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The indirect effect of social support on post-trauma psychopathology via self-compassion

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ABSTRACT

Following a traumatic event, external resources such as social support facilitate recovery. The mechanism underlying this relation is not well understood, however. Self-compassion is a positive coping strategy that has been negatively related to post-trauma psychopathology in prior work. It was hypothesized that the external resource of social support increased the internal resource of self-compassion, which resulted in decreased psychopathology. The current study tested the hypothesis that the association between social support and posttraumatic stress disorder (PTSD), generalized anxiety disorder (GAD), and depression symptoms had an indirect pathway via self-compassion. Using a community sample of individuals exposed to potentially traumatic events, social support was positively related to self-compassion. Self-compassion was negatively related to PTSD, GAD, and depression symptoms. Self-compassion mediated the relation between social support and PTSD, GAD, and depression symptoms. These results suggest that social support may reduce symptoms of PTSD, GAD, and depression through increased self-compassion in those who experienced a trauma.

1. Introduction

Exposure to potentially traumatic events (PTEs) is associated with increased risk for psychopathology including posttraumatic stress disorder (PTSD; Zatzick et al., 2007), depression (Elhai, Contractor, Palmieri, Forbes, & Richardson, 2011), and generalized anxiety disorder (GAD; Grant, Beck, Marques, Palyo, & Clapp, 2008). Not all individuals exposed to a PTE develop psychopathology, however. Several models provide a theoretical framework for the different post-trauma outcomes. The emotion processing theory proposes that limited processing of the PTE results in elevated psychopathology (Foa & Kozak, 1986). Cognitive models suggest that maladaptive interpretations of PTEs results in a persistent belief that one is under threat. This sustained belief results in negative outcomes (Ehlers & Clark, 2000).The conservation of resources model proposes that psychological health is a function of the retention of resources, broadly defined as variables that an individual values, such as mastery of a skillset, self-esteem, and professional roles (Hobfoll, 1989). PTEs deplete resources, which results in psychopathology. Each of these models proposes that exposure to PTEs alters internal processes that increase vulnerability to psychopathology.

Considerable evidence supports social support, an external process, as a protective factor against post-PTE psychopathology (Brewin, Andrews, & Valentine, 2000; Neria, Besser, Kiper, & Westphal, 2010; Ozer, Best, Lipsey, & Weiss, 2003). Defined as the provision of empathy and care by others (Ullman & Filipas, 2001), social support was negatively related to PTSD symptoms in combat veterans (Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009), natural disaster survivors (Feder et al., 2013), and women with histories of childhood abuse and intimate partner abuse (Schumm, Briggs-Phillips, & Hobfoll, 2006). Elevated social support was associated with reduced symptoms of PTSD, GAD, and depression for civilians in warzones (Mugisha, Muyinda, Malamba, & Kinyanda, 2015; Neria et al., 2010) and in samples of individuals exposed to a range of PTEs (Kwako, Szanton, Saligan, & Gill, 2011; Lian et al., 2014).

The precise mechanism by which social support protects against pathology, however, is unknown. The quality of social support is presumed to influence internal perceptions of the individual, which in turn reduces psychopathology. That is, negative social interactions increase negative self-perceptions whereas positive support increases positive self-perceptions. Victims of interpersonal traumas who experienced negative social reactions (e.g. blaming the victim) reported greater shame and PTSD symptoms than those who had positive social interactions (Turner, Bernard, Birchwood, Jackson, & Jones, 2013; Ullman, Townsend, Filipas, & Starzynski, 2007). Thus, poor social support may promote maladaptive internal perceptions about the event, which results in psychopathology. It is posited that improved social support would improve internal perceptions, which then reduces psychopathology.

An internal resource that is a protective factor against psychopathology is self-compassion. Self-compassion is conceptualized as the experience of supporting oneself during difficult times, which closely mirrors the benefit of social support. Self-compassion involves three

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distinct elements: being kind and understanding towards oneself in times of difficulty, being mindfully aware of painful thoughts and feelings to prevent over-identification with problematic emotions, and seeing one's struggles as part of a broader human experience (Neff, 2004). Self-compassion is positively associated with life satisfaction, emotional intelligence, and social connectedness in healthy adults (Neff, 2004). Self-compassion was negatively related to depressive symptoms and anxiety symptoms in community (Neff, 2003) and clinical samples (Krieger, Altenstein, Baettig, Doerig, & Holtforth, 2013). Higher self-compassion is also associated with less social anxiety (Werner et al., 2012).

Self-compassion may protect against post-PTE psychopathology. In a sample of children who witnessed a fire, those with high self-compassion showed lower depressive, suicidal, PTSD, and panic symptoms relative to those with low self-compassion (Zeller, Yuval, Nitzan-Assayag, & Bernstein, 2014). In a similar study, adults with a history of child maltreatment and low self-compassion had greater psychological distress, problematic alcohol use, and increased suicidality compared to those with high self-compassion (Tanaka, Wekerle, Schmuck, & Paglia-Boak, 2011). Disorder specific psychopathology was not assessed in this study, however. Self-compassion was negatively related to symptoms of avoidance but not re-experiencing, hyperarousal, or overall PTSD scores in a large sample of undergraduates with a history of PTE exposure (Thompson & Waltz, 2008). Finally, self-compassion was negatively related to PTSD symptoms after controlling for psychological inflexibility in a large undergraduate sample (Seligowski, Miron, & Orcutt, 2014).

The kindness offered in positive social interactions mirrors the kindness offered to oneself in self-compassionate individuals. The emphasis of self-compassion on experiencing suffering as part of humanity relates to the feelings of inclusion and community imparted from social support. Using the emotion processing theory, social support may allow for processing of the event in a manner that promotes self-compassion and thus symptom reduction. Within the cognitive model, social support may present the individual with alternate interpretations of the event that promote self-compassion and reduce symptoms. Consistent with the conservation of resources model, social support is an external resource that may increase the internal resource of self-compassion to protect against psychopathology after a PTE. Thus, social support and self-compassion are hypothesized to be part of a broader resilience process.

The present study examined self-compassion as a pathway by which social support is associated with psychopathology in a community sample of individuals exposed to a PTE. It was hypothesized that self-compassion was negatively related to PTSD, GAD, and depression symptoms in adults with a history of PTEs. Self-compassion was hypothesized to be positively associated with social support. Finally, it was hypothesized that self-compassion would account for a significant portion of the relation between social support and PTSD, GAD, and depression symptoms. Relevant covariates such as gender, age, racial/ethnic status, income level, and exposure to multiple types of trauma were included in the analysis. Additional relations concerning PTSD symptom clusters were explored as indicated by relevant prior literature.

2. Methods

2.1. Participants

Participants (N = 599) were recruited through an online crowdsourcing platform (Amazon's Mechanical Turk). This methodology offers several advantages over other survey recruitment methods including access to an ethnically diverse sample, efficient use of financial compensation, and added confidentiality (Paolacci, Chandler, & Ipeirotis, 2010). Recent work has demonstrated that samples with significant levels of psychopathology can be recruited via this method (Shapiro, Chandler, & Mueller, 2013). Participants were compensated for their time.

Participants were required to have experienced a Criterion A traumatic event to be included in the study. Demographic information is reported in Table 1.

2.2. Measures

2.2.1. Life Events Checklist-5 (LEC-5; Weathers, Blake, Schnurr, Kaloupe, Marx, & Keane, 2013)

The LEC-5 is a 17-item self-report measure that assesses exposure to 16 potentially traumatic events across the lifespan. For each event, participants indicated if they experienced the event personally, witnessed it, learned about it, experienced it as part of their job, were unsure if they experienced the event, or felt the event did not apply. A count of the number of types of traumas that each individual had direct exposure to or witnessed in person was calculated (Table 2). The extended form was used in which participants provided additional details about the most difficult trauma. The LEC was keyed to the DSM 5 and the worst event, as chosen by the participant, was described if multiple events were endorsed.

2.2.2. PTSD Checklist-5 (PCL-5; Weathers, Litz, Keane, Palmieri, Marx, & Schnurr, 2013)

The PCL-5 is a 20-item self-report measure that assesses PTSD symptoms in the last month according to the DSM 5 criteria. Items assess symptoms across the 4 clusters of PTSD (re-experiencing, numbing, avoidance, and hyperarousal) on a 0 to 4 Likert scale. For participants who experienced multiple PTEs, the PCL-5 questionnaire was completed for the most significant PTE. Total scores range from 0 to 80. Internal consistency for the for the present sample was excellent with $\alpha = 0.95$.

Table 1
Sample demographic statistics.

	n	%
Race and ethnicity		
African American	40	6.7
American Indian or Native Alaskan	12	2.0
Asian	69	11.5
Hispanic	45	7.5
Pacific Islander	3	0.5
White	418	69.8
Other	12	2.0
Female	301	50.3
Income		
<$25,000	161	26.9
$25,001–$50,000	204	34.1
$50,001–$75,000	117	19.5
$75,001–100,000	62	10.4
>$100,001	48	8.0
Did not disclose	7	1.2
Education		
High school diploma or GED	69	11.5
1–2 years of college	184	30.7
Completed college	232	38.7
Some graduate school	36	6.0
Masters degree	59	9.8
Advanced degree	10	1.7
Did not disclose	9	1.5
Employment		
Fulltime	330	5.1
Parttime	71	11.9
Student	52	8.7
Unemployed	60	10.0
Retired/disabled	10	1.6
Other	47	7.8
Did not disclose	29	4.8
Age (M, SD)	34.08	10.99