentification); PID-5-SF = Personality Inventory of
DSM-5 Short Form. The correlations prior to the slash represent the MTurk sample and the correlations
following the slash represent the PerP sample. Significant values are presented in boldface font
* Represent the correlations that met the threshold for the Bonferroni correction

Appendix B-3

Confidence Intervals for SCS and AMPD Criterion B: Trait Conceptualizations

	SelfKind_SelfJ	ComHum_Isol	Mindf_Overid	SCS total
Trait_ASPD	**-.20--.41*/-.11--.40**	**-.17--.38*/-.07--.37**	**-.29--.49*/-.23--.50***	**-.24--.45*/-.17--.45***
Trait_APD	**-.52--.67*/-.44--.66***	**-.47--.64*/-.41--.63***	**-.53--.68*/-.38--.62***	**-.55--.70*/-.48--.68***
Trait_BPD	**-.53--.68*/-.39--.63***	**-.45--.62*/-.35--.59***	**-.63--.76*/-.51--.71***	**-.59--.72*/-.48--.68***
Trait_GNPD	.04--.20/.10-.22	-.05--.19/.08--.23	**-.07--.30/-.02--.33**	**.00--.23/.04--.27**
Trait_VNPD	**-.46--.63*/-.35--.59***	**-.42--.59*/-.34--.48***	**-.59--.72*/-.46--.68***	**-.54--.69*/-.44--.66***
Trait_OCPD	**-.05--.28/.08--.23**	**-.14--.36*/.15--.17**	**-.18--.39*/.00--.31**	**-.14--.36*/.08--.23**
Trait_SZPD	**-.31--.50*/-.14--.43***	**-.31--.50*/-.19--.47***	**-.37--.56*/-.19--.47***	**-.36--.55*/-.21--.49***

Note: SelfKind_SelfJ = Self-kindness vs. Self-judgment; ComHum_Isol = Common humanity vs. Isolation; Mindf_Overid = Mindfulness vs. Overidentification); Trait = PID-5 trait conceptualizations; ASPD = Antisocial PD; APD = Avoidant PD; BPD = Borderline PD; GNPD = Grandiose Narcissistic PD; VNPD = Vulnerable Narcissistic PD; OCPD = Obsessive Compulsive PD; SZPD = Schizotypal PD. The correlations prior to the slash represent the MTurk sample and the correlations following the slash represent the PerP sample. Significant values are presented in boldface font
* Represent the correlations that met the threshold for the Bonferroni correction

Appendix B-4

Confidence for SCS and DSI

	SelfKind_SelfJ	ComHum_Isol	Mindf_Overid	SCS total
DSI_ASPD	-.03--.26/.08--.23	-.04--.27/.06--.25	-.07--.30/.07--.24	-.07--.30/.06--.25
DSI_APD	**-.46--.63*/-.45--.67***	**-.45--.62*/-.39--.63***	**-.48--.64*/-.37--.61***	**-.51--.66*/-.46--.68***
DSI_BPD	**-.55--.70*/-.45--.67***	**-.51--.66*/-.36--.60***	**-.59--.72*/-.44--.66***	**-.60--.73*/-.48--.68***
DSI_NPD	**-.32--.51*/-.26--.52***	**-.30--.49*/-.16--.45***	**-.38--.57*/-.31--.57***	**-.37--.56*/-.28--.54***
DSI_OCPD	**-.37--.56*/-.26--.52***	**-.34--.53*/-.20--.48***	**-.41--.58*/-.23--.50***	**-.42--.59*/-.27--.53***
DSI_SZPD	**-.47--.64*/-.29--.55***	**-.43--.60*/-.25--.52***	**-.51--.66*/-.31--.57***	**-.52--.67*/-.33--.58***

Note: SelfKind_SelfJ = Self-kindness vs. Self-judgment; ComHum_Isol = Common humanity vs. Isolation; Mindf_Overid = Mindfulness vs. Overidentification); DSI = Disorder Specific Impairment; ASPD = Antisocial PD; APD = Avoidant PD; BPD = Borderline PD; NPD = Narcissistic PD; OCPD = Obsessive Compulsive PD; SZPD = Schizotypal PD. The correlations prior to the slash represent the MTurk sample and the correlations following the slash represent the PerP sample. Significant values are presented in boldface font
* Represent the correlations that met the threshold for the Bonferroni correction

VITA

Emily B. Sorem_____

Sam Houston State University

EDUCATION_____

Sam Houston State University, Huntsville, Texas

Master of Arts Clinical Psychology Candidate, May 2020

GPA: 4.0

Presentations: Sorem, E., Priebe, K., Anderson, J. (2020, March) Paper presentation for Society of Personality Assessment Conference, San Diego, CA.

Grants: Society for Personality Assessment (December 2018) – Principal Investigator, *The Role of Self-Compassion in Personality Psychopathology*

Texas A&M University, College Station, Texas

Bachelor of Science, Psychology, *Cum Laude,* December 2016

GPA (Last 2 years): 3.88   **Overall GPA:** 3.62

Presentations: Sorem, E., Beauchamp, K., Peterson, T., & Adams, J. (2015, August). Poster presented at Elementary Statistics for Psychology research symposium, College Station, TX.

INTERNSHIPS_____

Texas Department of Criminal Justice – Ellis Unit, Huntsville, Texas (September 2019 – November 2019)

- Observed mental health evaluations (i.e., personality assessments, suicide risk assessments, offender protection investigations, etc.)

WORKHISTORY

Graduate Writing Tutor – Academic Success Center SHSU (August 2019-present)

- Conducted individualized tutoring in-person and online using Zoom

- Created reports summarizing and documenting tutoring sessions

High School Art Teacher – Eisenhower High School (September 2017- June 2018)

- Created lesson plans and incorporated accommodations for SPED, 504s, and ELLs

- Created a safe and inclusive environment for all students, while being mindful to each students' individual and cultural backgrounds

RESEARCHEXPERIENCE

Dr. Jaime Anderson's Assessment of Personality Psychopathology Lab (September 2018-Present)

- Applied for Society of Personality Assessment (SPA) student research grant; conducted thesis research

Dr. Heather Lench's Emotion Science Research (May 2015-December 2016)

- Proctored studies, coded responses to research questions, and supervised research assistants

- Performed literature reviews for studies and organized relevant articles

- Completed SONA ethics training in human subjects research and obtaining IRB approval

Dr. Brandon Schmeichel's Social Psychology Lab (May 2015-September 2015)

- Proctored studies, coded responses to research questions, as well as did research database entry development and management

PROFESSIONALSERVICE

Organized and hosted the TAMU Psi Chi International Honor Society's Induction

Ceremony (May 2016); Helped organize a panel of Psychology graduate students to

describe their experiences with graduate-level education (February 2016); Orchestrated

fundraising efforts and was a team captain for the American Alzheimer's Association

(October 2015)

AWARDS&HONORS

Psi Chi International Honor Society in Psychology (2015); Elected vice president in

Psychology Club, (2016); Elected Psi Chi International Honor Society chair (2016)