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A Thesis Examining Bullying Victimisation and Compassion: Systematic Review and Empirical Study

by

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Abstract

The first chapter comprises a systematic review to examine if self-compassion (SC) plays a moderating or mediating role in the relationship between bullying victimisation (BV) and anxiety and depression for adolescents. A comprehensive literature search identified six studies which met the inclusion/exclusion criteria. SC was found to mediate the relationship between BV and depression. Moderation-based studies showed mixed results regarding SC moderating the relationship between BV and anxiety and depression. However, identified a consistent moderating effect of SC when levels of SC were high. Despite the papers' limitations and the need for more research in this area, the review highlights the potential protective role SC can play for adolescents who have experienced BV and the importance of routinely assessing SC and considering SC interventions for this population.

Next, the empirical study aimed to investigate how the three flows of compassion (SC, compassion to others [CtO] and compassion from others [CfO]), inhibitors (self-criticism, shame, fears of compassion) and facilitators of compassion (self-reassurance [SR]), and early memories of warmth and safeness [EMWS]), present in adults who did and did not experience bullying in secondary school. A total of 383 participants completed self-report measures online. Independent between subject t-tests were conducted to assess differences in variables between victims of bullying (VB) and non-victims of bullying (NVB). Compared to NVB, VB had significantly lower levels of CfO and facilitators of compassion, and significantly higher levels of the inhibitors of compassion and anxiety and depression. No differences between groups were found for SC and CtO. Exploratory hierarchical linear regressions for VB and NVB identified predictor variables for each of the three flows of compassion. SR was identified as the strongest predictor of SC for both VB and NVB. The findings tentatively support the need for clinical assessments to include the measurement of the three flows of compassion, together with the inhibitors and facilitators of compassion to allow interventions to be tailored to meet the needs of individuals who have been bullied.

The final chapter provides an in-depth exploration and critique of the measurement of BV for children and adolescents. The following inconsistencies across BV measures are discussed: the presence or absence of a definition of bullying; terminology used; forms of bullying assessed; timeframes of reporting; and if assessment solely relies on self-reporting or if other views are utilised. The identified inconsistences result in several methodological challenges. Prevalence rates of BV vary dramatically, thereby preventing accurate assessment and monitoring of the problem, and evaluation of interventions. Heterogeneity of measures make it difficult to compare findings and carry out systematic reviews and meta-analyses. Lack of a consistent, inclusive and consistently used bullying definition, and variation in the construct being measured reduce the validity of measures, making it challenging to draw reliable conclusions. Future research would benefit from focusing on the identified areas to standardise assessment of BV to strengthen the validity and reliability of measurement tools in the field. A standardised measurement of BV may increase the accuracy of prevalence rates and allow appropriate interventions to be developed and evaluated.

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Research Thesis: Declaration of Authorship

Print name: Lauren Hewitt

Title of thesis: A Thesis Examining Bullying Victimisation and Compassion: Systematic Review and Empirical Study

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before

Signature: ..... Date:

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Definitions and Abbreviations

BAI ..... Beck Anxiety Inventory

BV ..... Bullying victimisation

CBI..... Cyberbullying Inventory

CDI ..... The Children's Depression Inventory

CEAS..... Compassionate Engagement and Action Scale

CESD ..... The Centre for Epidemiologic Studies Depression Scale

CfO..... Compassion from Others

CFT..... Compassion Focused Therapy

CtO..... Compassion to Others

DAS ..... Depression Anxiety Stress Scale

EISS ..... External Internal Shame Scale

EMWS..... Early Memories of Warmth and Safeness

EMWSS ..... Early Memories of Warmth and Safeness Scale

ERGO..... Ethics and Research Governance

FoCfO..... Fear of Compassion from others

FOCS ..... Fear of Compassion Scale

FoCtO..... Fear of Compassion to others

FOCtS..... Fear of Compassion to self

FSC/RS..... Forms of Self-Criticising/Attacking and Self-Reassurance Scale

GAD7..... Generalised Anxiety Disorder 7

HS..... Hated self

IS..... Inadequate Self

ITD ..... The Interpersonal Theory of Depression

MPVS ..... Multidimensional Peer Victimisation Scale

PHQ9..... Patient Health Questionnaire 9

PPI..... Patient and Public Involvement

PRISMA..... Preferred Reporting Items for Systematic Reviews and Meta-Analysis

PROSPERO..... Prospective Register for Systematic Reviews

SC..... Self-Compassion

SCS..... Self-Compassion Scale

SCS-SF..... Self-Compassion Scale Short Form

SMT..... Social Mentality Theory

(S)PANAS-CA..... Spanish version of the Positive Affect and Negative Affect for Children and Adolescents

SQAC..... The Standard Quality Assessment Criteria for Evaluating Primary Research Papers from a Variety of Fields

SR..... Self-reassurance

SWiM..... Synthesis Without Meta-analysis

NVB..... Non-Victims of Bullying

R-BDI..... Revised Beck Depression Inventory

RBQ..... Retrospective Bullying Questionnaire

RBQ-M..... Retrospective Bullying Questionnaire Modified

REQ..... Recency Effects Question

ROBQV..... Revised Olweus Bully/Victim Questionnaire

UOBS..... University of Illinois Bullying Scale

VB..... Victims of bullying

A Thesis Examining Bullying Victimisation and Compassion: Systematic Review and Empirical Study

Chapter 1: A Systematic Review to Examine the Role of Self-Compassion on Depression and Anxiety for Adolescents who Have Been the Victim of Peer Bullying

Journal Specification: The British Journal of Psychology was chosen to guide this systematic review. The author guidelines (see Appendix A) identify papers should be no more than 8000 words (excluding the abstract, reference list, tables and figures). The journal uses APA reference style.

Word count: 7928

Abstract

Experiencing bullying victimisation (BV) in adolescence is a significant risk factor for anxiety and depression. Self-compassion (SC) is known to be negatively associated with such emotions for young people. With this in mind, this review aimed to explore if SC plays a moderating or mediating role in the relationship between BV and anxiety and depression for adolescents. In line with PRISMA guidelines, a systematic search of PsychINFO, CINAHL, MEDLINE, Web of Science Core Collection and ProQuest was conducted identifying six studies which met the inclusion exclusion/criteria. Mediation-based research indicated that SC mediated the relationship between BV and increased depression. Moderation-based studies showed mixed results regarding an overall moderation effect of SC, which requires further exploration. However, identified a consistent moderating effect when SC levels were high. Despite the papers' limitations and the need for more research in this area, the review highlights the potential protective role SC can play for adolescents who have experienced BV and the importance of routinely assessing SC and considering SC interventions for this population.

Keywords: Self-Compassion, bullying, peer-victimisation, adolescents, depression, anxiety.

Introduction

BV in adolescents

BV, referring to the experience of being a victim of bullying, is a significant health issue negatively affecting young people globally (Biswas et al., 2020). Bullying occurs across age groups, ethnicity, gender, socioeconomic status, and culture (Craig et al., 2009; Sittichai & Smith, 2015; Tippett & Wolke, 2014) and is characterised by repeated intentional hurtful behaviours, with an imbalance of power in the bully victim dynamic (Wolke & Lereya, 2015). The focus of this review is peer bullying, which can take several forms and be categorised into direct (e.g., verbal abuse, physical violence, having property damaged or stolen) and indirect abuse (e.g., being ignored, excluded, having rumours spread about you) (Schäfer et al., 2004). Bullying can take place face to face or online, with estimates of a third of 10 to 15-year-olds in England and Wales being affected each year (Office for National Statistics, 2024). Global rates of bullying range from affecting 8.4% of adolescents in Europe to 45% in Africa and the Eastern Mediterranean region (Biswas et al., 2020). However, the complex nature of the phenomenon, contextual and cultural variances (Cook et al., 2009), and inconsistent measurement approaches make data on bullying difficult to compare (Thomas et al., 2015; Vivolo-Kantor et al., 2014).

The process of bullying can be theorised using individual and system-level frameworks. The latter acknowledges the influence of social systems on individuals' behaviour, suggesting bullying behaviours are shaped by environment and are encouraged or deterred by complex reciprocal interactions within and across social systems (Cross & Barnes, 2014; Olweus, 1993; Espelage & Swearer, 2011; Swearer & Hymel, 2015). Peer interactions play a key role in a young person's social system and increase in significance and influence as they grow older (Sun et al., 2019). BV signifies issues in the social network, which can cause a ripple effect disrupting multiple areas of life (Dong et al., 2024). Individual-level theoretical frameworks focus on intrapersonal processes and consider a range of factors including attachment (Bowlby, 1973; Monks et al., 2005) and personality traits (Kelly et al., 2017). Individual vulnerabilities such as emotional regulation or social skills deficits can increase risk of victimisation, and effect how individuals respond to bullying (Thomas et al., 2018). Both system and individual level perspectives must be considered together to better understand bullying in this population.

BV and psychopathology during adolescence

Research shows numerous mental health difficulties are experienced when BV from peers occurs during adolescence, with suicidal ideation, self-harm (Klomek et al., 2007; Moore et al., 2017) and anxiety and depression (Hawker & Boulton, 2000; Hemphill at al., 2011; Kaltiala-Heino et al., 2009) most frequently reported. The latter are known to cause adolescents significant functional impairment and can affect mental health into adulthood (Morales-Muñoz et al., 2023). A meta-analytic review by Hawker et al. (2000) assessing research over 20 years, found BV in children was most strongly related to depression, with victim's psychopathology most significantly defined by feelings of loneliness, negative thinking and dysphoria. Loneliness and isolation are commonly associated with BV and have been identified to increase vulnerability to psychopathology (Ime, 2025; Madsen et al., 2024). A more recent meta-analysis by Moore et al. (2017) supported Hawker et al.'s (2000) findings, presenting strong evidence for a causal relationship between BV and psychopathology, including anxiety and depression.

There are several factors to consider in understanding how BV increases vulnerability to anxiety and depression. Notably, adolescence is a particularly vulnerable period to experience BV due to the social, cognitive, and neurodevelopmental changes occurring during this time (Schore, 2015). Neuroplasticity refers to the brains ability to adapt in response to external experiences (Cramer et al., 2012). The prefrontal cortex, which influences multiple functions, including social cognition and emotional regulation, undergoes significant structural change during adolescence (Huttenlocher, 1979), indicating that experiences during this period are likely to have significant effects. In addition to external stressors such as transitioning to secondary school and increased academic demands, adolescents begin to develop a more stable sense of identify and are learning how to relate to themselves (Steinberg & Morris, 2001). Simultaneously, increased importance is placed on acceptance from, and comparison to, peers during this stage of development (Gilbert & Irons, 2009). Taken together, it seems fair to propose that these factors are likely to increase individuals' vulnerability to adverse outcomes if faced with bullying from peers during adolescence.

The Interpersonal Theory of Depression (ITD; Rudolph et al., 2008) posits that dysfunctional interpersonal relationships are a significant risk factor for depressive symptoms which illicit a threat response, heighten negative self-evaluation and affect emotional regulation. In support, Gilbert's (1992) social rank theory may provide further insight into how the relational dynamics involved in bullying lead to psychopathology. The theory suggests psychopathology can develop when individuals perceive themselves as inferior to others and feel trapped in subordinate positions.

Experiencing BV places individuals into a powerless and defensive position, which can lead to feelings of inferiority and submissive behaviour. These responses are strongly related to shame, social anxiety and depression (Gilbert et al., 2000). Shame is commonly experienced in response to BV and has been found to significantly negatively influence mental health outcomes in young people (Irwin at el., 2016). Shame can impact the developing sense of self (Lewis, 2003) and can be maintained by self-criticism, an internal shaming process (Gilbert et al., 2009), which has been associated with depression (Gilbert et al., 2006).

Additionally, emotional regulation may be an important process to consider in the link between BV and anxiety and depression. Experiencing BV, which is often chronic and uncontrollable, is a significant stressor for a young person (McLaughlin et al., 2009). Having to allocate internal resources to manage ongoing heighted arousal and stress can lead to challenges with emotion regulation, increasing vulnerability to mental health difficulties (McLaughlin et al., 2009).

Theories of compassion

SC has been identified as a potential regulator and protective factor of mental health (Neff, 2003) and has been found to have positive effects on transdiagnostic presentations, reducing depression, anxiety, self-criticism, shame and feelings of inferiority (Gilbert & Procter, 2006). One of the leading researchers in this area, Neff (2003; 2016) primarily draws from Buddhist philosophy and focuses on the self-to-self-relationship. Neff (2003) theorised that SC comprises three pairs of opposing components which sit on a continuum, each pair representing compassionate verses uncompassionate responses that influence one another. These distinct dimensions are self-kindness verses self-criticism; recognising individual experiences as part of common humanity verses isolation; and being mindful of painful internal experiences verses overidentifying with them. Neff (2003) devised the Self-Compassion Scale (SCS) which provides an overall score of SC. The measure is widely used in the literature (Ime, 2025; Jiang et al., 2016; Neff & McGehee, 2010; Neff et al., 2018), with meta-analyses (Lou et al., 2022; MacBeth & Gumley, 2012) providing evidence that lower levels of SC are related to increased levels of psychopathology in adult populations. In consideration of young people, Pullmer et al. (2019) found that SC may protect against the emergence and persistence of depression by decreasing symptoms, understanding risk factors and attenuating their harmful effects. Emerging evidence suggests SC interventions may be effective for decreasing anxiety and depression in young people (Bluth et al., 2016; Egan et al., 2022; Seekis et al., 2023) with an emphasis on decreasing self-criticism as a key to successful interventions (Egan et al., 2022).

In contrast, Gilbert (2009) draws on attachment theory (Bowlby, 1979), neuropsychological (Porges, 2007) and evolutionary approaches (Nesse & Ellsworth, 2009), understanding compassion as a multifaceted concept that flows in three directions: SC, compassion towards others (CtO) and from others (CfO). Gilbert (2014) defines compassion as *"a sensitivity to suffering in self and others, with a commitment to try and alleviate and prevent it"* (p. 19) and suggests the three flows of compassion are distinct yet related concepts, which are influenced by emotional regulation, namely the threat, drive and soothe systems. The soothe system fosters feelings of safeness and connection. An effective soothe system, which develops from more secure attachment experiences, acts to regulate the threat and drive systems (Gilbert, 2009; 2015). Gilbert (2009) hypothesises that individuals experiencing transdiagnostic presentations, such as shame and self-criticism, are less able to access the soothing system resulting in a threat orientated view of themselves and the world. Gilbert (2005) suggests an underdeveloped soothing system can be a barrier to engaging in compassion and increases the likelihood of mental health difficulties. In support, feelings of safeness and connection, fostered by the self-soothing system, have been associated with reduced anxiety and depression in young people (Alavi, 2021; Barcaccia et al., 2022). Gilbert et al. (2017) created the Compassionate Engagement and Action Scales (CEAS) to reflect the three flows of compassion by assessing individuals' motivations to engage with distress and how they actively cope in compassionate ways for each compassion orientation.

The literature identifies a wide range of mental health problems associated with experiencing BV for adolescents (Hawker & Boulton, 2000; Hemphill at al., 2011; Klomek et al., 2007; Moore et al., 2017). Therefore, the transdiagnostic application of SC is likely to be beneficial for this population. It stands to reason that SC, regardless of theoretical underpinning, may play a protective role for young people experiencing BV, by alleviating common difficulties which can result from bullying experiences, such as negative self-evaluation (Reijntjes et al., 2010), isolation (Ime, 2025) and shame (Irwin et al., 2016).

Aims of the current review

Taken together, bullying is a pervasive, multifaceted and harmful behaviour for its victims that directly impacts on psychological well-being. Due to its potential transdiagnostic applicability, it seems reasonable to propose that SC may be a key area to focus on clinically when working with survivors of bullying. In addition to this, adolescence is not only a key developmental period (Huttenlocher, 1979; Steinberg et al., 2001), but also a point in which significant bullying can occur, particularly between peers (Biswas et al., 2020), which in turn impacts on mental health

(Hawker & Boulton, 2000; Hemphill at al., 2011; Kaltiala-Heino et al., 2009; Klomek et al., 2007; Moore et al., 2017). There are, however, no reviews to date that systematically explore the potential influence of SC in young people who have been affected by peer bullying. Therefore, this review aims to explore 'what is the role of SC on anxiety and depression for adolescents who have been the victim of peer bullying?'. To answer this question, the review will include studies which examine SC in two ways: SC in a mediating role, whereby SC explains how BV leads to symptoms of depression or anxiety (e.g., BV affects depression through SC; Jose, et al., 2013); and SC in a moderating role, whereby SC may influence the strength or direction of the relationship between BV and depression or anxiety (e.g., the relationship between BV and depression may change dependant on levels of SC; Jose et al., 2013).

Methodology

Protocol

This systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) and registered with the International Prospective Register for Systematic Reviews (PROSPERO) on 09/03/2023 (CRD42023399689).

Eligibility criteria

Only quantitative studies were included that were available in English and included a validated measure of psychological distress (depression or anxiety) and SC (e.g., SCS, CEAS), with a self-report, but not necessarily validated, measure of BV (perpetrated by peers) in an adolescent population (age range or mean between 10-19 years). The statistical analysis needed to explicitly explore SC as a mediator or moderator between the experience of being bullied and depression or anxiety. Both published and unpublished studies were included.

All non-empirical literature (e.g., books, articles) and qualitative studies were excluded, as well as any studies including non-validated measures of the key variables, or that did not explore the moderation/mediation effect of SC on depression or anxiety. Studies were excluded if bullying was perpetrated by anyone other than peers and if population mean age was under 10 years or exceeded 19 years. The inclusion and exclusion criteria are shown in Table 1.1.

Table 1.1.

Inclusion exclusion criteria use for the screening process

Inclusion	Exclusion
Original research, empirical design, published and unpublished quantitative studies.	Qualitative studies. Articles, books, book chapters, reviews, guidelines (non-empirical literature).
Findings are available, and available in English	Findings are not available, or an English language version is not available.
Participants are an adolescence population, age range or mean between 10-19 years.	Participants mean age is younger than 10 years or older than 19 years.
A validated measure of depression or anxiety.	No validated measure of depression or anxiety.
A self-report measure of bullying victimisation. Bullying must be perpetrated by peers (e.g., school peers, friendship groups).	No self-report measure of bullying victimisation. Bullying is perpetrated by those other than peers (e.g., family members, romantic partners).
A validated measure of SC (e.g., SCS, SCS-SF, CEAS).	No validated measure of SC.
Statistical analysis explicitly explores and presents data analysing SC as a mediator or moderator between the experience of being bullied and depression and/or anxiety.	Statistical analysis does not include exploration, or present relevant data, of SC as a mediator or moderator between the experience of being bullied and depression and/or anxiety.

Information sources

Scoping searches were carried out on 05/01/2023 on PROSPERO and Google Scholar. Five electronic databases were then searched for eligible studies: PsychINFO, CINAHL, MEDLINE (EBSCOhost), Web of Science Core Collection and ProQuest. No publication date limits, or search filters were used. Google Scholar (first 100 results) was also searched to expand the scope. Searches took place between 02/10/2024 and 04/10/2024 and were repeated on 08/01/2025 to ensure all relevant studies were identified. The Compassionate Mind Foundation website “Recent Publications” section was searched for relevant publications, and authors of included studies were contacted to

enquire if they were aware of any applicable research. Additionally, citation mining and handsearching references of included studies was carried out.

Search terms and strategy

The search strategy was developed and piloted with an Expert Librarian and informed by the key concepts in the systematic review question, and terminology identified following scoping searches. Title and abstracts were searched for each area of interest. Bullying was the first phenomena of interest, which was searched with the following key words: "Bulli* OR bully* OR victim* OR peer victimi?ation OR "peer abuse OR cybervictimi?ation OR cyber victimi?ation OR cyber bull* OR cyberbull* OR school victimi?ation OR school bull* OR harass* OR teas*". SC was the second phenomena of interest. Key words used to search were: "Compassion* OR self N1 (compassion*)". The population of interest was searched using: "Adolescen* OR teen* OR child* OR youth* OR young N2 (person* OR people* OR girl* OR boy*) OR juvenil* OR school student* OR school child* OR student*". Controlled vocabulary searches were also carried out for each area of interest on databases where this function was available. Boolean Operator's 'OR' and 'AND' was used to combine all areas of interest for the final result. See Appendix B for individual search strategies used for each database.

Study selection process

In accordance with PRISMA guidelines (Page et al., 2021), all titles and abstracts were screened against the inclusion exclusion/criteria. To reduce bias, title and abstracts of 10% of studies, selected at random, were screened independently by a second reviewer using the eligibility criteria (Boland et al., 2017).

Data extraction

Key study characteristics of interest to the systematic review question were obtained from the included studies (see Table 1.2). Information included the study design, location, publication type, sample size, sample age, gender, and measures used. Key findings from each study were also extracted including statistical analysis, and the relationship between the variables of interest, including a measure of effect size if available (see Table 1.3). Data was grouped relating to if SC was assessed as a moderator or mediator between BV and depression and anxiety.

Quality assessment and risk of bias

'The Standard Quality Assessment Criteria for Evaluating Primary Research Papers from a Variety of Fields' (SQAC; Kmet et al., 2004) was used to assess the methodological quality of each study. This evaluation tool has been used in numerous systematic reviews in a variety of fields (e.g., Boukhris et al., 2024; Munawar et al., 2023; Janssens et al., 2023). The SQAC uses 14 questions which cover if key features are present, sufficient and appropriate, including: Study objectives, design, sampling methods, participant characteristics, measures, sample size, analysis, reporting results and estimates of variance. Responses of 'yes', 'partially' or 'no' indicate if each criterion has been met. Each response corresponds to a value (2, 1 or 0), which is summed to give a total score. Questions that were not relevant to the study were excluded from the count (i.e., 11 of the 14 questions were relevant for the included studies, therefore a maximum score of 22 was available). A score between 1 and 0 is then calculated by dividing the summed score by the total available score. Methodological quality can then be categorised into 'strong' (>.80), 'good' (.70-.80), 'adequate' (.50-.69) and' poor' (<.50; Kmet et al., 2004).

To reduce bias, each study was assessed independently by two reviewers using the SQAC (Kmet et al., 2004). Quality assessment scores and the strength interpretation was compared for each study (see Appendix C for individual assessments of each included study). Any differences in scores were discussed and a consensus reached. A third reviewer was available to assess potential discrepancies but was not required. All studies in the review were rated 'strong' reaching a score of .80 or above.

Data synthesis

As included studies used moderation or mediation analysis a meta-analysis was considered. However, this approach was infeasible as the current review did not meet the minimum requirement of ten effect sizes to provide sufficient power (Harrer et al., 2021). Therefore, a narrative synthesis, using the Synthesis Without Meta-analysis (SWiM) reporting guideline (Campbell et al., 2020) was carried out allowing all key findings to be included. Studies were grouped by analysis (moderation or mediation) to allow the different processes of influence to be clearly explored.

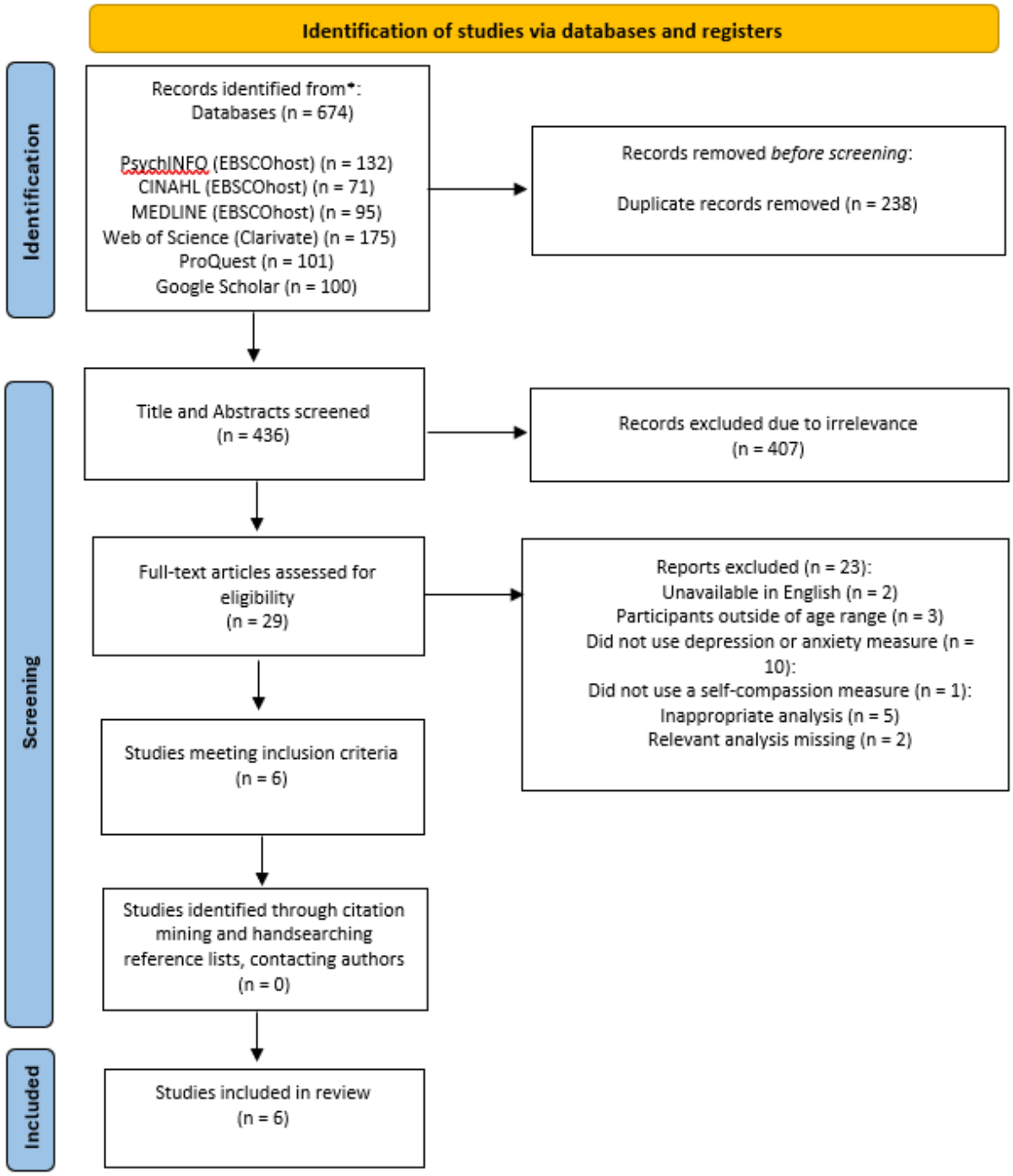
Results

Study selection

The study selection process was carried out in accordance with PRISMA guidelines (Page et al., 2021; see Figure 1.1). Electronic searches identified 674 studies, 436 of which remained after duplicates were removed. A second reviewer screened 44 of these at random and agreement was 100%. Twenty-nine studies were retained for full screening. After studies were read in full and eligibility criteria applied, 23 citations were excluded: two were not available in English (Martin et al., 2019; Múzquiz et al., 2021); 11 did not use appropriate measures (Bellows et al., 2023; Chen & Zhu, 2022; Geng et al., 2023; Hatchel et al., 2019; Ho et al., 2023; Iyer et al., 2022; Jiang et al., 2016; Nariswari & Muttaquin, 2023; Wang et al., 2022; Wang et al., 2024; Xu et al., 2024); five did not use appropriate statistical analysis to answer the research question (Carnelius & Dennhag, 2023; Játiva & Cerezo, 2014; Vigna et al., 2017; Vigna et al., 2018; Vigna et al., 2020); two did not include the relevant statistical analysis to answer the review question (Lian et al., 2023; Yaghoubi et al., 2021) and three used samples outside of the age range (Wang, 2024; Yan et al., 2022; Zhang & Wang, 2019). Subsequently, six studies met inclusion criteria for the current review (Chu et al., 2018; Bowornkittikun, 2020; Dong et al., 2024; Múzquiz et al., 2022; Lahtinen et al., 2020; Zhang et al., 2019). No further studies were identified from The Compassionate Mind Foundation website, through contacting authors of included studies, or through citation mining and hand searching reference lists of the included studies.

Figure 1.1.

PRISMA flow diagram (Page et al., 2021)



Study characteristics

Study and participant characteristics can be found in Table 1.2. Five studies were published in peer-reviewed journals between 2014 and 2024 (Chu et al., 2018; Dong et al., 2024; Múzquiz et al., 2022; Lahtinen et al., 2020; Zhang et al., 2019), while one was an unpublished dissertation (Bowornkittikun, 2020). Four of the studies were conducted in Asia: China (Chu et al., 2018; Dong et al., 2024; Zhang et al., 2019) and Thailand (Bowornkittikun, 2020). Two were from Western countries: Spain (Múzquiz et al., 2022) and Finland (Lahtinen et al., 2020). The ethnicity of participants was not reported in any of the studies. All recruited participants from schools with one study also recruiting from vocational institutions (Lahtinen et al., 2020). Three studies explored SC as a mediator (Bowornkittikun, 2020, Múzquiz et al., 2022; Zhang et al., 2019) and three explored SC as a moderator (Chu et al., 2018; Dong et al., 2024; Lahtinen et al., 2020) in the relationship between BV and depression and anxiety. All studies relied on self-report measures.

Mediation studies

The three mediation studies had similar methodologies but used different analysis methods including path analysis (Bowornkittikun, 2020), PROCESS macro (Zhang et al., 2019) and multiple regressions (Múzquiz et al., 2022). Sample sizes range from 371 (Bowornkittikun, 2020) to 1091 (Zhang et al., 2019). All samples were in early adolescence with mean age ranging from 12.95 years (Bowornkittikun, 2020) to 13.28 years (Múzquiz et al., 2022). The genders of the samples are largely equal between males and females, except for one study with 74.1% males (Bowornkittikun, 2020).

Moderation studies

All three moderation studies used regression analyses and two undertook further analysis using simple slope analysis (Chu et al., 2018; Dong et al., 2024). Sample sizes ranged from 489 (Chu et al., 2018) to 2383 (Lahtinen et al., 2020). Mean age of participants ranged from 16.23 years (Dong et al., 2024) to 12.67 years (Chu et al., 2018), with one study omitting a precise mean age “95% of participants aged between 16 and 18 years” (Lahtinen et al., 2020). The genders of the samples are largely equal between males and females.

Table 1.2.

Study and participant characteristics ordered by mediation and moderation analysis.

Study	Design	Publication type	Location	Sample size	Mean Age (SD) years	Gender %	Setting	Bullying measure	Types of bullying measured	Psychological distress measure	SC measure	Study quality score
Bowornkittikun, 2020	Correlational (Mediation)	Dissertation	Thailand	371	12.95 (.89)	M 74.1 F 25.9	3 schools	ROBVQ	Verbal, physical, relational, cyber	CDI (Depression)	SCS-SF	.86 (strong)
Múzquiz et al., 2022	Correlational (Mediation)	Peer reviewed	Spain	433	13.28 (.72)	M 49 F 51	4 schools	ROBVQ	Verbal, physical, relational	(S)PANAS-CA* (Depression)	SCS	.86 (strong)
Zhang et al., 2019	Correlational (Mediation)	Peer reviewed	China	1091	13.07 (1.23)	M 52.1 F 47.9	12 schools	UOBS	Verbal, physical, relational	CESD (Depression)	SCS	.95 (strong)
Chu et al., 2018	Correlational (Moderation)	Peer reviewed	China	489	12.67 (.75)	M 56.4 F 43.6	1 school	CBI	Cyber	CESD (Depression) BAI (Anxiety)	SCS	.95 (strong)

Dong et al., 2024	Correlational (Moderation, longitudinal)	Peer reviewed	China	722	16.23 (.79)	M 52.1 F 47.9	1 school	MPVS	Physical, relational, verbal, property	DAS* (Depression subscale)	SCS	.90 (strong)
Lahtinen et al., 2020	Correlational (Moderation)	Peer reviewed	Finland	2383	95% between 16-18	M 47.6 F 52.4	8 schools, 8 vocational institutions	ROBVQ	Physical, verbal, relational, cyber, property	R-BDI (Depression)	SCS	.81 (strong)

Note. All measures were translated into native languages, ROBVQ = Revised Olweus Bully/Victim Questionnaire, UOBS = University of Illinois Bullying Scale, CBI = Cyberbullying Inventory, MPVS = Multidimensional Peer Victimisation Scale, CDI = The Children's Depression Inventory, (S)PANAS-CA = Spanish Version of the Positive Affect and Negative Affect Scale for Children and Adolescents, CESD = The Centre for Epidemiologic Studies Depression Scale, BAI = Beck Anxiety Inventory, DAS = Depression Anxiety Stress Scale, R-BDI = Revised Beck Depression Inventory, SCS-SF = Self-compassion Scale Short Form, SCS = Self-compassion Scale

BV measures

Forms of BV measurement differed across studies and included verbal, physical, relational, cyber and damage or loss of property. All, except for Dong et al. (2024), included a definition of bullying, with five studies utilising an overall bullying score and one analysing 'direct' and 'relational' bullying separately (Múzquiz et al., 2022). Three studies used adapted versions of the victimisation section of the Revised Olweus Bully/Victim Questionnaire (ROBVQ; Olweus, 1996; Bowornkittikun, 2020; Lahtinen et al., 2020; Múzquiz et al., 2022). The remaining studies used the University of Illinois Bullying Scale (UIBS; Espelage & Holt, 2001; Zhang et al., 2019), the Multidimensional Peer Victimisation Scale (MPVS; Mynard & Joseph, 2000; Dong et al., 2024) and the Chinese version of the Cyberbullying Victimisation subscale (Zhou et al., 2013), from the Cyberbullying Inventory (CBI) (Erdur-Baker & Kavsut, 2007; Chu et al., 2018). All measures were presented in the language of the country of origin. Four studies used an adapted version of a validated measure (Bowornkittikun, 2020; Lahtinen et al., 2020; Múzquiz et al., 2022; Zhang et al., 2019), while two used the measures in their original validated form (Chu et al., 2018; Dong et al., 2024).

Depression and anxiety measures

The six studies used five different self-report measures of depression, with one study including a measure of anxiety (Chu et al., 2018). Two studies, both originating from China (Chu et al., 2018; Zhang et al., 2019), used The Centre for Epidemiologic Studies Depression Scale (CESD; Radloff, 1977). The remaining studies used The Children's Depression Inventory (CDI; Kovacs, 2003; Bowornkittikun, 2020), the Spanish version of the Positive and Negative Affect Schedule for Children and Adolescents (PANASN; Sandín, 2003; Múzquiz et al., 2022), the depression subscale of the Depression Anxiety Stress Scale (DAS; Lovibond & Lovibond, 1995; Dong et al., 2024) and the Revised Beck Depression Inventory (R-BDI; Raitasalo, 2007; Lahtinen et al., 2020). Additionally, Chu et al. (2018) used The Chinese version of The Beck Anxiety Inventory (BAI; Wang, 1999) to measure anxiety. All measures were validated in the language of the country of origin, showing adequate psychometric properties.

SC measures

Five of the studies used the SCS (Neff, 2003), with four using an overall score (Chu et al., 2018; Dong et al., 2024; Múzquiz et al., 2022; Zhang et al., 2019) and one using the two-factor structure of SC and self-coldness as distinct concepts (Lahtinen et al., 2020). One study used the Self-

Compassion Scale-Short Form (SCS-SF; Raes et al., 2011; Bowornkittikun, 2020). All measures were translated into the language of the country of origin. Four studies used a version of the measure that had been validated in the language of the country of origin, indicating adequate psychometric properties (Chu et al., 2018; Dong et al., 2024; Múzquiz et al., 2022; Zhang et al., 2019). Two studies used translated versions of the measures without published validation studies (Bowornkittikun, 2020; Lahtinen et al., 2020).

Risk of bias

The SQAC (Kmet et al., 2004) was used to assess the methodological quality of each study. Scores ranged from .81 (Lahtinen et al., 2020) to .95 (Chu et al., 2018; Zhang et al., 2019), with all studies categorised as 'strong'. See Appendix C for individual risk of bias assessments for each study.

Mediation studies

Based on the SQAC (Kmet et al., 2004), quality scores for mediation studies ranged from .86 to .95, demonstrating strong methodological qualities (see Table 1.2.). All three studies used cross-sectional correlational designs, rather than multiple timepoints, meaning causation could not be inferred (Field, 2024). Múzquiz et al. (2022) and Zhang et al. (2019) were clear about this limitation when drawing conclusions from their results, acknowledging that longitudinal studies were necessary to confirm the mediating relationships observed. However, Bowornkittikun (2020) was unclear about the implications of this limitation, providing an ambiguous statement regarding the use of a cross-sectional design "*a conclusion could not be drawn from the results*" (p. 84). Adding clarity around the reasons a cross-sectional design was limited in drawing conclusions, and including how future research could address this limitation would have increased transparency.

All studies appeared to have adequate sample sizes (Schönbrodt & Perugini, 2013), but only one study provided confirmatory power analysis (Bowornkittikun, 2020). Two studies controlled for confounding variables to some degree such as gender and/or age (Múzquiz et al., 2022; Zhang et al., 2019), while one did not report on this (Bowornkittikun, 2020). Two studies provided estimates of variance for the main results (Bowornkittikun, 2020; Zhang et al., 2019), while one omitted this information (Múzquiz et al., 2022) compromising the reliability of the results (Field, 2024). All participants were recruited from multiple schools; however, were potentially biased by other aspects of recruitment. For example, timing of data collection (Bowornkittikun, 2020) and geography (Zhang et al., 2019), making direct comparison difficult due to the potential biases impacting each study.

Moderation studies

The quality of the moderation studies ranged from .81 to .95 based on the SQAC (Kmet et al., 2004) all indicating strong methodologies (see Table 1.2). All have adequate sample sizes for correlational designs (Schönbrodt et al., 2013) and controlled for a variety of confounding variables, with one study using a longitudinal approach, controlling for a baseline measure of depression (Dong et al., 2024). Two studies had scope to report findings in more detail (Dong et al., 2024; Lahtinen et al., 2020), omitting some non-significant p values. Conclusions were fully supported by the results in two studies (Chu et al., 2018; Lahtinen et al., 2020), and partially in another (Dong et al., 2024), where the term “marginal significance” was used to draw conclusions from results, which may indicate potential publication bias.

Narrative synthesis

This synthesis groups studies by SC being explored in either a mediating or a moderating role. All study results can be found in Table 1.3.

Table 1.3.

Study results

Study	Analysis	Confounding controlled for	Summary of key findings
Bowornkittikun, 2020	Path analysis (theoretical mediation)	Resilience	**BV affected depression partially through SC.** BV has an indirect effect on depression through SC and resilience (β = .13, *p* = .006, S.E = .02, 95% C.I. [.09, .19]), suggesting BV affects depression through SC and resilience. Overall, the model (BV, SC and resilience) explained 44% of the variance in depression (R^2 = .44). The relatively small standard errors and narrow confidence intervals indicate findings are robust, precise and reliable. Standardised betas are reported.
Múzquiz et al., 2022	Linear regression (The Sobel approach) (theoretical mediation)	None	**SC significantly affected the relationship between both direct BV and relational BV and depression.** Direct BV: This relationship is weakened when SC was included in the model (β = .21, *p* < .001, R^2 = .37) with The Sobel test value showing significant indirect effects (4.02, p< .001). Overall, this suggests SC plays a protective role in the effects of direct BV on depression, with the total explained variance increasing to 37%. Relational BV: This relationship weakened when SC was included (β = .22, *p* < .001, R^2 = .37) with The Sobel test value showing significant indirect effects (5.42, p< .001). This suggests SC plays a protective role in the effects of relational BV on depression, with the total explained variance also increasing to 37%.

			Standard errors and confidence intervals are not reported. Standardised betas are reported.
Zhang et al., 2019	PROCESS macro (Theoretical mediation)	Controlling for age, gender, SES	**BV was positively associated with depression through decreased SC.** There was a significant indirect effect of BV on depression through SC (β = .151, $p < .001$, SE = .023, 95% (CI [0.106, 0.198]), meaning experiencing BV was associated with lower levels of SC, which was associated with increased depressive symptoms. The relatively small standard errors and narrow confidence intervals indicate findings are robust, precise and reliable. Unstandardised betas are reported.
Chu et al., 2018	PROCESS macro (Mediation [HL], moderation [SC]) Simple slope analysis.	Controlling for age and gender, hopelessness	**The direct effects of BV on depression and anxiety and mediation effect of hopelessness are moderated by SC. Effects are stronger for those with lower SC.** Interaction effects on depression: The interaction of BV and SC had a significant effect on depression (β = -.16, $p < .001$, SE =.04, [CI -0.245, -.082], $R^2 = .42$) suggesting SC moderated the association between BV and depression. This means when SC increases, the negative impact of BV on depression decreases, with the model explaining 42% if the variation in depressive symptoms. Simple slopes (depression): For low SC individuals, BV was associated with depression (β simple = .36, $p < .05$). For high SC individuals, there was a non-significant relationship with depressive symptoms (β simple = -.10, p = 0.40). This suggests for low SC individuals BV increases feelings depression, for high SC individuals the negative impact of BV on depressive symptoms was not present. The positive direct effect of BV on depression and indirect effect of BV on depression through HL were present when SC was moderate and low but not when SC was high.

			Interaction effects on anxiety: The interaction of BV and SC had a significant effect on anxiety (β = -.22, p < .001, SE =.04 [CI -.303, -.137], R^2 = .39), meaning when SC increased, the negative impact of BV on anxiety symptoms decreased, with the model explaining 39% if the variation in anxiety symptoms. Simple slopes (anxiety): For low SC individuals, BV was associated with anxiety (β simple = .40, p < .01). For high SC individuals, the effects BV on anxiety were non-significant (β simple = .12, p = 0.33). Meaning when SC increased, the negative impact of BV on anxiety decreased. The positive direct effect of BV on anxiety and indirect effect of BV on anxiety through HL were present when SC was moderate and low but not when SC was high. Where reported the relatively small standard errors and narrow confidence intervals indicate findings are robust, precise and reliable. Standardised betas are reported.
Dong et al., 2024	Linear regression. PROCESS macro was used to test moderating role of SC. Simple slope analysis. Johnson-Neyman approach used (as variables were continuous) to mathematically	Controlling for age, gender and depression at time 1.	**SC did not significantly moderate the relationship between BV and depression.** The interaction of BV and SC on depression (time 2) was non-significant (β = -.127, p = .073, SE = .071, [CI -.266, .012], R^2 = .249. The overall model explained 24.9% of the variance in depression (time 2), with the interaction adding a small amount of explanatory power ΔR^2 = .003. Simple slopes: BV positively significantly predicted depression (p < .05) for adolescents with lower SC. BV no longer predicted depression (p > .05) for those with higher SC. (Threshold was a score of .15 SD below the average SC score: above 2.94). Interaction by gender:

	derives the "regions of significance" (Bauer & Curran, 2005).		When broken down by gender the moderating effect of SC between BV and depression was non-significant for boys (p = .243) and for girls (β = -.187, p = .076, SE = .105 [CI -.393, .020], R^2 = .254.) A relatively large standard error and confidence interval crossing 0 suggests non-significance, statistical uncertainty and weak reliability. Simple slopes for girls: The relationship between BV and depression became non-significant (p>.05) for girls when their SC scores were higher than 2.71 (0.55 standard deviations below the average). This suggests for girls with higher levels of SC, experiencing BV was less likely to lead to depression. There was a non-significant interaction between BV, SC and gender (F= .22, p = .637), meaning there was no significant difference in the way BV and SC related to depression for girls or boys. Unstandardised betas are reported.
Lahtinen et al., 2020	Hierarchical regression and simple slope analysis (Moderation)	Controlling for gender and school type (secondary school or vocational institution)	**SC or self-coldness did not moderate the relationship between BV and depression.** SC as a moderator: The interaction between BV and SC was not a statistically significantly related to depression (β = -.01) (p value not provided). Gender and school explained 5% of the variance (ΔR^2 = .05), 15% additional variance was explained by BV and SC (ΔR^2 = .15). No additional variance explained by the interaction (ΔR^2 = .00) suggesting that having higher or lower levels of SC does not significantly change how BV effected depression. Self-coldness as a moderator: The interaction between BV and self-coldness did not predict depression (β = -.02). Gender and school explained 5% of the variance (ΔR^2 = .05), 25% additional variance was explained by BV and SC (ΔR^2 = .25). A significant but small increase in variance was explained by the interaction ΔR^2 = .00. Findings suggest self-coldness does not significantly change how BV affects depression.

No standard error or confidence intervals provided. Unstandardised betas are reported.

Mediation studies

All mediation studies found SC significantly affected the relationship between BV and depression symptoms. Two studies used standardised beta coefficients (Bowornkittikun, 2020; Múzquiz et al., 2022) allowing their findings to be directly compared. One study reported unstandardised beta coefficients (Zhang et al., 2019), therefore meaningful direct comparison of these results was not possible.

Indirect effects of BV on depression

The results show significant positive indirect effects of BV on depression, with small effects found in the studies with standardised beta coefficients (Bowornkittikun, 2020; Múzquiz et al., 2022). Resilience was also identified as a mediating variable, with BV found to have an indirect effect on depression through SC and resilience (Bowornkittikun, 2020). Similarity, the relationship between direct BV and depression, and relational BV and depression was weakened when SC was included (Múzquiz et al., 2022). Indirect effects of direct BV and relational BV were similar indicating no overt difference in the role of SC for these types of BV. The proportion of variance in depression symptoms explained by these models was 44% (Bowornkittikun, 2020) and 37% (Múzquiz et al., 2022) respectively. Although not directly comparable due to unstandardised beta coefficients, Zhang et al. (2019) also found that BV was positively associated with depression through decreased SC. The proportion of variance in depression symptoms explained by the model was not reported.

Moderation studies

Moderation studies showed mixed results regarding SC as a moderator in the relationship between BV and depression and anxiety. However, further simple slope analysis conducted by two studies (Chu et al., 2018; Dong et al., 2024) which identified BV significantly related to depression and anxiety when SC was low and moderate but not when SC was high. Only Chu et al. (2018) used standardised beta coefficients, and the other two studies used beta coefficients that were unstandardised, therefore direct meaningful comparison of findings was not possible.

Interaction effects

Findings were mixed regarding SC and self-coldness as moderators in the relationship between BV and depression and anxiety. Chu et al. (2018) only measured cyberbullying and found SC significantly moderated the relationship between BV and depression and anxiety, with the models

accounting for 42% and 39% of the variance in depression and anxiety respectively, suggesting when SC increases, the negative impact of BV on depression and anxiety decreases.

In contrast, two of the studies reported non-significant interactions (Lahtinen et al., 2020; Dong et al., 2024). Dong et al. (2024) found SC did not moderate the relationship between BV and symptoms of depression, with the model accounting for 26% of the variance in depression symptoms. This interaction remained non-significant when broken down by gender. It is pertinent to note that estimates of variance were large indicating the results hold less statistical reliability (Field, 2024). In Lahtinen et al.'s (2020) paper, the SC subscales (SC and self-coldness) were not found to significantly moderate the relationship between BV and depression, with minimal additional variance explained by the interactions, suggesting SC and self-coldness do not significantly moderate how BV affects depression.

Simple slope analysis

Two of the studies (Chu et al., 2018; Dong et al., 2024) carried out further analysis to understand the strength of the relationship between BV and depression and anxiety at different levels of SC. Results were consistent, showing BV significantly related to depression when SC was low and moderate but not when SC was high, with the same pattern observed for anxiety. It is important to note Dong et al. (2024) only carried out simple slope analysis on the female sample as this group were deemed to have a 'marginally significant' interaction in the main analysis, despite both genders producing a non-significant result for overall moderation effects.

Discussion

Summary of findings

This systematic review aimed to explore the role of SC on anxiety and depression for adolescents who have been the victim of peer bullying. The results are discussed, exploring the mediation and moderation findings separately.

SC as a mediator

The results from the mediation-based research indicated that BV contributed to symptoms of depression through the pathway of reduced SC (Múzquiz et al., 2022; Zhang et al., 2019). In addition, Bowornkittikun (2020) identified partial mediation, suggesting BV affects depression through SC and resilience. Overall these findings are in line with a growing evidence-base that identifies SC as a key

process through which mental health is affected for those who have experienced BV, including adolescents (Hatchel et al., 2019; Ime, 2025; Lain et al., 2023; Yaghoubi et al., 2021), younger children (Yan et al., 2022), and young adults (Wang, 2023; Zhang et al., 2019).

In consideration of identifying resilience as a mediating factor together with SC (Bowornkittikun, 2020), it is important to note that these two phenomena are potentially inter-related. Insofar as resilience is a complex concept which involves an interaction between facing adversity, and utilising internal and external protective factors (Rutter, 1987). Internal factors may include empathy and temperament, while external factors involve experiencing warmth and feeling valued by family (Werner & Smith, 1982). Factors that increase an individual's resilience such as experiencing a loving family environment can also facilitate the development of SC (Cunha et al., 2014). Furthermore, SC has been identified as a way of relating to oneself which promotes resilience among adolescents (Neff & McGhee, 2010). Therefore, it seems reasonable that SC may be an internal factor to draw from in the process of resilience, and that both SC and resilience may be important factors to consider in understanding how BV impacts young people.

SC as a moderator

The moderation-based studies showed mixed results. Chu et al. (2018) found a significant main effect that suggests as SC increases the negative impact of BV on depression and anxiety consistently decreases. In contrast, Dong et al. (2024) who looked at SC and Lahtinen et al. (2020) who divided the measure into SC and self-coldness, found that these SC variables did not significantly moderate the relationship between BV and depression. However, there are some important statistical limitations that require consideration when interpreting these results. Dong et al. (2024) reported wide confidence intervals and large standard errors which indicate high levels of uncertainty regarding the accuracy of the results, compromising the robustness of these findings (Field, 2024). These factors suggest increased likelihood that findings may differ between samples, reducing their reliability (Roberts & Priest, 2006). Lahtinen et al. (2020) omits any data allowing the accuracy of results to be assessed, therefore both findings need to be taken with caution when inferring claims regarding the relationship in question. Additionally, low levels of BV reported in Lahtinen et al.'s (2020) study may have impacted findings, as rates of BV may not have been high enough for a moderation effect of SC to be detected (Memon et al., 2019).

While inferences from patterns across studies are limited due to the small number included, there are factors to consider relating to the mixed findings. Indeed, participants were older in the studies that did not find a moderation effect (mean age 16 years; Dong et al, 2024; 95% aged

between 16-to-18 years; Lahtinen et al., 2020), than the moderation study identifying a significant main effect (mean age 12.76 years; Chu et al., 2018). Although the literature suggests that occurrences of BV decrease with age (Green et al., 2010; Pepler at al., 2006), a meta-analysis by Moore et al. (2017) found adolescents who experienced BV more frequently over time were at higher risk of mental health problems. It is plausible that older adolescents are potentially more likely to have experienced prolonged exposure to BV, leading to poorer mental health. Higher levels of anxiety and depression are known to relate to lower levels of SC (Marsh et al., 2018), which may together reduce detection of potential moderating effects (Memon et al., 2019). Other factors, including increased external stressors such as exam pressure, and peer relationships increasing in significance and complexity (Sun et al., 2019), may impact SC failing to play a protective role in this process. These factors suggest increased likelihood that findings may differ between samples, reducing their ability of detecting a moderating effect (Memon et al., 2019).

Interestingly, Chu et al. (2018) and Dong et al. (2024) carried out further analysis and found that BV was significantly associated with depression (Chu et al., 2018; Dong et al., 2024) and anxiety (Chu et al., 2018) when levels of SC were low and moderate but not when levels of SC were high. This suggests that high levels of SC may buffer the effects of BV on anxiety and depression. It is possible that these contrasting effects at different SC levels may cancel each other out when analysing overall main effects, obscuring a moderating effect, which emerges when examining specific levels of SC (Field, 2024). Current findings are in line with the developing evidence base which indicates high levels of SC can buffer the relationship between BV and various psychopathology, such as disordered eating (Bellows at al., 2023) and self-harm (Geng et al., 2023; Jiang et al., 2016). Jiang et al. (2016) observed this moderating effect longitudinally, with BV significantly predicting self-harm behaviours after one year, but only among adolescents with low SC. For adolescents with high SC, no significant relationship between BV and subsequent self-harm was found. Results from the simple slope analysis and emerging evidence base suggests further exploration of the buffering effects of high levels of SC is warranted.

Theoretical considerations

The current review indicates SC may play a role in the relationship between BV and symptoms of anxiety and depression for adolescents. Neff's (2003) conceptualisation of SC may offer helpful insights into the current findings. Neff (2003) proposes that the positive core components of SC are self-kindness, recognition of shared human experience and mindful awareness. These ways of self-relating are in direct opposition to typical experiences commonly reported for individuals

experiencing BV (Hawker et al., 2000; Marini et al., 2006). This adds theoretical support to the current findings that suggest SC is a significant factor which effects the relationship between BV and anxiety and depression, and previous research identifying SC as a mechanism by which BV affects mental health (e.g., Chen & Zhu, 2022; Yaghoubi et al., 2021). In consideration of the mixed results, Neff (2003) identifies recognising individual experiences as part of common humanity as a core element of SC. However, it may be difficult for young people who have not yet developed a secure sense of self, to feel connected to others in the face of BV, hindering the development of SC. Furthermore, as adolescence is a time of developing emotional regulation skills (McLaughlin et al., 2009), SC as a way of self-relating may not be well practiced and difficult to establish in threatening circumstances such as experiencing BV, reducing its buffering effects.

Gilbert et al. (2009) suggests when adverse experiences such as BV occur, the threat system is activated causing externalising or internalising defences, namely internalising shame, leading to self-criticism, depression and anxiety. SC has been identified as an antidote to shame (Callow et al., 2021), a common emotion related to BV (Carlisle & Rofes, 2007). Therefore, it is plausible that SC may serve as an opposing mechanism to shame by engaging the soothing system and compassionate self-responding when suffering with anxiety and depression. Gilbert (2010) posits an effective soothing regulation system, which facilitates SC, can act to regulate negative emotions by recognising suffering and providing feelings of warmth and safeness. However, individuals with an underdeveloped soothing regulation system and overdeveloped threat system may experience lower levels of SC and therefore find it more difficult to access feelings of reassurance in the context of stressful experiences such as BV (Gilbert, 2009). These individuals may be more likely to engage in self-criticism (Gilbert, 2005) which can increase psychopathology (Gilbert et al., 2006). Therefore, although experiencing BV is likely to illicit negative emotions, those with higher levels of SC may cope better with these distressing experiences. In agreement, Neff and Germer (2013) suggest that the protective influence of SC can be understood as a self-regulating process. Furthermore, adolescents with higher levels of SC are likely to have developed a nurturing dialogue with themselves, facilitating kindness and the ability to hold a more balanced view of their experiences, maintaining a sense of self-worth, rather than internalising negative judgements from others (Neff, 2023).

Although the studies in the current review focus on SC, compassion can be understood as a multifaceted concept (Gilbert, 2009), with factors that can inhibit or facilitate individuals' regulatory systems, impacting their ability to receive and provide compassion (Gilbert & Mascaro, 2017). Fears of compassion have been identified as inhibitors of compassion which increase vulnerability to experiencing BV (Zăbavă, T., 2020). Self-criticism and shame, which are commonly reported following

experiences of BV (Carlisle et al., 2007; Sigurdson et al., 2015), have been identified as reasons individuals may develop fears of compassion (Gilbert et al., 2012; Kirby et al., 2019). Therefore, fears of compassion may play a significant role in the relationship between BV and anxiety and depression and may be important to consider regarding the mixed results.

Strengths, limitations and future research

This review is the first to explore the mediating and moderating role of SC in the relationship between peer BV and depression and anxiety in adolescents. The review adds to the developing research base substantiating that SC plays a significant role in this process and highlighting potential directions for future research. PRISMA and SWiM guidelines were followed. The methodology is therefore transparent and replicable, minimising bias. The review included studies from a variety of countries encompassing Eastern (Bowornkittikun, 2020; Chu et al., 2018; Dong et al., 2024; Zhang et al., 2019) and Western cultures and provided a balanced representation across gender, increasing the generalisability of findings. Interestingly, the current review showed no clear pattern of findings in relation to Western (Lahtinen et al., 2020; Múzquiz et al., 2022) and Eastern cultures (Bowornkittikun, 2020; Chu et al., 2018; Dong et al., 2024; Zhang et al., 2019), which is likely due to the small number of studies. It is important to note however that studies examining cross-cultural differences in peer victimisation have found similarities between mainland China, Hong Kong and Western countries, with academic challenges, aggressive and withdrawn behaviours found to relate to BV (Schwartz et al., 2001; Tom et al., 2010). However, it may be beneficial for future research to consider the influences of culture, as religion has been identified as an important factor potentially effecting SC (Kariyawasam et al., 2022).

The review was limited by the small number of studies included, with only half reporting standardised regression values, reducing the ability to compare results. Including a wider age range to incorporate University students would allow a larger number of studies to be included (Wang, 2024; Yan et al., 2022; Zhang & Wang, 2019), increasing opportunities for comparisons and identifying patterns across studies. For example, potential influences of culture and age. Furthermore, it would be beneficial to re-examine the role of SC for adolescents who have experienced BV when the evidence base has progressed, with an increased number of methodologically strong studies, and a meta-analysis is feasible.

There are several limitations of the literature to take into consideration when interpreting findings. Only one study included longitudinal elements (Dong et al., 2024), while the others were cross-sectional in design, meaning causal relationships could not be inferred across all studies

(Kesmodel, 2018). As the mediation studies (Bowornkittikun, 2020; Múzquiz et al., 2022; Zhang et al., 2019) did not collect data at multiple timepoints temporal precedence could not be established (Field, 2024). Without measuring SC before and after BV it cannot be established that the BV effects depression through a process of reduced SC. Therefore, true mediation cannot be inferred, only that BV and symptoms of depression having a shared association with SC (Field, 2024). Future research utilising longitudinal designs would improve the methodology and provide stronger evidence for SC as a process through which BV impacts depression.

Individual methodological issues such as failure to control for confounding variables (Bowornkittikun, 2020; Múzquiz et al., 2022), omitting estimates of variance (Lahtinen et al., 2020; Múzquiz et al., 2022), risk of selection (Zhang et al., 2019), temporal (Bowornkittikun, 2020) and publication bias (Dong et al., 2024) reduce the validity and reliability of findings and require results to be interpreted with caution (Roberts et al., 2006).

This review highlighted the variety of different bullying measures (ROBVQ, UOBS, CBI, MPVS) which add to the challenges of drawing comparisons across studies. Key differences include the presence or absence of a bullying definition, and which types of bullying are measured (Vivolo-Kantor et al., 2014). All bullying measures in the review assess type and frequency of bullying, but neglect to account for the perceived psychological impact on victims, which is mirrored across the literature (e.g., Bellows et al., 2023; Geng et al., 2023; Hatchel et al., 2019; Jiang et al., 2016). Future research prioritising development and use of bullying measures which incorporate victims' subjective distress is likely to improve our understanding of the true severity and impact of the experience.

Furthermore, all studies used the SCS, derived from Neff's (2003) theory of SC. There is, however, an ongoing debate as to whether SC can be accurately measured as one construct (Gilbert et al., 2011), with studies indicating the SCS most accurately provides a six or two factor measure such as positive and negative constructs (Arimitsu, 2014; Brenner et al., 2017; López et al., 2015; Petrocchi et al, 2013; Williams et al., 2014). Moreover, negative constructs in the scale have been positively associated with psychopathology, suggesting these subscales measure a vulnerability rather than a protection, and that an overall SCS score may result in an inflated inverse relationship between SC and poorer mental health (Muris and Petrocchi, 2017). To address this limitation some researchers have used the positive and negative SCS items separately (Fung et al., 2021; Kara et al., 2023), which has been supported by the concepts having distinctive relationships with distress and wellbeing (Brenner et al., 2017).

Lahtinen et al. (2019) were the only researchers to measure compassionate and uncompassionate responding separately, which may have contributed to the inconsistent findings. Additionally, SC and self-coldness were observed to be weakly related (r = -.07), whereas a strong negative association would be expected if the concepts sat at two ends of a continuum. It is possible that using these subscales provides a more accurate measure of compassionate and uncompassionate responding and therefore increases the validity of the study. Furthermore, other studies in the review may be at risk of overestimating the relationship between SC and anxiety and depression and therefore overstating the protective role of SC. Future research may benefit from exploring the role of SC using the CEAS to address the potential limitations of the SCS, and to understand the influences of the different compassion orientations in the relationship between BV and anxiety and depression. Additionally, as fears of compassion have been associated with experiencing BV (Zăbavă, 2020), these inhibitors of compassion may also be important to consider in future research, to inform effective targeted interventions.

Implications for clinical practice

It is widely accepted that BV negatively impacts mental health outcomes for adolescents (Hawker et al., 2000; Moore et al., 2017). Additionally, an emerging evidence base indicates that SC is positively associated with wellbeing (Ime, 2025) and negatively associated with psychopathology for young people (e.g., Marsh et al., 2017; Neuenschwander & von Guten, 2024; Pullmer et al., 2019). The current review highlights the potential protective role SC may play for adolescents who have experienced BV. The routine assessment of SC and considering the applicability of SC interventions may target the mechanisms by which BV effects anxiety and depression. For example, Compassion Focused Therapy (CFT; Gilbert, 2009) is an integrative approach which focuses on compassionate mind training, facilitating experiences of inner safeness and warmth, and has been found to be effective for young people (Bluth et al., 2016; Egan et al., 2022; Seekis et al., 2023). Peer bullying in schools remain prevalent (Wolke et al., 2015; ONS, 2024). Therefore, delivering psychoeducation in this setting, and within anti-bullying programs, to support young people to develop SC skills as a preventative measure, may be beneficial. Particularly as higher levels of SC appear to be a helpful protective factor (Chu et al., 2018; Dong et al., 2024).

Conclusions

The aim of this systematic review was to synthesise and critique the current research base that explored SC as a moderator or mediator in the relationship between BV and anxiety and

depression. Overall, the findings suggest SC may be an important mechanism that acts as a protective factor against these emotions in adolescents exposed to BV. However, it is noteworthy that this buffering effect is not experienced at all levels of SC and appears to be threshold dependent, requiring high levels of SC for effective psychological protection. Mixed results regarding SC as a moderator in the relationship between BV and depression warrant further exploration and the particularly limited anxiety research needs addressing. Future research should also use the CEAS to address the weaknesses of the SCS (Arimitsu, 2014; Brenner et al., 2017; López et al., 2015; Petrocchi et al, 2013; Williams et al., 2014). Despite the limitations of the included studies, the current review adds to the developing research base on the role of SC for adolescents who have experienced BV, highlighting SC as a potentially valuable way to foster resilience for these young people.

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Chapter 2: Exploring the Impact of Bullying Victimisation in Secondary School on Compassion and the Inhibitors and Facilitators of Compassion in Adulthood

Journal Specification: The Journal of Current Psychology was chosen to guide this paper. The author guidelines (see Appendix A) identify papers should be no more than 10,000 words (excluding the abstract, reference list, tables and figures). The journal uses APA reference style.

Word count: 9,995 words

Abstract

This study investigated the similarities and differences in the three flows of compassion (self-compassion [SC], compassion to others [CtO] and compassion from others [CfO]) and inhibitors (self-criticism, shame, fears of compassion) and facilitators of compassion (self-reassurance [SR] and early memories of warmth and safeness [EMWS]), as well as predictors of the three flows of compassion between adults who experienced bullying in secondary school and those who did not. A cross-sectional between-participants design was used. The final sample consisted of 383 participants (84.6% female, with a mean age of 25 years, SD = 11.31). Independent between-subject t-tests were carried to assess differences in the flows of compassion, inhibitors and facilitators of compassion and anxiety and depression between victims of bullying (VB) and non-victims of bullying (NVB). Compared to NVB, VB had significantly lower levels of CfO and facilitators of compassion, and significantly higher levels of inhibitors of compassion and anxiety and depression. No differences between groups were found for SC and CtO. Exploratory hierarchical linear multiple regressions for VB and NVB examined the similarities and differences between the predictor variables for each of the three flows of compassion, controlling for demographic variables, bullying recall accuracy and anxiety and depression. SR was identified as the strongest predictor of SC for both groups. The findings tentatively support the need for compassion-based interventions for VB, and assessment of the flows of compassion and inhibitors and facilitators of compassion to allow interventions to be tailored to the individual and appropriate areas to be targeted.

Keywords: Bullying victimisation, Compassion, Inhibitors, Facilitators

Introduction

Olweus (1993) identifies bullying as a process of repeated and deliberate hurtful behaviour, either psychological or physical, characterised by an imbalance of power, meaning the victim is unable to protect themselves. This behaviour can be observed across and within cultures and can be understood from an evolutionary perspective to ensure survival through status, securing resources and mating opportunities (Wolke & Lereya, 2015). Bullying victimisation, referring to the experience of being bullied, is recognised as a public health issue negatively affecting young people globally (Moore et al., 2017), with bullying from peers found to be the most common form of abuse (Radford et al., 2013). The Department for Education (Long et al., 2020) found 17% of children in England aged 10-15 years reported experiencing bullying in school that caused them emotional distress in the last 12-months. Furthermore, 29% of secondary school head teachers in England receive reports of physical and non-physical bullying on a weekly basis (Long et al., 2020). Bullying behaviours can be divided into four broad categories: verbal bullying (e.g., name calling and hurtful words); physical bullying (e.g., physical harm and force); relational bullying (e.g., spreading rumours, excluding and ostracizing); and cyberbullying (e.g., being targeted or threatened via the internet) (David-Ferdon & Hertz, 2009; Gladden at al., 2013). The Annual Bullying Survey (Smith, 2019) of 12–20-year-olds identified verbal bullying was most frequently reported, followed by physical and then cyberbullying. Physical appearance (58%) was reported as the most common reason bullying victimisation occurred, followed by disability (13%), sexuality (10%) and race (9%; Smith, 2019).

It is widely accepted that bullying victimisation negatively impacts upon young people in a variety of ways, including a detrimental impact on mental health, particularly anxiety and depression (e.g., Hawker & Boulton, 2000; Kaltiala-Heino et al., 2010; Moore et al., 2017; Sweeting et al., 2006), physical health (e.g., Gini & Pozzoli, 2013) and academic achievement (e.g., Nakamoto & Schwartz, 2010). Victims of bullying are more likely to internalise problems and have negative experiences of relationships, related to a lack of trust in others and increased social isolation (Marini et al., 2006). It is well established that experiencing bullying victimisation in childhood can also have negative effects on mental health that last into adulthood (e.g., Copeland et al., 2013; Beduna & Perrone-McGovern, 2019; Roth et al., 2002), damaging self to self and self to other relationships (e.g., Carlisle & Rofes, 2007; Schäfer et al., 2004; Sigurdson et al., 2015; Takizawa et al., 2014). For example, adults who have experienced bullying in childhood have demonstrated higher levels of self-criticism (Sigurdson et al., 2015), shame (Carlisle et al., 2007), negative perceptions of relating to others (Schäfer et al., 2004) and difficulties sustaining relationships (Takizawa et al., 2014).

In consideration of adolescence, the experience of bullying victimisation during secondary school, and/or primary and secondary school, is associated with increased likelihood of the aforementioned negative outcomes in adulthood (Schäfer et al., 2004). One explanation for this is that adolescents may be more vulnerable during this developmental period. Adolescence is a time when young people experience a strong desire for belonging and acceptance from their counterparts (Gilbert & Irons, 2009), with primary relationships shifting from parents to peers (Allan & Miga, 2010). Furthermore, this is a period of rapid neuropsychological growth, including the development of systems which regulate emotion, and forming of self-identify (Schore, 2015). As emotional dysregulation and viewing oneself in a negative way are transdiagnostic factors for numerous mental health presentations (Kring & Sloan, 2010; Werner at al., 2019), these issues are likely to contribute to longer-term psychological distress.

The concept of compassion may be helpful to consider as a potential buffer to the negative impacts of bullying. Gilbert (2015) theorises that humans have three systems acting to regulate each other, our emotions, and drive behaviour: the threat system aims to identity danger and protect; the drive system acts to pursue resources; the soothing system fosters feelings of safeness, connection and care. These systems can be activated or suppressed by external or internal triggers, for example, being criticised by others or oneself (Gilbert, 2009). Gilbert et al. (2017) conceptualises compassion as a motivation which flows in three directions, namely SC, CtO and CfO. The Compassionate Engagement and Action Scales (CEAS: Gilbert et al., 2017) measure individuals' related motivations and actions within the three flows conceptualisation. These motivations are expressed through care giving and care-seeking behaviours, which can activate and inhibit the threat, drive and soothing systems. Gilbert (2005) proposes that distress is experienced when these systems are imbalanced, often due to the under-development of the soothing system, making it difficult to experience compassion and increasing vulnerability to psychopathology.

Gilbert and Mascaro (2017) suggest there are multiple factors which can inhibit or facilitate individuals' regulatory systems and therefore their ability to provide and receive compassion. Gilbert (2005) proposes that early experiences of warmth and kindness can facilitate the development of the self-soothing system, which fosters subsequent care of oneself and others. Consistent with this, studies have shown experiencing love and warmth from parental figures significantly correlates with increased SC and SR, and lower fears of compassion (e.g., Irons et al., 2006; Naismith et al., 2019; Kelly & Dupasquier, 2016). SR involves a warm and positive attitude towards oneself, responding with acceptance and understanding in the face of difficulties or failures (Gilbert et al., 2004). SR is identified in the literature as the most effective facilitator of compassion (Gilbert & Mascaro, 2017)

and as a key mediator of the effects of Compassion Focused Therapy (CFT; Sommers-Spijkerman et al., 2018).

Conversely, there are factors which can in inhibit compassion. Studies have shown fear of compassion to the self (FoCtS) and fear of compassion from others (FoCfO), inhibit one's ability to self-soothe and reassure (Gilbert et al., 2014; Matos et al., 2017). In support, a meta-analysis by Kirby et al. (2019) found FoCtS and FoCfO were strongly associated with shame and self-criticism which are both well-established transdiagnostic presentations known to inhibit compassion and increase anxiety and depression (e.g., Fergus et al., Gilbert & Irons, 2005; Thompson & Berenbaum, 2006). Shame, whereby one holds a global negative evaluation of themselves and believes they are held negatively in the mind of others (Gilbert, 1998), has been associated with experiences of bullying victimisation, as well as significantly lower levels of SC (Beduna et al., 2019; Ferreira et al. 2013; Naismith et al., 2019). Self-criticism is an internal shaming process, which Gilbert et al. (2004) conceptualises in two forms: inadequate self (IS), focusing on mistakes and wanting to improve oneself, and hatred self (HS), focusing on desires to punish oneself for perceived failures. Kopala-Sibley et al. (2013) found experiencing different forms of peer victimisation in childhood was linked to different forms of self-criticism in adulthood, with psychological hostility predicting IS, and physical aggression predicting HS. They hypothesised being bullied or rejected by peers increases self-criticism through prolonged messaging that the individual is disliked and flawed, creating a vulnerability to depression.

SC has been identified as a potential buffer to the detrimental effects of bullying for young people (e.g., Chen & Zhu., 2022; Chu et al., 2018; Múzquiz et al., 2022; Yaghoubi et al., 2021; Zhang et al., 2019). The link between bullying and SC is explored in the literature by looking at the role SC plays in victim, bullying and bystander roles, with findings suggesting a negative association between SC and the likelihood of being victim or aggressor (Fasihi & Abolghasemi, 2017; Geng & Lei, 2021; Zăbavă, 2020). Furthermore, SC can potentially positively buffer the negative effects of bully victimisation for adolescents, with a body of evidence suggesting that SC can protect against symptoms of anxiety and depression (Chen & Zhu, 2022; Chu et al., 2018; Muzquiz et al., 2022; Yaghoubi et al., 2021; Zhang et al., 2019). However, there is a lack of research on the potential long-term impacts in adulthood, of experiencing bullying during secondary school on the three flows of compassion.

The current evidence base largely uses the Self-Compassion Scale (SCS; Neff, 2003), which focuses on SC as a way of relating to oneself, measuring three pairs of opposing components:

mindfulness versus over-identification; self-kindness versus self-judgement and common humanity versus isolation. The SCS is scored by combining SC and reverse scored self-criticism items. Although this measure is widely used, current theoretical understanding suggests SC and self-criticism may be distinct from each other and activate different neural regulation systems, rather than one construct operating at opposite ends of the same spectrum (Gilbert et al., 2017; MacBeth & Gumley, 2012). Factor analyses have substantiated this critique with studies finding six distinct yet related factors to be a better conceptual fit, and that combining constructs could mask meaningful differences (Arimitsu, 2014; Brenner et al., 2017; López et al., 2015; Petrocchi et al, 2014; Williams et al., 2014). A meta-analysis by Muris and Petrocchi (2017) raised concerns that the SCS may overestimate relationships between SC and psychopathology due to the inclusion of the negative components. Others have raised questions that some populations and cultures may find items in the SCS too abstract to use accurately (Cleare et al., 2018; Williams et al., 2014).

In contrast, the CEAS (Gilbert et al., 2017) attempts to address these issues and was developed from an evolutionary (Nesse & Ellsworth, 2009), neuropsychological (Porges, 2007) and attachment (Bowlby, 1979) theoretical base, rather than attempting to translate nuanced Buddhist concepts. The three flows of compassion are measured without self-criticism to avoid masking or confounding positive and negative items. Compassionate motivations, sensitivity to suffering and helping behaviours are identified separately within each flow, using behavioural examples (Gilbert et al., 2017). Measuring the three orientations of compassion separately provides a more complex multifaceted picture of compassion: The flows can differ from one another, which suggests they are related but distinct components, which would influence clinical application (Gilbert et al., 2017; Lopez et al., 2018). To extend the literature further, there is the need to consider the impacts of experiencing childhood bullying victimisation on the three flows of compassion in adulthood. The present study aims to add to the current evidence base of the long-term effects of bullying victimisation (e.g., Copeland et al., 2013; Beduna et al., 2019; Roth et al., 2002), specifically how the experience impacts the three flows of compassion. Furthermore, understanding which facilitators and inhibitors of compassion are predictive of each compassion orientation could support identification of beneficial processes to target to cultivate the three flows of compassion for both those affected by bullying and in the general population.

This study initially aims to explore the differences in the three flows of compassion (SC, CtO, CfO), inhibitors of compassion (FoCtS, FoCfO, fear of compassion to others [FoCtO], self-criticisms [IS, HS] and shame), facilitators of compassion (EMWS and SR) and psychopathology (anxiety and

depression) between those who have experienced bullying during secondary school (VB) and those who have not (NVB), while controlling for demographics.

The hypotheses are:

1. VB will have significantly lower levels of SC, SR, EMWS than NVB
2. VB will have significantly higher levels of self-criticism (HS and IS), shame, anxiety and depression than NVB.

Due to the lack of research, exploratory hypotheses propose that:

3. Significant differences will be found between VB and NVB for CtO, CfO, FoCtS, FoCfO and FoCtO.

Secondly, relationships between the inhibitors, facilitators, and the three flows of compassion will be investigated through exploratory analysis to determine which predict each of the three flows of compassion for VB and NVB.

Method

Study design

The study used a cross-sectional between-participants quantitative design, with all participants asked to complete all self-report measures. Power analysis was conducted using G*power (version 3.1.9.7; Faul et al., 2009). A medium effect size was identified from existing research investigating group differences and predictors of compassion (Kariyawasam et al., 2022). Assuming a medium effect size, alpha value of 0.05 and power of 0.80, a minimum of 128 participants were required to explore group differences through t-tests and ANCOVAs with one covariate. A minimum of 163 participants were required to explore relationships using hierarchical linear regressions with 15 predictor variables.

Participants

In total, 624 participants meeting the eligibility criteria (over 18 years of age, currently living in and have attended secondary school in the United Kingdom) consented to complete the study. After data was cleaned (see Data Analysis section), the final sample consisted of 383 participants (84.6% female), with a mean age of 25 years, SD = 11.31, range= 18-78 years. Participants were

identified as VB (37%) or NVB (63%)[1], with 84% confirming their answers were solely related to secondary school bullying, and 16% acknowledging experiences may have been outside of this period. The ethnicities of the sample comprised a range of backgrounds including White (82.5%), Asian (9.1%), Black (4.2%) and mixed heritage (4.2%). See Appendix D for full details of participant backgrounds. Most participants identified as heterosexual (73.9%), followed by bisexual (16.4%) and gay/lesbian (5.7%). See Table 2.1. for demographic information.

[1]. Questions measuring cyberbullying were added from an adapted version of the measure (RBQ-M; Mitchell et al., 2016). Seven (1.82%) participants were classed as VB due to cyberbullying alone.

Table 2.1.

Participants' Demographic Information

Participant characteristics	N	%	Mean	Range	SD
Age (years)	383		25	18-78	11.31
Bully victim status					
Victim	142	37.1			
Non-victim	241	62.9			
Gender					
Female	324	84.6			
Male	54	14.1			
Non-binary	5	1.3			
Ethnicity					
White	316	82.5			
Asian	35	9.1			
Black	16	4.2			
Mixed heritage	16	4.2			
Sexuality					
Heterosexual	283	73.9			
Bisexual	63	16.4			
Gay/lesbian	22	5.7			
Pansexual	6	1.6			
Asexual	4	1			
Other	5	1.3			
Bullying victimisation experience					
Solely related to secondary school	321	84.8			
May have been outside of secondary school	62	16.2			
Psychological treatment					
Currently in treatment	44	11.5			
Not currently in treatment	339	88.5			
University of Southampton student					
Student	300	78.3			
Non-student	83	21.7			

Measures

Sociodemographic information

Participants provided sociodemographic information including their age, gender, ethnicity, sexuality, if they were currently engaged in any psychological treatment, and if they were currently a University of Southampton student to allow for the allocation of research credits.

The Retrospective Bullying Questionnaire (RBQ)

Six questions were chosen from The RBQ (Schäfer et al., 2004) as they specifically focus on experiences of bullying during secondary school rather than bullying victimisation at other times in life. Participants were initially presented with a definition of bullying (Olweus, 1993). The six items asked about different forms of bullying including physical (e.g., "*hitting and kicking, and having things stolen from you*"), verbal (e.g., "*being called nasty names and being threatened*") and indirect (e.g., "*having lies or nasty rumours told about you behind your back or being deliberately excluded from social groups*"). Participants were asked about the frequency of these attacks, with responses provided on a five-point Likert scale from one ("*Never*") to five ("*Constantly*"), and the perceived severity of the attacks, from one ("*I wasn't bullied*") to five ("*Extremely serious*"). Two items relating to cyberbullying (e.g., "*Received threatening or insulting text messages, or had embarrassing jokes, rumours, gossip, or threatening comments written about you on the Internet*") were added from an adapted version of the measure (RBQ-M; Mitchell et al., 2016), with the same Likert scales. Internal consistency for the cyberbullying items in the adapted measure were acceptable, measured by Cronbach's alpha of .72 (Mitchell et al., 2016). The original RBQ secondary school section has a good two-month retest validity (r = .87). Cronbach's alpha for measure in the current sample was .87. The measure identifies participants as having been the victim of bullying during secondary school if they report being bullied in one or more ways "*sometimes*" or more frequently. As well as considering the experience to be "*quite serious*" or more in severity.

Recency Effects Question (REQ)

Patient and Public Involvement (PPI) from The Diana Award, a charity engaging young people and their networks in changing the culture of bullying, generated an additional question aiming to address potential recency effects. The question stated: *"You may have experienced bullying behaviour at times in your life other than secondary school. Please indicate how much you*

agree with the following statement: My answers above were solely related to secondary school experiences". Answers were provided on a five-point Likert scale from 1 ("*Strongly agree*") to 5 ("*Strongly disagree*").

The Compassionate Engagement and Action Scales (CEAS)

The CEAS (Gilbert et al., 2017) explores the three flows of compassion: SC (e.g., "*I am motivated to engage and work with my distress when it arises*"), CtO (e.g., "*I am motivated to engage and work with others distress when it arises*") CfO (e.g., "*Other people are actively motivated to engage and work with my distress when it arises*"). Each of the three subscales has 13 items: eight items measuring engagement (the ability to be motivated to engage with things and feelings that are difficult) and five items measuring action (the ability to focus on what's helpful to us). All items are on a 10-point Likert scale (1 = Never to 10 = Always). A total score can be calculated for each of the three flows of compassion by summing the engagement and actions subscales for each flow of compassion. All three sub-scales have good internal validity, with a Cronbach's alpha of .90 for CtO for engagement and .94 for action. A Cronbach's alpha of .89 for CfO for engagement and .91 for action. A Cronbach's alpha of .77 for SC for engagement and .90 for action; Gilbert et al., 2017). Cronbach's alphas for the current study for were all good or excellent for both VB (.87 for SC, .91 for CtO and .94 for CfO) and NVB groups (.83 for SC, .91 for CtO and .93 for CfO).

Fears of Compassion Scale (FOCS)

The FOCS (Gilbert et al., 2011), a 38-item scale measuring fears of compassion with three sub-scales: FoCtO, comprising of 10 items (e.g., "*being too compassionate makes people soft and easy to take advantage of*"), FoCfO, comprising of 13 items (e.g., "*I try to keep my distance from others even if I know they are kind*"), and FoCtS, comprising of 15 items (e.g., "*I worry that if I start to develop compassion for myself I will become dependent on it*"). Participants rated each item on a five-point Likert scale (0 = Don't agree at all to 4= completely agree). Items from each subscale are summed with higher scores indicating higher fears of compassion. All subscales have good internal consistency with a Cronbach's alpha of .78 for FoCtO, .87 for FoCfO and .88 for FoCtS (Gilbert et al., 2011). Cronbach's alphas for the current study were all good or excellent for both VB (.87 for FoCtO, .90 for FoCfO and .93 for FoCtS) and NVB groups (.84 for FoCtO, .897 for FoCfO and .91 for FoCtS).

The Internal External Shame Scale (EISS)

The EISS (Ferreira et al., 2020) is an 8-item scale aiming to offer a global measure of shame as well as two dimensions of shame, with four items measuring external shame, focusing on perceiving the self to be judged negatively by others (e.g., "*Other people see me as not being up to their standards*"), and four items measuring internal shame, focusing on negative evaluations of the self (e.g., "*I am unworthy as a person*"). The current study used the global measure. Items are rated on a five-point Likert scale (0= Never to 4= Always). Scores are summed, with higher values indicating higher levels of shame. The measure has good internal validity with a Cronbach's alpha of .89 (Ferreira et al., 2020). Cronbach's alphas for the current study are good for both VB (.86) and NVB groups (.87).

The Forms of Self-Criticising/Attacking & Self-Reassurance Scale (FSCRS)

The FSCRS (Gilbert et al., 2004) is a 22-item scale, measuring ways in which people think and feel about themselves when things go wrong. Items are split into three components, with two forms of self-criticism: IS (e.g., "*I am easily disappointed with myself*") and HS; (e.g., "*I have become so angry with myself that I want to hurt or injure myself*"), and the ability to self-reassure (SR; e.g., "*I am able to remind myself of positive things about myself*"). Responses are on a five-point Likert scale ranging from 0= "*not at all like me"* to 4= "*extremely like me*". Scores are summed on each of the three subscales with higher scores indicating higher levels of each component. The scale has a Cronbach's alpha of .89 for HS and SR, and .90 for IS (Gilbert et al., 2004). Cronbach's alphas for the current study were all good for both VB (.89 for SR and IS, and .80 for HS) and NVB groups (.86 for SR, .89 for IS and .85 for HS).

Early Memories of Warmth and Safeness Scale (EMWSS)

The EMWS (Richter et al., 2009) is a 21-item scale measuring emotional memories of warmth, safety and of feeling cared for during childhood. Responses to statements exploring positive and pleasant emotional memories of childhood (e.g., "*I felt cared about; I felt appreciated in the way I was*") were rated on a five-point Likert scale from 0= "*No, never*" to 4= "*Yes, most of the time*". Scores are summed to create a global measure with higher scores indicating greater EMWS. The scale has good internal validity, measured with a Cronbach's alpha of .77 (Richter et al., 2009). Cronbach's alphas for the current study were excellent for both VB (.97) and NVB groups (.98).

Generalised Anxiety Disorder (GAD7)

The GAD7 (Spitzer et al., 2006), is a seven-item scale measuring symptoms and severity of generalised anxiety. Participants were asked how often over the last two weeks, they had been bothered by a list of generalised anxiety symptoms (e.g., "*Feeling nervous, anxious or on edge*"). Responses were rated on a four-point Likert scale from 0= "*Not at all*" to 3= "*Nearly every day*". Higher scores indicate greater levels of generalised anxiety, with 0-4 indicating below clinical levels, 5-9 indicating mild, 10-14 indicating moderate and 15-21 indicating severe symptoms of generalised anxiety. The scale has excellent internal validity, measured with a Cronbach's alpha of .92, and good retest validity of r = .83 (Spitzer et al., 2006). Cronbach's alphas for the current study were excellent for the VB group (.91) and good for the NVB group (.89).

Patient Health Questionnaire (PHQ9)

The PHQ9 (Kroenke et al., 2001), is a nine-item scale aiming to identify symptoms and severity of depression. Participants were asked how often in the last two weeks had they been bothered by a range of depressive symptoms (e.g., "*Little interest or pleasure in doing things*"). Responses are rated on a four-point Likert scale from 0= "*Not at all*" to 3= "*Nearly every day*". Higher scores indicate greater levels of depression, with 0-4 indicating below clinical levels, 5-9 indicating mild, 10-14 indicating moderate, 15-19 indicating moderately severe and 20-27 indicating severe symptoms of depression. The scale has good internal validity, measured by a Cronbach's alpha of .89, and good retest validity of r = .84 (Kroenke et al., 2001). Cronbach's alphas for the current study were good for both the VB (.88) and NVB group (.86).

Procedure

Ethical approval for this study was granted from the University of Southampton Ethics and Research Governance committee (ERGO ID 79374.A2; see Appendix E). Participants were recruited through the University of Southampton's research website (78.3%; see Appendix F for survey advert), with the remainder of participants recruited via mental health and bullying charities (e.g., Anti-bullying Alliance, The Diana Award, Anxiety UK), social media (e.g., "Instagram", "LinkedIn"), and opportunity sampling through the researchers professional and personal networks (21.7%; e.g., email, WhatsApp). The survey was accessed via a link or QR code and administered through Qualtrics (Qualtrics, 2025), an online survey distribution platform. Online data collection was chosen to foster

a larger and more diverse sample and to be cost and time efficient (Kraut et al., 2003). Once accessed, study information and a statement explaining confidentiality and anonymity were presented. Participants gave informed consent via online consent statements after reading the participant information sheet (see Appendix G). Measures were then presented in the following order: eligibility criteria, demographics, RBQ, REQ, CEAS, FOCS, EISS, FSCRS, EMWSS, GAD7 and PHQ9 (see Appendix H). Participants included in the final sample took an average of 53 minutes to complete the study and were provided with a debrief statement (see Appendix I) explaining the purpose of the study and provided options of support services relating to bullying and mental health. Participants were provided with SC resources and the option to enter a prize draw to win one of five £50 Amazon vouchers. Students from the University of Southampton could alternatively opt for 'study credits' required to complete their degree.

Data analysis

Analysis was carried out using SPSS v29 (IBM, 2021) with statistical significance set at $p = .05$. Data was screened for outliers, missing values, and bots due to the online nature of the study. Of the 624 participants who consented to complete the study and fitted the eligibility criteria, 582 completed the first two measures (RBQ and CEAS) meaning there was sufficient data to consider them for inclusion in further analysis. Of these, 37 participants were removed due to having a ReCAPTCHA score of 0.5 or below, as this is recognised as the threshold for identifying bots (Awla et al., 2022). Participants with a completion time exceeding 24 hours, as the stated timeframe in the survey (three participants), or less than 15 minutes, as this was deemed an unrealistic completion time (158 participants), were also excluded from analysis (Arevalo et al., 2022). One case was removed due to contradictory and consecutive responses (Arevalo et al., 2022) after being identified by multiple outliers. In the final sample of 383 participants, seven had completed some but not all measures. Therefore, these participants were included in analysis on all measures they had completed. Five extreme outliers were changed to the next closest value plus or minus one (Field, 2024), totalling 0.21% of all values. Visual inspection of the histogram suggested age was not normally distributed, therefore analysis including this variable employed bootstrap procedures (Field, 2024). Histograms, boxplots and scatterplots suggested all other data met the parametric assumptions of normality, linearity and homoscedasticity.

Chi-square tests were carried out to assess differences between VB and NVB groups for gender, ethnicity, sexuality and recollections of bullying occurring during, or outside of secondary

school. Data was then grouped into binary categories. Independent between subject t-tests were carried to assess differences between VB and NVB groups for age, SC, CtO, CfO, FoCtS, FoCtO, FoCfO, self-criticism (IS, HS), shame, SR, EMWS and anxiety and depression. Analysis of Covariates (ANCOVA) were carried as supplementary sensitivity analysis to explore if accounting for each covariate separately impacted any differences identified between the groups.

Correlations were run between all variables with bootstrap procedures based on 1000 samples as age violated assumption of normality (Field, 2024). Hierarchical linear multiple regressions for VB and NVB examined the relationship between, and contributions from, predictor variables (FoCtS, FoCtO, FoCfO, HS, IS, shame, SR and EMWS) for each of the three flows of compassion (SC, CtO, CfO). The models controlled for demographics (age, gender, ethnicity, sexuality and bullying recall accuracy), which were entered at step 1, and psychopathology (anxiety and depression), which were entered at step 2. All other predictor variables (inhibitors and facilitators of compassion) were entered at step 3.

Results

Hypotheses 1: VB will have significantly lower levels of SC, EMWS and SR than NVB.[2]

Independent between-subject t-tests were carried out with equal variances unassumed. All differences are reported in Table 2.2. Effect sizes of all differences observed ranged from small to moderate. Contrary to the initial hypothesis, there were no significant differences between VB and NVB for SC, t (266.34) = -.913, p= .181, d = -.10. However, VB reported significantly less EMWS than NVB, t (308.75) = -4.67, p <.001, d = -.49. Although there were lower levels of SR in VB than NVB, t (292.43) = -2.37, p = .009, d = -.25, once the Bonferroni critical p-value was adjusted for multiple comparisons to p = .003, this was no longer deemed to be significant. These results suggest that levels of SC and SR in adulthood were not significantly different between those who experienced bullying in secondary school and those who had not. However, participants who experienced

[2] Analysis was also conducted removing participants which were currently in psychological treatment (11.5%; n = 44). However, differences between VB and NVB remained unchanged so these participants were included in analysis.

bullying were able to recall fewer positive memories of feeling safe and cared for in childhood than those who did not experience bullying during this time.

Hypotheses 2: VB will have significantly higher levels of self-criticism (IS and HS), shame, anxiety and depression than NVB.

The hypotheses were supported with VB reporting higher levels of HS, t (289.73) = 2.92, p = .002, d = .31 and IS, t (307.29) = 4.76, p <.001, d = .49, as well as higher levels of shame, t (293.99) = 5.48, p <.001, d = .58, anxiety t (260.31) = 4.28, p <.001, d = .47 and depression, t (265.41) = 3.99, p <.001, d = .44 than NVB. These findings suggest that those who experienced bullying during secondary school were more likely to experience anxiety, depression and increased feelings of shame in adulthood compared to those who did not have these experiences. The results also indicate VB criticise themselves more, experience feelings of personal inadequacy and desires to persecute themselves, than those who did not experience bullying in secondary school. All results remain significant with the Bonferroni corrected critical p-value of .003, accounting for multiple comparisons.

Hypotheses 3: There will be a significant difference between CtO, CfO, FoCtO, FoCfO and FoCtS between the VB and NVB groups.

There were no significant differences between the two groups in CtO, t (293.54) = .21, p = .419, d = -.10. However, VB showed significantly lower levels of CfO, t (271.78) = -2.99, p = .003, d =-.33, greater levels of FoCtO, t (268.05) = 3.62, p <.001, d = .38, FoCfO, t (274.91) = 4.88, p <.001, d = .53 and FoCtS, t (253.10) = 4.12, p <.001, d = .46 than NVB. These results suggest that irrespective of experiencing bulling during secondary school, levels of CtO are not affected. However, VB show significantly less ability to receive compassion from others than NVB. Interestingly, those who had been bullied were more fearful of expressing compassion to others and themselves, as well as receiving compassion from others, than those who had not experienced bullying. All results remain significant with the Bonferroni corrected critical p-value of .003, accounting for multiple comparisons.

Table 2.2.

T tests showing differences in all measures between VB and NVB

	n		m (sd)		df	*t*	*p*	Cohen's *d*
	VB	NVB	VB	NVB				
Self-compassion	142	241	59.15 (14.39)	60.49 (12.66)	266.34	-.913	.181	-.10
Compassion to others	142	241	77.70 (12.94)	77.42 (12.82)	293.54	.21	.419	.02
Compassion from others	142	241	58.55 (16.28)	63.52 (14.68)	271.78	-2.99	**.003***	-.33
Fears of compassion to others	142	240	28.52 (8.09)	25.55 (7.16)	268.05	3.62	**<.001****	.38
Fears of compassion from others	141	239	33.63 (10.32)	28.43 (9.51)	274.91	4.88	**<.001****	.53
Fears of compassion to self	141	239	36.06 (13.37)	30.55 (11.14)	253.10	4.12	**<.001****	.46
Internal external shame	141	239	25.51 (5.73)	22.18 (5.74)	293.99	5.48	**<.001****	.58
Inadequate self	141	239	32.27 (7.60)	28.34 (8.05)	307.29	4.76	**<.001****	.49
Hated self	141	239	11.39 (4.77)	9.93 (4.69)	289.73	2.92	**.002***	.31
Self-reassurance	141	239	24.35 (6.09)	25.87 (6.06)	292.43	-2.37	.009	-.25
Early memories of warmth and safeness	139	238	67.61 (19.17)	77.48 (20.85)	308.75	-4.67	**<.001****	-.49
Generalised anxiety	139	238	17.29 (5.62)	14.83 (4.95)	260.31	4.28	**<.001****	.47
Depression	139	237	19.13 (6.07)	16.63 (5.47)	265.41	3.99	**<.001****	.44

Note. *p < .05, **p < .001. p values reported for CfO, FoCtO, FoCfO and FoCtS are two-tailed, p values for all other differences are one-tailed. Cohen's d effect size= small effect size = .2, medium effect size = .5, large effect size = .8. The Bonferroni corrected critical p-value accounting for multiple comparisons was .003. Therefore, with the corrected p-value, levels of SR were no longer significantly different between VB and NVB.

Confounding variables

Bootstrap procedures were used based on 1000 samples as age violated assumption of normality (Field, 2024). There were no significant differences between VB and NVB groups in age, t (381) = .57, p = .567, d = .06. Each remaining demographic variable was each split into two groups to allow enough in each category to conduct analysis. Chi-square tests found that there were no significant differences between the VB and NVB group in gender χ^2 (1) = .01, p = .93, ϕ = -.004, when accounting for men and woman (excluding non-binary participants). There were no significant differences in ethnicity between VB and NVB groups χ^2 (1) = .26, p = .608, ϕ = -.03 when backgrounds were grouped into 'white and other'. However, the VB group had a significantly more queer (gay/ lesbian, bisexual, pansexual) or asexual participants (32%) than the NVB group (22.4%), when grouped into 'queer and heterosexual', χ^2 (1) = 4.620, p = .03, with a small effect size, ϕ = -.11. This finding suggests that that a greater proportion of those who experienced bullying in secondary school identified as queer or asexual compared to those who did not experiencing bullying.

There was no significant difference between the VB and NVB in those who reported their recollections of experiences of bullying were solely related to occurring during secondary school (83.4%) and those who reported they may have been outside of this period, (16.2%), χ^2 (1) = .75, p = .387, ϕ = -.04.

ANCOVA was carried out as supplementary sensitivity analysis for all variables that were found to have a significant difference between VB and NVB groups (see Supplementary Materials). Significant differences between VB and NVB remained between all variables after controlling for age, gender and ethnicity separately. Sexuality and recollections of bullying occurring during or outside of secondary school were not included as covariates as these variables violated the parametric assumptions for this analysis (Field, 2024).

Exploratory analysis

Hierarchical linear regressions explored if barriers (FoCtO, FoCfO, FoCtS, shame, IS and HS) and facilitators (SR, EMWS) of compassion predict each of the three flows of compassion (SC, CtO, CfO) separately for the VB and NVB groups, after controlling for demographic variables (age, gender, ethnicity and bullying recall accuracy) and psychopathology (anxiety and depression). Bootstrap procedures were used based on 1000 samples as age violated parametric assumptions (Field, 2024). Demographics were entered at step 1, psychopathology at step 2 and barriers and facilitators of compassion at step 3 for each hierarchical regression. For each regression VIF scores were checked for multicollinearity, however no issues were identified (Myers, 1990). Correlations between variables are shown in table 2.3 and 2.4.

Predictors of SC for VB

The hierarchical regression for SC for VB was statistically significant, controlling for age, gender, ethnicity, sexuality and bullying recall accuracy at step 1, $R^2 = .47$, $F(15, 119) = 6.95$, $p < .001$. The addition of psychopathology (step 2) led to a statistically significant increase in R^2 of .11, $F(2, 127) = 8.03$, $p < .001$. The addition of the barriers and facilitators of compassion (step 3) also led to a statistically significant increase in R^2 of .32, $F(8, 119) = 8.91$, $p < .001$, with the final model accounting for 47% of the total variance. The model indicated that only SR significantly predicted SC (see Table 2.5.), with a medium effect size ($sr^2 = .11$), indicating those who were able to offer themselves reassurance were also able to be more self-compassionate.

Table 2.3

Correlations between variables for victims of bullying.

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1.Age	-														
2.Gender	-.05	-													
3.Ethnicity	**.18***	.11	-												
4.Sexuality	**.22***	**.17***	.07	-											
5.Time of bullying experience	-.06	.02	.16	.09	-										
6.Anxiety	**-.24****	.07	-.06	-.16	-.13	-									
7.Depression	**-.18***	.10	-.02	-.14	**-.20***	**.63****	-								
8.Fear of compassion to others	**-.35****	-.04	**-.29****	.05	-.14	**.02***	**.23****	-							
9.Fear of compassion from others	**-.15****	.01	-.12	-.04	**-.21***	**.37****	**.42****	**.51****	-						
10.Fear of compassion to self	-.15	.01	-.08	.01	**-.18***	**.47****	**.47****	**.35****	**.65****	-					
11.Internal external shame	-.10	.09	.04	-.16	**-.17***	**.49****	**.53****	**.19***	**.63****	**.61****	-				
12.Self-reassurance	.02	-.02	-.14	.01	.02	**-.44****	**-.41****	.01	**-.32****	**-.58****	**-.60****	-			
13.Inadequate self	**-.25****	.04	-.12	-.14	-.01	**.55****	**.46****	**.23***	**.41****	**.64****	**.61****	**-.67****	-		
14.Hated self	-.14	.01	.06	-.15	-.06	**.42****	**.46****	.11	**.43****	**.63****	**.61****	**-.50****	**.62****	-	
15.Early memories of warmth and safeness	-.07	.04	.17	.14	.12	-.14	**-.20***	-.06	**-.45****	**-.27****	**-.29****	**.28****	**-.28****	**-.30****	-

Note. *$p < .05$, ** $p < .01$

Table 2.4

Correlations between variables for non-victims of bullying.

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1.Age	-														
2.Gender	**.21***	-													
3.Ethnicity	**.16***	.07	-												
4.Sexuality	**.22****	.07	.01	-											
5.Time of bullying experience	-.09	.03	.08	-.10	-										
6.Anxiety	**-.17***	-.07	-.01	**-.28****	.09	-									
7.Depression	**-.18****	-.06	-.03	**-.26****	.08	**.70****	-								
8.Fear of compassion to others	**-.24****	.11	**-.22****	**-.16***	.07	**.35****	**.33****	-							
9.Fear of compassion from others	**-.14***	-.11	-.05	**-.25****	.01	**.42****	**.54****	**.56****	-						
10.Fear of compassion to self	-.09	-.03	.04	**-.13***	.04	**.46****	**.58****	**.46****	**.74****	-					
11.Internal external shame	-.01	-.08	.09	**-.28****	.09	**.49****	**.56****	**.24****	**.61****	**.64****	-				
12.Self-reassurance	.04	.10	-.01	**.18****	-.09	**-.38****	**-.49****	-.12	**-.48****	**-.54****	**-.62****	-			
13.Inadequate self	-.09	-.04	.02	**-.25****	**.14***	**.57****	**.57****	**.25****	**.51****	**.60****	**.74****	**-.57****	-		
14.Hated self	.04	-.09	.04	**-.37****	.05	**.55****	**.68****	**.24****	**.58****	**.65****	**.67****	**-.59****	**.67****	-	
15.Early memories of warmth and safeness	**-.15***	.03	.09	**.27****	-.07	**.27****	**-.41****	-.09	**-.46****	**-.40****	**-.45****	**.46****	**-.37****	**-.56****	-

Note. *$p < .05$, ** $p < .01$

Table 2.5.

Hierarchical linear regression analysis predicting self-compassion for victims of bullying during secondary school.

Predictor variables for SC (VB)	*B*	*SE B*	*β*	*t*	*Sig.*	*Zero-order*	*sr²*	95% CI lower	95% CI upper	VIF
Step 3										
Age	.087	.098	.073	.910	.374	.165	.00	-.109	.277	1.423
Gender	-2.401	2.487	-.060	-.861	.319	-.069	.00	-7.565	3.164	1.092
Ethnicity	1.163	3.368	.030	.389	.727	-.019	.00	-5.543	8.083	1.306
Sexuality	-.725	2.331	-.024	-.313	.785	-.046	.00	-5.015	3.783	1.278
Bullying recall accuracy	.855	1.467	.047	.647	.552	.032	.00	-1.887	3.355	1.173
Anxiety	.375	.243	.149	1.578	.125	-.273	.01	-.161	.858	1.993
Depression	-.302	.209	-.125	-1.328	.146	-.331	.01	-.742	.151	1.986
Fears of compassion to others	-.270	.184	-.150	-1.667	.145	-.176	.01	-.634	.077	1.801
Fears of compassion from others	.154	.164	.111	.939	.354	-.218	.00	-.196	.493	3.133
Fears of compassion to self	-.145	.114	-.133	-1.123	.202	-.462	.01	-.399	.122	3.141
Internal external shame	.147	.353	.059	.511	.677	-.371	.00	-.552	.827	2.989
Self-reassurance	1.352	.293	.558	5.027	**<.001**	.614	.11	.748	2.021	2.747
Inadequate self	-.238	.228	-.127	-1.065	.309	-.522	.01	-.662,	.252	3.197
Hated self	-.035	.318	-.011	-.110	.904	-.356	.00	-.657	.524	2.255
Early memories of warmth and safeness	-.064	.072	-.084	-1.020	.389	.077	.00	-.217	.076	1.520

Note. sr^2 = .02 (small effect size), .13 (medium effect size), .26 (large effect size).

Predictors of SC for NVB

The hierarchical regression for SC for NVB was statistically significant, controlling for age, gender, ethnicity, sexuality and bullying recall accuracy at step 1**,** R^2 = .47, F(15, 220) = 12.95, p < .001. The addition of psychopathology led to a statistically significant increase in R^2 of .09, F(2, 228) = 11.98, p <.001. The addition of the barriers and facilitators of compassion also led to a statistically significant increase in R^2 of .30, F(8, 220) = 15.68, p <.001. The final model accounted for 47% of the total variance. Similarly to the VB group, SR significantly predicted SC (see Table 2.6.) with a medium effect size (sr^2 = .11), suggesting those that can SR have increased levels of SC. The model also indicated that FoCtS significantly predicted SC (sr^2 = .01), suggesting that being less fearful of showing oneself compassion related to being increased levels of SC. Following this, age next significantly predicted SC (sr^2 = .02), suggesting that SC increased with age. Finally, FoCtO significantly predicted SC (sr^2 = .01), suggesting that feeling more fearful about showing compassion to others related to having higher levels of compassion for oneself.

Table 2.6.

Hierarchical linear regression analysis predicting self-compassion for those who have not experienced bullying during secondary school

Predictor variables for SC (NVB)	*B*	*SE B*	*Beta*	*t*	*Sig.*	*r zero order*	*sr²*	95% CI lower	95% CI upper	VIF
Block 3										
Age	.205	.063	.177	3.123	**.002**	.178	.02	.097	.343	1.333
Gender	.891	1.656	.024	.460	.578	-.103	.00	-2.431	4.354	1.154
Ethnicity	.236	1.767	.007	.134	.886	-.015	.00	-3.320	3.555	1.190
Sexuality	2.551	1.854	.083	1.459	.157	.236	.01	-.868	6.163	1.340
Time of bullying experiences	-.150	1.002	-.008	-.162	.865	.058	.00	-2.174	1.787	1.077
Anxiety	-.219	.180	-.084	-1.135	.227	-.314	.00	-.569	.132	2.292
Depression	.277	.185	.118	1.428	.125	-.354	.00	-.082	.637	2.809
Fear of compassion to others	.305	.133	.172	2.480	**.025**	-.080	.01	.009	.571	1.988
Fear of compassion from others	-.099	.120	-.074	-.837	.416	-.416	.00	-.325	.128	3.280
Fear of compassion to self	-.239	.117	-.208	-2.378	**.042**	-.469	.01	-.473	-.008	3.172
Internal external shame	-.248	.206	-.111	-1.287	.244	-.492	.00	-.647	.188	3.111
Self-reassurance	.961	.145	.457	6.607	**<.001**	.623	.11	.659	1.261	1.982
Inadequate self	.102	.145	.064	.773	.476	-.416	.00	-.164	.389	2.869
Hated self	.050	.270	.018	.201	.839	-.451	.00	-.473	.575	3.375
Early memories of warmth and safety	.030	.042	.048	.727	.464	.347	.00	-.050	.111	1.843

Note. sr^2 = .02 (small effect size), .13 (medium effect size), .26 (large effect size).

Predictors of CtO for VB

The hierarchical regression to examine predictors of CtO for VB was statistically significant, controlling for age, gender, ethnicity, sexuality and bullying recall accuracy at step 1, R^2 = .25, F(15, 119) = 2.69, p = .001. Adding psychopathology (step 2) to demographics did not lead to a statistically significant increase in R^2 of .03, F(2, 227) = 2.18, p = .117, suggesting these variables alone do not predict CtO. However, the addition of the barriers and facilitators of compassion (step 3) showed a significant increase in R^2 of .16, F(8, 119) = 3.27, p = .002. The final model accounted for 25% of the total variance. The model indicated that IS predicted CtO (sr^2 = .04), indicating those who experienced a sense of personal inadequacy were more compassionate towards others. SR also significantly predicted CtO (sr^2 = .05), suggesting those who were able to reassure themselves were able to show higher levels of compassion towards others.

Table 2.7.

Hierarchical linear regression analysis predicting compassion to others for those who have experienced bullying during secondary school

Predictor variables for CtO (VB)	*B*	*SE B*	*Beta*	*t*	*Sig.*	*r zero order*	*sr²*	95% CI lower	95% CI upper	VIF
Block 3										
Age	.114	.093	.106	1.116	.217	.129	.00	-.066	.303	1.424
Gender	.019	2.374	.001	.010	.992	-.080	.00	-5.248	4.300	1.184
Ethnicity	.280	.377	.076	.851	.487	.105	.00	-.437	1.013	1.269
Sexuality	-1.392	1.027	-.125	-1.384	.178	-.076	.01	-3.389	.506	1.286
Time of bullying experiences	.688	3.440	.021	.247	.852	.098	.00	-6.183	6.976	1.170
Anxiety	.422	.239	.188	1.643	.077	.017	.02	-.067	.870	2.054
Depression	-.293	.210	-.141	-1.231	.168	-.109	.00	-.714	.109	2.057
Fear of compassion to others	-.316	.173	-.199	-1.874	.072	-.250	.02	-.651	.026	1.773
Fear of compassion from others	-.142	.202	-.116	-.821	.494	-.209	.00	-.570	.209	3.139
Fear of compassion to self	-.198	.147	-.207	-1.431	.184	-.179	.01	-.484	.099	3.291
Internal external shame	.281	.298	.128	.921	.365	-.043	.00	-.237	.918	3.019
Self-reassurance	.805	.281	.380	2.795	**.004**	.108	.04	.238	1.326	2.904
Inadequate self	.551	.249	.331	2.342	**.029**	.030	.03	.096	1.066	3.137
Hated self	.487	.381	.178	1.457	.230	.053	.03	-.286	1.157	2.367
Early memories of warmth and safety	-.014	.068	-.021	-.211	.823	.050	.00	-.145	.123	1.609

Note. sr^2 = .02 (small effect size), .13 (medium effect size), .26 (large effect size).

Predictors of CtO for NVB

The hierarchical regression for predictors of CtO for NVB was statistically significant, controlling for age, gender, ethnicity, sexuality and bullying recall accuracy at step 1, R^2 = .27, F(15, 220) = 5.47, p < .001. The addition of psychopathology to the prediction of demographics did not lead to a significant increase in R^2 of .01, F(2, 228) = .91, p = .403. However, adding the barriers and facilitators of compassion indicated a statistically significant increase in R^2 of .17, F(8, 220) = 6.42, p <.001. The final model accounted for 27% of the total variance. The model indicated that gender significantly predicted CtO (sr^2 = .07; see Table 2.8.), indicating women showed higher levels of CtO (M = 78.62) compared to men (M = 70.03). Following this, barriers to compassion of IS (sr^2 = .05) and FoCtS (sr^2 = .02) were found to be significant predictors of CtO, suggesting those who experienced less FoCtS had increased compassion for others, while those who saw themselves as inadequate had increased levels of compassion for others. Depression significantly predicted CtO (sr^2 = .04), suggesting those experiencing symptoms of depression had higher levels of compassion for others. Following this SR significantly predicted CtO (sr^2 = .02), indicating those with the ability to reassure themselves were able to be more compassionate towards others. Finally, age was found to predict CtO (sr^2 = .01), suggesting CtO increases as participants got older.

Table 2.8.

Hierarchical linear regression analysis predicting compassion to others for those who have not experienced bullying during secondary school

Predictor variables for CtO (NVB)	*B*	*SE B*	*Beta*	*t*	*Sig.*	*r zero order*	*sr²*	95% CI lower	95% CI upper	VIF
Block 3										
Age	.137	.065	.118	1.773	**.035**	.029	.01	.011	.248	1.333
Gender	10.206	2.274	.276	4.461	**<.001**	.233	.07	6.122	14.881	1.154
Ethnicity	2.033	2.073	.062	.983	.325	.077	.00	-2.321	6.068	1.190
Sexuality	-2.631	1.931	-.085	-1.275	.166	-.086	.01	-6.199	.921	1.340
Time of bullying experiences	-1.891	1.097	-.103	-1.733	.085	-.139	.01	-4.064	.265	1.077
Anxiety	-.184	.210	-.070	-.807	.368	.079	.00	-.598	.234	2.292
Depression	.812	.212	.342	3.551	**<.001**	.106	.04	.392	1.208	2.809
Fear of compassion to others	-.106	.151	-.059	-.732	.483	-.181	.00	-.438	.162	1.988
Fear of compassion from others	-.233	.149	-.173	-1.662	.125	-.158	.01	-.523	.073	3.280
Fear of compassion to self	-.281	.136	-.243	-2.367	**.042**	-.161	.02	-.549	.046	3.172
Internal external shame	.098	.259	.044	.430	.708	.045	.00	-.421	.642	3.111
Self-reassurance	.375	.151	.177	2.185	**.014**	.063	.02	.074	.712	1.982
Inadequate self	.604	.138	.378	3.880	**<.001**	.149	.05	.334	.879	2.869
Hated self	-.426	.346	-.155	-1.464	.218	-.001	.01	-1.138	.186	3.375
Early memories of warmth and safety	.004	.047	.007	.086	.949	.029	.00	-.082	.096	1.843

Note. sr^2 = .02 (small effect size), .13 (medium effect size), .26 (large effect size).

Predictors of CfO for VB

The model predicting CfO for VB was statistically significant, controlling for age, gender, ethnicity, sexuality and bullying recall accuracy at step 1, R^2 = .32, F(15, 119) = 3.76, p < .001. The addition of psychopathology to the model led to a statistically significant increase in R^2 of .05, F(2, 127) = 3.69, p = .028. The addition of the barriers and facilitators of compassion to the model also led to a statistically significant increase in R^2 of .20, F(8, 119) = 4.43, p <.001. The final model accounted for 32% of the total variance. The model indicated that FoCfO (sr^2 = .03) and shame (sr^2 = .02) significantly predicted CfO (see Table 2.9.). These finding suggests those experiencing less FoCfO are more able to receive compassion from others. Similarly, those who experience lower levels of shame, also allow compassion to be accepted from others.

Table 2.9.

Hierarchical linear regression analysis predicting compassion from others for those who have experienced bullying during secondary school

Predictor variables for CfO (VB)	*B*	*SE B*	*Beta*	*t*	*Sig.*	*r zero order*	*sr²*	95% CI lower	95% CI upper	VIF
Block 3										
Age	-.120	.117	-.089	-.984	.310	-.094	.00	-.381	.102	1.423
Gender	3.394	3.370	.075	.954	.321	.067	.01	-2.937	9.659	1.092
Ethnicity	-2.325	3.997	-.053	-.610	.563	-.023	.00	-11.334	5.069	1.306
Sexuality	3.380	3.000	.098	1.144	.261	.149	.01	-2.440	9.681	1.278
Time of bullying experiences	-1.133	1.738	-.055	-.672	.508	-.181	.00	-4.799	2.275	1.173
Anxiety	-.407	.351	-.143	-1.342	.247	-.212	.01	-1.070	.302	1.993
Depression	.077	.275	.028	.267	.779	-.209	.00	-.468	.629	1.986
Fear of compassion to others	.052	.204	.025	.250	.814	-.084	.00	-.361	.432	1.801
Fear of compassion from others	-.498	.196	-.319	-2.388	**.015**	-.418	.03	-.926	-.092	3.133
Fear of compassion to self	.130	.169	.106	.789	.446	-.203	.00	-.206	.436	3.141
Internal external shame	-.714	.354	-.255	-1.950	**.040**	-.374	.02	-1.350	-.029	2.989
Self-reassurance	.222	.423	.081	.647	.615	.198	.00	-.547	1.042	2.747
Inadequate self	.450	.324	.213	1.575	.172	-.102	.01	-.183	1.070	3.197
Hated self	.324	.402	.092	.808	.425	-.157	.00	-.483	1.157	2.255
Early memories of warmth and safety	.175	.093	.203	2.183	.066	.358	.03	-.020	.350	1.520

Note. *sr²* = .02 (small effect size), .13 (medium effect size), .26 (large effect size).

Predictors of CfO for NVB

The hierarchical regression exploring predictors of CfO for NVB was statistically significant, controlling for age, gender, ethnicity, sexuality and bullying recall accuracy at step 1, R^2 = .23, F(15, 220) = 4.43, p < .001. Every step of the model led to a significant change in R^2, with the addition of psychopathology creating an increase in R^2 of .05, F(2, 128) = 8.03, p = .004 and the addition of the barriers and facilitators of compassion, an increase in R^2 of .13, F(8, 202) = 4.78, p <.001. The final model accounted for 23% of the total variance overall. The model indicated that EMWS significantly predict CfO (sr^2 = .02; see Table 2.10.), suggesting those who recalled feeling safe and cared for as a child were better able to receive compassion from others in adulthood. Similarly to the VB group, FoCfO (sr^2 = .02) and shame (sr^2 = .02) were found to significantly predict CfO, suggesting experiencing lower levels of FoCfO and shame allowed compassion to be accepted from others. Finally, gender significantly predicted CfO (sr^2 = .05), with females showing higher levels of compassion from others (M = 64.63) compared to males (M = 56.79).

Table 2.10.

Hierarchical linear regression analysis predicting compassion from others for those who have not experienced bullying during secondary school

Predictor variables for CfO (NVB)	*B*	*SE B*	*Beta*	*t*	*Sig.*	*r zero order*	*sr²*	95% CI lower	95% CI upper	VIF
Block 3										
Age	.064	.101	.048	.701	.516	-.055	.00	-.152	.233	1.333
Gender	10.488	2.480	.248	3.901	**<.001**	.199	.05	6.203	15.090	1.154
Ethnicity	-2.740	2.465	-.073	-1.127	.261	-.077	.00	-7.394	2.378	1.190
Sexuality	-1.076	2.459	-.030	-.444	.657	.083	.07	-5.848	3.614	1.340
Time of bullying experiences	.191	1.331	.009	.149	.876	.030	.00	-2.357	2.827	1.077
Anxiety	.410	.278	.137	1.531	.148	-.052	.01	-.114	.915	2.292
Depression	-.174	.317	-.064	-.646	.579	-.185	.00	-.774	.437	2.809
Fear of compassion to others	.068	.171	.033	.401	.699	-.096	.00	-.263	.421	1.988
Fear of compassion from others	-.350	.155	-.227	-2.124	**.026**	-.294	.02	-.666	-.029	3.280
Fear of compassion to self	.107	.144	.081	.768	.456	-.226	.00	-.189	.403	3.172
Internal external shame	-.634	.255	-.248	-2.375	**.012**	-.292	.02	-1.168	-.094	3.111
Self-reassurance	.147	.195	.061	.729	.456	.236	.00	-.253	.573	1.982
Inadequate self	.311	.194	.170	1.701	.106	-.140	.01	-.107	.697	2.869
Hated self	-.073	.340	-.023	-.215	.821	-.234	.00	-.781	.566	3.375
Early memories of warmth and safety	.140	.062	.199	2.478	**.030**	.320	.02	.018	.255	1.843

Note. sr^2 = .02 (small effect size), .13 (medium effect size), .26 (large effect size).

Discussion

Results in context

This study aimed to explore the differences and similarities in the three flows of compassion (SC, CtO, CfO), the facilitators (SR, EMWS) and inhibitors of compassion (shame, self-criticisms, fears of compassion) and psychopathology (anxiety and depression) between adults who had experienced bullying in secondary school and those who had not. Additionally, differences and similarities between individual predictors of the three flows of compassion for the two groups were explored to identify areas beneficial to target clinically. The findings are discussed below in the context of existing research and theoretical frameworks.

The three flows of compassion

Surprisingly, there were no differences between the two groups in terms of SC, despite previous research indicating that higher rates of bullying victimisation are associated with lower levels of SC in adolescence (Chu et al., 2018; Dong et al., 2014; Lahtinen et al., 2020; Múzquiz et al., 2022; Zhang et al., 2019). It is important to note that this previous research used the SCS (Neff, 2003), rather than the CEAS used in this study, and focused on an adolescent population. Compared to NVB, VB may be expected to have lower levels of SC as experiences of bullying victimisation have been found to have long-term adverse effects on the self-to-self relationship (Schäfer et al., 2004). Bullying victimisation has also been related to increased levels of self-criticism in adulthood (Sigurdson at el., 2015), which has been associated with lower levels of SC (Biermann et al., 2021). However, there are a lack of longitudinal studies exploring the long-term impacts of bullying victimisation on SC, and these results tentatively suggest that SC may not be impacted in the longer term. As existing research exploring this relationship focuses on an adolescent population (Chu et al., 2018; Dong et al., 2014; Lahtinen et al., 2020; Múzquiz et al., 2022; Zhang et al., 2019), the current finding could indicate the relationship does not sustain into adulthood. In view of this unexpected finding, it is fair to suggest that future research is needed in this area using the CEAS.

Participants' ability to receive CfO was significantly lower for those who had experienced bullying victimisation compared to those who had not. Schäfer et al. (2004) proposes that experiencing bullying victimisation in childhood creates a negative internal working model of relationships with others, which may lead to a lack of trust and fears of intimacy in adulthood (Marini et al., 2006). Furthermore, this population may struggle to recognise compassionate care from others as the world may be experienced as more hostile due to an overactive threat response (Gilbert,

2009). Additionally, VB were found to have higher levels of depression and self-criticism than NVB, which together with lower levels of CfO aligns with existing literature suggesting difficulties in receiving care is associated with higher levels of depression and self-criticism (Bowlby, 1982).

It could be expected that if VB tend to have negative internal working models of relationships with others (Schäfer et al., 2004) characterised by a lack of trust and fear (Marini et al., 2006), they may be less comfortable offering CtO than NVB and therefore report lower levels. The current study, however, found no significant difference in CtO between VB and NVB. One explanation for similar levels of CtO in the two groups may be VB using caring motivations as a submissive behaviour to appease others and avoid conflict, as they may perceive themselves to be a comparatively lower social status (Gilbert and Allan, 1994). This protective strategy may reflect a learnt response for those with histories of bullying, providing a mechanism to safely navigate social interactions. In contrast, the underlying motivation for CtO may be different for NVB, in that they may not use it as an appeasing strategy, but as a typical way to relate to others, consistent with Gilbert's theory (2014).

Facilitators of compassion

EMWS, which encompass feeling safe, secure and supported in childhood and by family (Richer et al., 2009), were found to be lower in the VB group when compared to NVB. In line with the current findings, a supportive home environment has been identified as an important factor in the occurrence and impact of bullying victimisation for young people (Haynie et al., 2001). Furthermore, loving relationships have been found to buffer the negative impacts of bullying victimisation (Biswas et al., 2020; Claes et al., 2015; Miranda et al., 2019). The current finding adds to existing research by indicating that those who experienced bullying victimisation recalled experiencing fewer relationships that provided acceptance, understanding and warmth. However, further exploration is required into this potential relationship, as the current study is only able to establish a significant difference of EMWS between VB and NVB rather than a relationship between the two experiences.

Interestingly, SR was initially found to be significantly lower for VB compared to NVB. SR has been described as an effective emotional regulation strategy, negatively associated with self-criticism (Gilbert et al., 2004), and depression in clinical and non-clinical populations (Gilbert et al., 2004; Kupeli et al., 2012; Petrocchi at el., 2018). Duarte et al. (2017) found bullying experiences were negatively related to SR for adolescent girls, however no studies have examined this relationship in adulthood. Similar to self-criticism, it has been argued that the ability to reassure oneself can be internalised from early experiences (Gilbert et al., 2004). It is therefore plausible that experiences of bullying victimisation in secondary school may have had a negative effect on individuals' ability to

reassure themselves in adulthood, accounting for VB initially having significantly lower levels of SR than NVB. However, once Bonferroni corrections were applied, this finding became non-significant. There is a debate in the literature regarding if this correction should be applied (Greenland & Hofman, 2019). Taken together it seems fair to suggest that future research is needed in this area to continue to explore the role of SR in bullying.

Inhibitors of compassion

In line with the hypotheses, in comparison with NVB, VB reported higher levels of anxiety and depression and higher levels of the inhibitors of compassion (shame, self-criticism and fears of compassion). These findings support previous research suggesting experiences of bullying victimisation in childhood can have long-term adverse consequences including symptoms of anxiety and depression (Castle et al., 2007; Copeland et al., 2013; Roth et al., 2000), self-criticism (Kopala-Sibley et al., 2013; Sigurdson et al., 2015) and feelings of shame (Beduna et al., 2019; Carlisle et al., 2007). The current findings extend the understanding of the potential long-term impacts of bullying victimisation on psychological outcomes by including possible mechanisms such as fears of compassion, which are related to poorer mental health (Kirby et al., 2019).

Although literature exploring the potential relationship between bullying victimisation and fears of compassion is sparce, FoCtS has been identified as a strong predictor of vulnerability to experiencing bullying victimisation (Zăbavă, 2020). Furthermore, long-term impacts of bullying such as shame and self-criticism have been identified as reasons why individuals may develop fears of compassion (Gilbert et al., 2012; Kirby et al., 2019). Experiences of receiving warmth and support can be seen as frightening to those who have had traumatic backgrounds (Gilbert & Procter, 2006), or bring feelings of grief relating to longing for, but not receiving, warmth from others (Gilbert, 2010). Gilbert (2010) suggests that experiencing difficult emotions in response to compassion can cause individuals to feel uncomfortable or overwhelmed, increasing fears of compassion and creating significant barriers to recovery and forming healthy relationships (Gilbert & Mascaro, 2017). Higher levels of fears of compassion in VB compared to NVB, offers a novel insight into the potential long-term impacts of childhood bullying on key inhibitors of compassion in adulthood.

Predictors of the three flows of compassion

SR was the strongest predictor of SC for both participant groups. This finding is supported by the literature, which identifies SR as the most effective facilitator of SC (Gilbert & Mascaro, 2017) and a key mechanism in CFT (Sommers-Spijkerman et al., 2018). SR and SC are positively associated

(Hermanto and Zuroff, 2016) and have both been found to buffer against depression and self-criticism (Petrocchi et al., 2018).

IS was identified as a predictor of CtO for both groups. Experiencing feelings of inadequacy towards oneself may increase empathy for others, leading to increased CtO (Gambin and Sharp, 2016). In line with this theory, higher levels of anxiety have been associated with feelings of empathy towards others (Gambin et al., 2016), suggesting experiencing internal angst may increase understanding and support for others distress.

Lower feelings of shame predicted increased CfO for both groups. In consideration of this finding, Matos & Pinto-Gouveia (2010) posit that shame activates the threat regulation system, increasing fear and avoidance in response to compassion (Matos et al., 2017). Furthermore, shame memories have been identified to influence individuals' sense of identity and negatively relate to being able to receive CfO (Steindl et al., 2018). Therefore, consistent with theory, these findings suggest that lower levels of shame relate to an increased ability to receive CfO, irrespective of levels of bullying.

In line with theoretical expectations (Gilbert & Mascaro, 2017), lower FoCtS and lower FoCfO related to higher levels of the related compassion orientation for either or both groups (e.g., FoCtS and SC). These findings support existing literature which identify fears of compassion as key processes blocking compassion (Kariyawasam et al., 2022) and fundamental to address in therapy (Matos et al., 2017). Intriguingly, higher levels of FoCtO were found to significantly predict higher levels of SC for NBV and FoCtO did not predict CtO for either group. These findings are theoretically contradicting, highlighting that the flows of compassion are related, yet distinct motivations, which operate within an interactive system of social mentalities warranting further investigation.

Interestingly, being older predicted higher levels of SC and CtO, and being female predicted CtO and CfO for NVB. The latter aligns with the literature which suggests females intrinsically tend to engage in compassion more readily than men (Stellar et al., 2012), with CtO found to be higher in women (Kariyawasam et al., 2022; López et al., 2018,) potentially due to caregiving tendencies such as nurturing and supporting others (Sprecher and Fehr, 2005). Typically, girls are socialised to focus on the needs of others from an early age (López et al., 2018). The literature also supports findings that SC and CtO increase with age in the general population (Lopez et al., 2018). However, gender and age were not significant predictors of the three flows of compassion for VB, which may be understood using a developmental framework. Interpersonal trauma in childhood is known to affect emotional development in adulthood, including emotional regulation (Dugal et al., 2016).

Experiences such as bullying victimisation can hold traumatic qualities, for example hyperarousal and emotional avoidance (Matos et al., 2010), affecting how future events are perceived. Therefore, experiencing bullying victimisation in secondary school could interrupt the typical development of the flows of compassion which have been found to naturally increase with age (Karakasidou et al., 2020) or override socialised gender norms with threat-based strategies employed, such as avoidance, interrupting the usual process.

Theoretical considerations

The findings in some part contradict Gilbert's (2014) theory, which would expect SC to be lower in those who have experienced bullying victimisation. Gilbert and colleagues argued that VB may have greater difficulty accessing the soothing regulation system and identifying with SC characteristics such as offering themselves support and encouragement when they encounter distressing thoughts and situations. Gilbert's (1989, 2000) Social Mentality Theory (SMT) may offer a helpful framework to understand this finding. SMT proposes humans have evolved innate neuropsychological systems which facilitate inter and intrapersonal relating. Each system, or mentality, produces patterns of thought, emotion and behaviour, which aid navigation of social situations and therefore survival. VB having significantly lower levels of CfO, but not SC or CtO, when compared to NVB, highlight the flows of compassion being distinct motivations, and supports the SMT which identifies caregiving and care-seeking as sperate social mentalities.

In consideration of this study's findings, it seems reasonable to propose that experiencing repeated harm from others through bullying victimisation may disrupt the care-seeking mentality which enables the acceptance of comfort from others, leading to lower levels of CfO in the VB group. The social ranking mentality (Gilbert, 1989), which aids navigation of social hierarchies, may also play a role because bullying victimisation places individuals in a subordinate and vulnerable position, leading to potential power imbalances. Receiving compassion can be perceived as a weakness (Gilbert et al., 2011), which may create a perceived vulnerability and a subordinate role for VB by placing the compassionate other in a dominant role. Similar to experiences they felt when being bullied. Therefore, victims of bullying may avoid CfO to try and remain safe in their interactions with others.

In consideration of the facilitators and inhibitors of compassion, individuals exposed to experiences that activate the threat system, such as bullying victimisation, may become more sensitive to potential external or internal threats (Gilbert, 2009). Inhibitors of compassion are known to suppress the self-soothing regulation system and facilitate the threat system, which can maintain

this imbalance (Gilbert, 2020). Conversely, early experiences of safety and warmth play an important role in the development of the self-soothing system, increasing individuals' abilities to reassure and care for themselves, receive care from others and regulate emotions in response to challenging life events (Duaete & Pinto-Gouveia, 2017; Gilbert, 2005; Gilbert et al., 2006). However, if early experiences lack warmth and safety (e.g. bullying during adolescence), individuals may be internally and externally threat orientated due to an underdeveloped self-soothing system (Gilbert, 2009). This reduces accessibility of this regulation system and its ability to downregulate the threat system in the face of adversity, leading to threat-based responses such as self-criticism and shame rather than SR and SC (Gilbert, 2009). As EMWS predicted CfO for NVB, but not VB, it seems fair to suggest that those with more secure attachment backgrounds and less exposure to threat may be more comfortable receiving CfO and feel more able to seek support when distressed due to historically positive experiences (Gilbert et al., 2017). Whereas past negative experiences may activate the threat response, in line with Gilbert's (2014) theory.

SR was identified as the strongest predictor of SC, as well as predicting CtO for both VB and NVB. SC and SR, as forms of intrapersonal relating, have been identified as activating caregiving and care-seeking mentalities (Hermanto et al., 2016). Gilbert (2014) suggests the self-to-self caregiving mentality is activated by SR in response to distress, which then promotes SC. Despite SR being significantly lower in those who had experienced bullying victimisation compared to those who had not, SR strongly predicted SC equally for both groups. This suggests that SR plays a similar role, regardless of experiences of bullying victimisation.

Strengths, limitations and future research

The findings offer new insights into the potential long-term impacts of bullying victimisation adding to the existing evidence base (e.g., Carlisle et al., 2007; Copeland et al., 2013; Beduna et al., 2019; Kopala-Sibley et al., 2013; Roth et al., 2000; Sigurdson et al., 2015). The study's methodology is strengthened by use of validated and standardised measures (Price et al., 2015). Furthermore, incorporating the CEAS allowed compassion to be measured as a multifaceted concept (Gilbert et al., 2017), and addresses the limitations of the SCS.

The study relied, however, on retrospective self-reported assessment of bullying victimisation leading to potential recall bias. For example, underreporting of adverse childhood events due to memory issues (Hardt & Rutter, 2004), or current psychological well-being influencing reporting (Ni et al., 2024). Current feelings of contentment may reduce recollection of bullying experiences or mental health difficulties increasing reporting, inflating associations with poorer

outcomes (Ni et al., 2024). However, it has been argued that utilising retrospective reporting methods does not invalidate results (Hardt et al., 2004; Ni et al., 2024), with recall bias found to account for minimal variance in the recall of historical abuse (Fergusson et al., 2011).

The RBQ, with the addition of two items measuring cyberbullying RBQ-M, categorises respondents as 'victims' if they have experienced one or more forms of bullying victimisation "*sometimes*" or more frequently, and deem this to have been "*quite*" or "*extremely serious*". While the RBQ shows adequate psychometric properties (Schäfer et al., 2004) and is well used in the literature (Lie et al., 2021; Makrydaki et al., 2024; Manoli et al., 2023; Valmaggia et al., 2015), categorising individuals into VB and NVB risks missing instances of bullying which may have had significant negative impacts. For example, individuals who reported a form of bullying victimisation occurred "*rarely*" but classed this as "*extremely serious*" would be classed as NVB. Furthermore, the measure fails to account for the psychological impact for victims. Bullying victimisation can be a significant interpersonal trauma (Beduna et al., 2019) and may be more accurately captured as such by including subjective distress caused by the incidents. Limitations of the RBQ highlight the need for future research to address this gap, developing a comprehensive bullying victimisation assessment tool, including all manifestations of bullying behaviours and subjective distress caused, improving measurement validity and therefore our understanding of the phenomena.

As participants were in UK schools, mainly white, female students, the generalisability of findings is limited. Future research recruiting a more diverse sample would be valuable, as experiences of bullying and the relationship with the variables explored may differ with protected characteristics (Hatchel et al., 2019; Xu et al., 2020). Furthermore, regression analysis for VB were marginally underpowered with a deficit of 21 participants. Future research exploring these relationships could benefit from larger sample sizes to ensure all relevant predictor variables are detected. The current study used a correlational design meaning causation cannot be inferred (Kesmodel, 2018). Future research using longitudinal designs would allow temporal precedence to be established (Field, 2024). Furthermore, including related variables in regression analysis, which may share explanatory power could mask identifying individual variables as significant predictors of the three flows of compassion (Field, 2024). Future studies may benefit from focusing on specific predictors, such as facilitators or inhibitors of compassion individually, to better understand these relationships. Limiting the number of variables would also reduce the number of questionnaires and time required to complete the study, which may protect against the effects of participant boredom and fatigue known to increase dropout and decrease response quality (Galesic, 2006).

Clinical implications

The findings tentatively support the need for compassion-based transdiagnostic interventions such as CFT (Gilbert, 2014) in supporting individuals who have experienced bullying victimisation, and that the effects of adverse interpersonal trauma are vital to consider when planning individual treatment. Using the CEAS and fears of compassion measures in the clinical assessment for VB would be beneficial to allow interventions to be tailored to the individual and appropriate areas to be targeted. The findings highlight the importance of exploring and attending to CfO for those with a history of bullying victimisation, as overlooking this potential deficit may prevent the therapeutic relationship from being used effectively, and mean therapy is of limited impact.

SR was identified as the strongest predictor of SC, as well as predicting CtO for both VB and NVB, suggesting that therapeutic interventions targeting SR may be universally effective. It is plausible that being able to adopt a warm and positive attitude towards oneself allows this approach to be adopted towards others, and that this way of self-relating may be a key step in developing positive inter and interpersonal relating. Interventions for this population, such as CFT, should consider developing SR skills and addressing inhibitors of compassion such as shame, self-criticisms and fears of compassion. This process may facilitate activation of the self-soothing system and increased engagement with the three flows of compassion autonomously (Gilbert, 2020; Matos et al., 2017) as current findings indicate this process is unlikely to occur naturally overtime or due to socialised gender norms following experiences of bullying victimisation.

Student support services in schools may benefit from utilising CFT techniques with students who are being bullied. For example, schools investing in resources such the SC app (Balanced Minds, 2023), which has been shown to reduce anxiety and self-criticism and increase SC and well-being being (Beaumont et al., 2024; Beaumont et al., 2022; Craig et al., 2020), could allow many students to engage in CFT exercises in an accessible way.

Conclusion

This study provides novel findings regarding the similarities and differences in the three flows of compassion and inhibitors and facilitators of compassion, as well as predictors of the three flows of compassion between adults who experienced bullying in secondary school and those who did not. Findings indicate that adults who experienced bullying in secondary school had lower levels of CfO, facilitators of compassion (EMWS and SR) and higher levels of the inhibitors of compassion (shame, self-criticisms and fears of compassion) than those who had not experienced bullying during this

time. SR was identified as the strongest predictor of SC and CtO for VB supporting evidence that this is a key skill to focus on in CFT (Gilbert et al., 2004). SC and CtO increased with age, and being female significantly predicted CtO and CfO for those without bullying histories but not for those with. Clinically, VB may therefore require support in developing the flows of compassion as their typical development may have been interrupted by bullying victimisation experiences. Further research should include a larger, more diverse sample with less variables to better understand the relationships between the inhibitors and facilitators of compassion for VB. Overall, this study highlights the importance of attending to individuals' experiences of bullying victimisation and how traumatic interpersonal experiences may heighten factors known to inhibit aspects of compassion and reduce factors recognised to facilitate compassion, influencing one's ability to engage in the three flows of compassion.

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Chapter 3: Bridging Chapter

Bullying is common amongst young people (Solberg & Olweus, 2003) and is a significant public health issue known to negatively impact the mental health of those affected in the short (e.g., Hawker & Boulton, 2000; Kaltiala-Heino et al., 2010; Moore et al., 2017) and long-term (e.g., Beduna & Perrone-McGovern, 2019; Copeland et al., 2013;). However, the prevalence and scale of the problem is difficult to understand due to inconsistencies in the measurement of bullying in the field (Atik, 2011). Despite a wealth of research over the last three decades (e.g., Makrydaki et al., 2024; Olweus, 1994; Solberg et al., 2003; Wolke & Lereya, 2015), there is no standardised measure of bullying consistently used, with inconsistencies in measurement approaches creating methodological challenges, such as reduced validity and large variation in prevalence estimates (Vivolo-Kantor et al., 2014). The chapters in this thesis have briefly discussed the issues of measurement including failing to account for the psychological impact of bullying victimisation, challenges of categorising respondents into binary groups, and the presence or absence of a definition of bullying. The aim of this chapter is to provide an in-depth exploration on the measurement of bullying victimisation for children and adolescents in further detail along with other important inconsistences across measures.

Olweus (1993) provided a widely used definition of bullying encompassing three main components, in that the behaviour must be intentional aggression, repeated, with an imbalance of power. More recently the Centre for Disease Control and Prevention (Gladden et al., 2014) published a standardised definition. This definition adds to the aforementioned factors, incorporating that the behaviour must be unwanted, exclude dating and sibling violence, and acknowledge that bullying can be a single incident if it is likely to be repeated. For example, if there are threats of further abuse (Gladden et al., 2014). However, measures of bullying do not consistently use a definition (e.g., Espelage & Holt, 2001; Orpinas & Horne, 2006; Tarshis & Huffman, 2007) or measure all the key elements of the construct (Hunter et al., 2007; Vivolo-Kantor et al., 2014). Additionally, a variety of terminology is used interchangeably (Swearer et al., 2010) including bullying, peer aggression and peer victimisation (e.g., Mynard & Joseph, 2000; Perry et al., 1988; Wolke et al., 2000), which without definition may mean the researcher and respondent are referring to different constructs reducing the validity of the measure.

Although bullying is often used as an umbrella term, young people have varying interpretations of what constitutes bullying (Smith et al., 2002). Discrepancies in students and researchers understanding of bullying has been identified, namely students overlooking repetition,

intentionality and an imbalance of power as being key elements of bullying behaviour (Land, 2003; Naylor et al., 2006; Vaillancourt et al., 2008). Furthermore, when present, definitions of bullying lack standardisation, excluding key components such as intentionality and power discrepancies (Hamburger et al., 2011). Interestingly, fewer bullying behaviours have been reported when the term "bully" or "victim" have been used (Kert et al., 2010; Ybarra et al., 2012), and less victimisation reported when a definition of bullying has been provided (Vaillancourt et al., 2008), compared to no definition. This demonstrates the significant effect of language and the presence or absence of a bullying definition on outcomes within a research, and potentially clinical setting.

Regarding terminology, Jia and Mikami (2018) argue that there is a clear distinction between experiencing bullying victimisation and peer aggression that is overlooked in the literature. They suggest that bullying (intentional with a power imbalance) is a subtype of peer aggression (aggression due to impulsivity or carelessness), and that the characteristics of children affected by these two types of behaviours differ. For example, Felix et al. (2011) found self-identified victims aged 10 to 18 who acknowledged a power imbalance also reported increased subjective distress, while victims who did not perceive a power imbalance reported higher behavioural and conduct difficulties. However, terms such bullying victimisation and peer aggression being used interchangeably in bullying measures means these potentially distinct groups are being merged, confounding our understanding of the issues (Jia et al., 2018).

Another major inconsistency across measures of bullying are the forms of bullying explored. Bullying is largely categorised in two main ways in the literature, either into groups of behaviours: verbal (e.g., name calling), physical (e.g., physical harm), relational (spreading rumours and exclusion) and cyberbullying (being targeted online; David-Ferdon & Hertz, 2009; Gladden at al., 2014); or into direct (verbal, physical, property damage) and indirect (being excluded, rumours spread) forms of bullying (Schäfer et al., 2004). This leads to bullying measures varying greatly in the forms of bullying assessed, with different measures capturing different forms of bullying and excluding others entirely. For example, the Olweus Bullying Questionnaire (Solberg et al., 1993), captures verbal, physical and relational bullying, the Multidimensional Peer Victimisation Scale (Mynard et al., 2000) captures verbal, physical, relational and property damage, while The Cyberbullying Inventory (Erdur-Baker & Kavsut, 2007) captures cyberbullying alone. A systematic review and content analysis of bullying measures by Vivolo-Kantor et al. (2014) identified that only seven of the 41 measures reviewed included assessment of cyberbullying. However, this form of abuse has increased in the last decade (Brochado et al., 2016), is associated with significant psychological distress (Gamez-Guadix et al., 2014), and has high suicide risk for adolescents (Bonanno & Hymel, 2013; Sinclaire et al., 2012).

Measurement tools also differ significantly in timeframes of reporting, with measures assessing if bullying victimisation has occurred over a wide range of periods such as, the last seven (Orpinas & Horne, 2006) or 30 days (Espelage et al., 2001), or use more ambiguous terms such as "*recently*" (Bond et al., 2007). Whereas others assess frequency of bullying victimisation (e.g., "*once a week*", "*several times a week*"; Solberg et al., 2003). These differences can substantially affect prevalence rates, especially depending on when a measure is administered. In consideration of school age children, rates may be lower if data is gathered in early September using a measure which asks respondents the frequency of bullying over the last 30 days, as students would be on holiday during this period. Compared to if bullying was assessed in the middle of the academic year, where children have been in school more regularly, and are likely to be exposed to more bullying from peers (Vivolo-Kantor et al., 2014).

Another important factor is whether the assessment of bullying victimisation relies on self-report or the views of others (e.g., family member, teacher) are utilised. Although self-report is most widely used (Bond et al., 2007; Espelage et al., 2001; Mynard et al., 2000; Solberg et al., 2003), little is known in the field regarding the accuracy, with ongoing debate to which captures incidents of bullying most accurately (Vivolo-Kantor et al., 2014). Challenges regarding self-reporting have been identified regarding a victim's ability to assess a perpetrator's intention and the power differentials (Furlong et al., 2010), particularly as younger children may struggle to adopt other's perspectives (Vaillancourt et al., 2008).

In contrast, some measures use parent, teacher or peer reports alongside the young person's reported experiences (Cornell et al., 2004; Leff et al., 2011; Veenstra et al., 2005). Interestingly, higher levels of agreement have been found between teacher and peer reports, compared to self-report and peer or teacher reporting, highlighting potential issues with the accuracy of self-reporting alone (Cornell et al., 2004). However, there is a lack of agreement of what would be the most appropriate actions to take when disagreements occur between accounts (Jia et al., 2018). Self-reporting and observer reports may differ due to different perceptions of interactions due to individual differences. For example, children who internalise negative experiences have been found to self-report being bullied more frequently (Fekkes et al., 2006). This may be due to bullying victimisation increasing the tendency for children to internalise problems (Jia et al., 2018), or cognitive biases impacting individuals' perceptions of the interactions (Galdstone & Kaslow, 1995). Differences in perceptions of bullying from parental and victim perspectives were explored by Thomas et al. (2016). They found that parents identified bullying more often when harm appeared to

be intended by the perpetrator, compared to when harm was not intended by the perpetrator, but harm was perceived by the victim.

Whether bullying measures should incorporate reports outside of the potential victim is further complicated by cyberbullying, as less observation from the outside is possible and approximately 60% of perpetrators are unknown to their victim (Kowalski & Limber, 2007). However, it could be argued that victim reports should be prioritised as they may be more aware of covert bullying (Olweus, 2013). Furthermore, it could be proposed that the personal subjective experience of bullying victimisation is the most important factor to understand due to the associated negative outcomes (e.g., Hawker & Boulton, 2000; Kaltiala-Heino et al., 2010; Moore et al., 2017). Yet, the lack of subjective distress included in bullying measures leaves this facet of the experience as largely unknown.

Taken together, it seems fair to propose that these inconsistencies are problematic for several reasons. For example, the impact on prevalence rates for bullying victimisation varying dramatically, which prevent accurate assessment and monitoring of the problem, or evaluation of interventions (Vivolo-Kantor et al., 2014). Significant variability has been reported regarding experiences of bullying and victimisation, with ranges as wide as 8.4% to 45% for adolescents (Biswas et al., 2020). Furthermore, large scale studies also differ in their estimates, with some reporting bullying prevalence is stable across cultures (Carney & Merrell, 2001), and others finding considerable variation across multiple counties and cultures (Nansel et al., 2004). This wide variation of prevalence rates makes it challenging to draw reliable conclusions. In addition, the lack of an inclusive and consistently used bullying definition, and variation in the construct being measured reduce the validity of findings (Jia et al., 2018). In support, Vivolo-Kantor et al.'s (2014) review reported that bullying measures commonly demonstrate moderate or high reliability, suggesting results are consistent when assessments are repeated, but often fail to report psychometrics on validity, making it difficult to assess if the intended construct is being measured. Similarly, A compendium of bullying assessment tools by Hamburger et al., (2011), including 28 measures assessing bullying victimisation, report available reliability psychometrics for four measures (Arora & Thompson, 1987; Bond et al., 2007; Chan et al., 2005; Perry et al., 1988), but fail to report specific validity psychometrics at all. Furthermore, the heterogeneity of measures makes it challenging to compare findings and conduct systematic reviews and meta-analysis, which prevents knowledge from being consolidated, patterns across studies being established and directions for future research being identified (Guzzo et al., 1987).

Future research may benefit from focusing on several areas to standardise assessment of bullying victimisation to strengthen the validity and reliability of measurement tools in the field. The presence of a standardised definition of bullying and using language appropriate to the construct may improve validity, ensuring that the phenomenon of interest is being measured (Cohen et al., 2017). Utilising a standardised construct of bullying may allow interventions to be tailored to better target key constructs of bullying (Vivolo-Kantor et al., 2014). For example, decreasing the power imbalance between victim and bully, through strengthening victims' social networks and reducing factors which may act to reinforce the perpetrators behaviours (Andreou et al., 2007; Rosenbluth et al., 2004). Interestingly, a study by Ybarra et al. (2012) experimented with the presence and absence of the term bullying and a definition of bullying. Victims were identified most accurately when the term bully was used, along with questions which specified if a power imbalance was present in each incident, suggesting this combination may increase the validity of measures. However, further studies assessing how measures can most accurately measure bullying as a construct are needed, as other components of the construct, such as intentionality were not included (Ybarra et al., 2012). Additionally, measurement tools including all forms of bullying, and utilising a more consistent timeframe, may be able to accurately capture individuals' experiences and allow data to be compared across studies more easily.

This chapter aimed to address some of the key inconsistences identified across bullying measurement tools such as variations in the use of a bullying definition, terminology used, and construct described (Hunter et al., 2007; Swearer et al., 2010; Vivolo-Kantor et al., 2014). Measures vary in which forms of bullying are assessed (Vivolo-Kantor et al., 2014) and assessment of the timeframes in which bullying occurred (e.g., Bond et al., 2007; Espelage et al., 2001; Espelage & Holt, 2001; Orpinas et al., 2006). Furthermore, there is ongoing debate regarding if self-report alone or the addition of reports from other informants more accurately capture incidents of victimisation (Cornell et al., 2004; Jia et al., 2018; Thomas et al., 2016). Further research is needed to address these inconsistences and develop measures that are reliable and valid, which would provide more robust findings, with transparent reporting of their psychometric properties and limitations. A standardised measurement of bullying may increase the accuracy of prevalence rates and allow appropriate interventions to be developed and evaluated (Vivolo-Kantor et al., 2014).

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Appendix A Journal Author Guidelines

The British Journal of Psychology Author Guidelines:

https://bpspsychub.onlinelibrary.wiley.com/hub/journal/20448295/homepage/forauthors.html

Current Psychology Author Guidelines:

https://link.springer.com/journal/12144/submission-guidelines

Appendix B Individual Search Strategies for Each Database.

Database: PsychINFO, EBSCO

Date of search: 08/01/2025

Total number of results: 132

Phenomena of interest: Bullying	
Key words:	TI "(Bulli* OR bully* OR N1 victim* OR peer victimi?ation OR peer abuse OR cybervictimi?ation OR cyber victimi?ation OR cyber bull* OR cyberbull* OR school victimi?ation OR school bull* OR harass* OR teas*) OR AB (Bulli* OR bully* OR bull* N1 victim OR peer victimi?ation OR peer abuse OR cybervictimi?ation OR cyber victimi?ation OR cyber bull* OR cyberbull* OR school victimi?ation OR school bull* OR harass* OR teas*)"
OR	
Controlled vocabulary (DE Subject (exact):	DE "(bullying OR cyberbullying OR harassment OR teasing)"
AND	
Population: Adolescence	
Key words:	TI "(Adolescen* OR teen* OR child* OR youth* OR young N2 (person* OR people* OR girl* OR boy*) OR juvenil* OR school student* OR school child* OR student*) OR AB (Adolescen* OR teen* OR child* OR youth* OR young N2 (person* OR people* OR girl* OR boy*) OR juvenil* OR school student* OR school child* OR student*)"
OR	
Controlled vocabulary:	DE "(Adolescent psychology OR adolescent psychopathology)"
AND	
Phenomena of interest: Self-Compassion	
Key words:	TI "(compassion* OR self N1 compassion*) OR AB "(compassion* OR self N1 compassion*)"
OR	
Controlled vocabulary:	DE "self-compassion OR compassion"

Database: CINAHL Plus with Full Text, EBSCO

Date of search: 08/01/2025

Total number of results: 71

Phenomena of interest: Bullying	
Key words:	TI "(Bulli* OR bully* N1 victim OR peer victimi?ation OR peer abuse OR cybervictimi?ation OR cyber victimi?ation OR cyber bull* OR cyberbull* OR school victimi?ation OR school bull* OR harass* OR teas* OR aggress*) OR AB (Bulli* OR bully* OR bull* N1 victim OR peer victimi?ation OR peer abuse OR cybervictimi?ation OR cyber victimi?ation OR cyber bull* OR cyberbull* OR school victimi?ation OR school bull* OR harass* OR teas* OR aggress*)"
OR	
Controlled vocabulary:	MH "Bullying" OR cyberbullying"
AND	
Population: Adolescence	
Key words:	TI "(Adolescen* OR teen* OR child* OR youth* OR young N2 (person* OR people* OR girl* OR boy*) OR juvenil* OR childhood* OR school student* OR school child* OR student*)" OR AB (Adolescen* OR teen* OR child* OR youth* OR young N2 (person* OR people* OR girl* OR boy*) OR juvenil* OR childhood* OR school student* OR school child* OR student*)"
Controlled vocabulary:	MH "Adolescence"
AND	
Phenomena of interest: Self-Compassion	
Key words:	TI "(compassion* OR self N1 compassion)* OR AB "(compassion* OR self N1 compassion*)"
OR	
Controlled vocabulary:	MH "Compassion OR Self-Compassion"

Database: MEDLINE, EBSCO

Date of search: 08/01/2025

Total number of results: 95

Phenomena of interest: Bullying	
Key words:	TI “(Bulli* OR bully* N1 victim OR peer victimi?ation OR peer abuse OR cybervictimi?ation OR cyber victimi?ation OR cyber bull* OR cyberbull* OR school victimi?ation OR school bull* OR harass* OR teas* OR aggress*) OR AB (Bulli* OR bully* OR bull* N1 victim OR peer victimi?ation OR peer abuse OR cybervictimi?ation OR cyber victimi?ation OR cyber bull* OR cyberbull* OR school victimi?ation OR school bull* OR harass* OR teas* OR aggress*)”
OR	
Controlled vocabulary:	MH “Bullying OR Cyberbullying”
AND	
Population: Adolescence	
Kay words	TI “(Adolescen* OR teen* OR child* OR youth* OR young N2 (person* OR people* OR girl* OR boy*) OR juvenil* OR childhood* OR school student* OR school child* student*) OR AB (Adolescen* OR teen* OR child* OR youth* OR young N2 (person* OR people* OR girl* OR boy*) OR juvenil* OR childhood* OR school student* OR school child* OR student*)”
Controlled vocabulary:	MH “Adolescent OR Psychology, Adolescent”
AND	
Phenomena of interest: Self-Compassion	
Key words:	TI “(compassion* OR self N1 compassion)* OR AB “(compassion* OR self N1 compassion*)”
OR	
Controlled vocabulary:	MH “Self-Compassion”

Database: Wed of Science Core Collection

Date of search: 08/01/2025

Total number of results: 175

Phenomena of interest: Bullying	
Key words:	TI “(Bulli* OR bully* NEAR/1 victim OR peer victimi$ation OR peer abuse OR cybervictimi$ation OR cyber victimi$ation OR cyber bull* OR cyberbull* OR school victimi$ation OR school bull* OR harass* OR teas* OR aggress*) OR AB (Bulli* OR bully* OR bull* NEAR/1 victim OR peer victimi$ation OR peer abuse OR cybervictimi$ation OR cyber victimi$ation OR cyber bull* OR cyberbull* OR school victimi$ation OR school bull* OR harass* OR teas* OR aggress*)”
AND	
Population: Adolescence	
Key words:	TI “(Adolescen* OR teen* OR child* OR youth* OR young NEAR/2 (person* OR people* OR girl* OR boy*) OR juvenil* OR childhood* OR school student* OR school child* OR student*) OR AB (Adolescen* OR teen* OR child* OR youth* OR young NEAR/2 (person* OR people* OR girl* OR boy*) OR juvenil* OR childhood* OR school student* OR school child* OR student*)”
AND	
Phenomena of interest: Self-Compassion	
Key words:	TI “(compassion* OR self NEAR/1 compassion* OR AB “(compassion* OR self NEAR/1 (compassion*)

Database: ProQuest (for Dissertations & Thesis)

Date of search: 08/01/2025

Total number of results: 101

Phenomena of interest: Bullying	
Key words:	TI "(Bulli* OR bully* OR bull* NEAR/1 victim OR peer victimi?ation OR peer abuse OR cybervictimi?ation OR cyber victimi?ation OR cyber bull* OR cyberbull* OR school victimi?ation OR school bull* OR harass* OR teas* OR aggress*) OR AB (Bulli* OR bully* OR bull* NEAR/1 victim OR peer victimi?ation OR peer abuse OR cybervictimi?ation OR cyber victimi?ation OR cyber bull* OR cyberbull* OR school victimi?ation OR school bull* OR harass* OR teas* OR aggress*)"
AND	
Population: Adolescence	
Key words:	TI "(Adolescen* OR teen* OR child* OR youth* OR young NEAR/2 (person* OR people* OR girl* OR boy*) OR juvenil* OR childhood* OR school student* OR school child* OR student*)" OR AB (Adolescen* OR teen* OR child* OR youth* OR young NEAR/2 (person* OR people* OR girl* OR boy*) OR juvenil* OR childhood* OR school student* OR school child* OR student*)"
AND	
Phenomena of interest: Self-Compassion	
Key words:	TI "(compassion* OR self NEAR/1 compassion*OR AB "(compassion* OR self NEAR/1 (compassion*)

Appendix C Risk of Bias Assessment for Each Study

Study: Bowornkittikun, 2020					
Criteria	**Yes (2)**	**Partially (1)**	**No (0)**	**N/A**	**Comment**
1.Question/ objection sufficiently described?	✓				p. 7
2.Study design evident and appropriate?	✓				Design identified clearly. Mediation is carried out which requires a longitudinal design but study notes they use a theoretical model.
3.Method of participant selection described and appropriate?	✓				Yes, rationale for sample stated
4.Subject characteristics sufficiently described?	✓				Yes, basic relevant participant characteristics reported (age, gender, grade)
5. N/A				✓	
6. N/				✓	
7. N/A				✓	
8.Outcome and exposure measure(s) well defined and robust to measurement/ misclassification bias? Means of assessment reported?	✓				Measures described in detail p. 52-63
9.Sample size appropriate?	✓				Yes, sample size meets the requirement of power calculation
10.Anylitic methods described/justified and appropriate?	✓				Described clearly and appropriate for the objective of theoretical mediation.
11. Some estimate of variance is reported for the main results? (e.g., means, standard deviations)	✓				Means and SD reported p 68, confidence intervals and SEs reported p. 73.
12. Controlled for confounding?			✓		Cross sectional data of a single group was used, however no other confounding variables such as gender were considered.
13.Results reported in sufficient detail	✓				All main and follow up results reported
14.Conclusions supported by the results?		✓			Conclusions are partially supported by the data- although the author acknowledges that 'theoretical mediation' has been used

					and cross-sectional data is a limitation- the statement is vague as to what this means for understanding the findings and their clinical application. Mediation is inferred throughout but true causation cannot be inferred from a single timepoint.
Score: 19/22 = .86 (strong)					

Study: Múzquiz et al., 2022					
Criteria	**Yes (2)**	**Partially (1)**	**No (0)**	**N/A**	**Comment**
1.Question/ objection sufficiently described?	✓				Study objectives clearly described in abstract
2.Study design evident and appropriate?		✓			Design not clearly identified but appears appropriate to answer the study aims. Mediation is carried out which requires a longitudinal design but study notes correlational design is a limitation.
3.Method of participant selection described and appropriate?	✓				Sampling procedure clearly described,
4.Subject characteristics sufficiently described?	✓				Sample characteristics reported.
5. N/A				✓	
6. N/A				✓	
7. N/A				✓	
8.Outcome and exposure measure(s) well defined and robust to measurement/ misclassification bias? Means of assessment reported?	✓				All measures described clearly and appropriate
9.Sample size appropriate?	✓				Sample size seems appropriate, however no power analysis reported.
10.Anylitic methods described/justified and appropriate?	✓				Analysis described and appropriate, p. 15877, theoretical medication not explicitly noted, however limitation of cross sectional data noted in discussion.
11.Some estimate of variance is reported for the main results?		✓			Means and standard deviations included, however no other variance reported.
12.Controlled for confounding		✓			Gender differences explored, however confounding variables not controlled for in main analysis. Gender was included in the regression model.
13.Results reported in sufficient detail	✓				Main results reported
14.Conclusions supported by the results?	✓				Conclusions are supported by the data, limitation of cross-sectional correlational design recognised in

					discussion, although theoretical nature of the mediation could be clearer throughout.
Score: 19/22 = .86 (Strong)					

Study: Zhang et al., 2019					
Criteria	**Yes (2)**	**Partially (1)**	**No (0)**	**N/A**	**Comment**
1.Question/ objection sufficiently described?	✓				Study aims stated p. 3
2.Study design evident and appropriate?		✓			Study design not specified but can be inferred from the study description and is appropriate for theoretical mediation, although this is not stated until the discussion.
3.Method of participant selection described and appropriate?	✓				Sample strategy identified and appropriate
4.Subject characteristics sufficiently described?	✓				Sample adequately described- age, gender, SES
5. N/A				✓	
6. N/A				✓	
7. N/A				✓	
8.Outcome and exposure measure(s) well defined and robust to measurement/ misclassification bias? Means of assessment reported?	✓				All measures described clearly and appropriate
9.Sample size appropriate?	✓				Sample size fairly large although no power analysis reported.
10.Anylitic methods described/justified and appropriate?	✓				Analysis methods described and appropriate
11.Some estimate of variance is reported for the main results? (e.g., means, standard deviations)	✓				Means, SD, Confidence intervals and standard error reported
12.Controlled for confounding	✓				Age, gender and family economic status controlled for
13.Results reported in sufficient detail	✓				Main results reported
14.Conclusions supported by the results?	✓				Data supports conclusions- the limitation of the cross-sectional design on drawing causal conclusion was clearly stated, with the need for longitudinal designs to test these relationships in the future.

Score: 21/22 = .95 = Strong

Study: Chu et al., 2018					
Criteria	**Yes (2)**	**Partially (1)**	**No (0)**	**N/A**	**Comment**
1.Question/ objection sufficiently described?	✓				p. 379
2.Study design evident and appropriate?		✓			Design is appropriate, although not overtly stated until discussion.
3.Method of participant selection described and appropriate?	✓				Method of sample selection is stated and appropriate p. 379
4.Subject characteristics sufficiently described?	✓				Yes, although ethnicity not stated
5. N/A				✓	
6. N/A				✓	
7. N/A				✓	
8.Outcome and exposure measure(s) well defined and robust to measurement/ misclassification bias? Means of assessment reported?	✓				All measures described clearly and appropriate
9.Sample size appropriate?	✓				A fairly large sample size, no power calculation stated.
10.Anylitic methods described/justified and appropriate?	✓				Analysis described and appropriate, study notes the models are conceptual (rather than true mediation with multiple timepoints).
11.Some estimate of variance is reported for the main results? (e.g., means, standard deviations)	✓				Means and SD p 380. Confidence intervals and SE reported p. 381 & p. 383
12. Controlled for confounding?	✓				Analysis included and reported confounding variables.
13.Results reported in sufficient detail	✓				All main and follow up results reported
14.Conclusions supported by the results?	✓				Conclusions are supported by the data as limitation of the cross-sectional design mentioned, noting causation cannot be inferred and that longitudinal studies are needed going forward. Tentative language is used when discussing findings.
Score: 21/22 = .95 (Strong)					

Study: Dong et al., 2014					
Criteria	**Yes (2)**	**Partially (1)**	**No (0)**	**N/A**	**Comment**
1.Question/ objection sufficiently described?	✓				Study aims clearly stated in introduction with hypothesis.
2.Study design evident and appropriate?	✓				Study design identified and appropriate, although could be described in more detail.
3.Method of participant selection described and appropriate?	✓				Sampling process clearly reported in procedure p. 3694
4.Subject characteristics sufficiently described?	✓				Sample characteristics described in detail.
5. N/A				✓	
6. N/A				✓	
7. N/A				✓	
8.Outcome and exposure measure(s) well defined and robust to measurement/ misclassification bias? Means of assessment reported?	✓				All measures described clearly and appropriate
9.Sample size appropriate?	✓				Fairly large sample size, although does not state if sufficiently powered.
10.Anylitic methods described/justified and appropriate?	✓				Analysis described and appropriate
11.Some estimate of variance is reported for the main results? (e.g., means, standard deviations)	✓				Confidence intervals and standard error reported p. 3698
12.Controlled for confounding	✓				Analysis included and reported confounding variables
13.Results reported in sufficient detail		✓			Most main results reported; however some non-significant findings are missing.
14.Conclusions supported by the results?		✓			Reports “marginal significance rather than conforming to significance as p< .05. Conclusions are

					partially supported by the data.
Score: 20/22 = .90 (Strong)					

Study: Lahtinen et al., 2020					
Criteria	**Yes (2)**	**Partially (1)**	**No (0)**	**N/A**	**Comment**
1.Question/ objection sufficiently described?	✓				Identified clearly p. 435
2.Study design evident and appropriate?		✓			Study design can be inferred from paper but is not explicitly stated.
3.Method of participant selection described and appropriate?	✓				Clearly described and appropriate.
4.Subject characteristics sufficiently described?		✓			Some baseline demographics provided but basic information such as age poorly defined (95% of students between 16-18 years old)
5. N/A				✓	
6. N/A				✓	
7. N/A				✓	
8.Outcome and exposure measure(s) well defined and robust to measurement/ misclassification bias? Means of assessment reported?	✓				
9.Sample size appropriate?	✓				Large sample size, however no power analysis included.
10.Anylitic methods described/justified and appropriate?	✓				Analysis described and appropriate.
11.Some estimate of variance is reported for the main results? (e.g., means, standard deviations)		✓			Means and SD provided but no SE or CI for main results.
12.Controlled for confounding	✓				Gender, school type and academic difficulties controlled for. Age not included.
13.Results reported in sufficient detail		✓			CI or SE could have added to understanding the results in more detail. Non-significant p values not reported.
14.Conclusions supported by the results?	✓				Conclusions supported by results.
Score: 18/22 = .81 = strong					

Appendix D Participant backgrounds

What is your ethnicity?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Asian or Asian British; Indian	12	3.1	3.1	3.1
	Asian or Asian British; Pakistani	6	1.6	1.6	4.7
	Asian or Asian British; Bangladeshi	1	.3	.3	5.0
	Asian or Asian British; Chinese	9	2.3	2.3	7.3
	Asian or Asian British; Any other Asian background	7	1.8	1.8	9.1
	Black, Black British, Caribbean or African; Caribbean	6	1.6	1.6	10.7
	Black, Black British, Caribbean or African; African	10	2.6	2.6	13.3
	Mixed or multiple ethnic groups; White and Black Caribbean	3	.8	.8	14.1
	Mixed or multiple ethnic groups; White and Black African	2	.5	.5	14.6
	Mixed or multiple ethnic groups; White and Asian	8	2.1	2.1	16.7
	Mixed or multiple ethnic groups; Any other Mixed or multiple ethnic background	3	.8	.8	17.5
	White; English, Welsh, Scottish, Northern Irish or British Irish	280	73.1	73.1	90.6
	White; Irish	8	2.1	2.1	92.7
	White; Roma	1	.3	.3	93.0
	White; Any other White background	27	7.0	7.0	100.0
	Total	383	100.0	100.0	

Appendix E ERGO Ethical Approval

Approved by Faculty Ethics Committee - ERGO II 71049

University of Southampton

ERGO II – Ethics and Research Governance Online https://www.ergo2.soton.ac.uk

Submission ID: 71049
Submission Title: Clinicians' perspectives on delivering CBT for eating disorders online during the Covid-19 pandemic: A service evaluation
Submitter Name: Lauren Hewitt

Your submission has now been approved by the Faculty Ethics Committee. You can begin your research unless you are still awaiting any other reviews or conditions of your approval.

Comments:

•

Click here to view the submission

TId: 23011_Email_to_submitter___Approval_from_Faculty_Ethics_committee__cat_B___C_ Id: 471792

L.A.Hewitt@soton.ac.uk coordinator

Appendix F Study Advertisement

PARTICIPANTS NEEDED

We are looking for volunteers to take part in a study who **HAVE** or **HAVE NOT** experienced bullying

ARE YOU:

- ✓ **Aged 18 + and living in the UK?**
- ✓ **Someone who has attended secondary school in the UK?**

SCHOOL BULLYING AND COMPASSION

35-40 minutes of your time to complete online questionnaires

Chance to win 1 of 5 x £50 Amazon Vouchers or 6 study credits!

Follow the link or scan the QR code:

https://southampton.qualtrics.com/jfe/form/SV_0OLsVkuZcJ3Eb1c

Study Title: Exploring the Impact of Bullying in Childhood on Compassion, and Barriers and Facilitators of Compassion in Adulthood

For more information please contact: Lauren Hewitt (Trainee Clinical Psychologist) Lh8n21@soton.ac.uk

ERGO 79374 [28.03.23- Version3]

Image by gstudioimagen on Freepik

Appendix G Participant Information Sheet and Consent Form

Study Title: Exploring the Impact of Bullying in Childhood on Compassion, and Barriers and Facilitators of Compassion in Adulthood.

Researcher(s): Lauren Hewitt, Dr Margo Ononaiye, Dr Alison Bennetts, Dr Chris Ions

University email: lh8n21@soton.ac.uk

Ethics/ERGO no: 79374 Version and date: Version 3- 24.04.2023

What is the research about?

My name is Lauren Hewitt, and I am studying to become a Doctor in Clinical Psychology at the University of Southampton. As part of my doctorate, I am conducting research into an area of interest and writing this up as a thesis. My area of interest is compassion, and how this is affected by our experiences growing up and on our mental health as adults. Specifically, the current study aims to explore the impact of being bullied or not being bullied in secondary school, on wellbeing and components of compassion in adulthood.

Compassion is often thought of as being kind to ourselves (self-compassion) and others. It can be defined as our ability to recognise suffering and to be motivated to relieve this suffering. However, there are many components to compassion, for example the ability to be compassionate to ourselves and others as well as being able to accept compassion from others. There are also things that get in the way of our ability to be compassionate and accept compassion, such as feelings of shame, fearing compassion and criticising ourselves.

The study aims to understand if our ability to be compassionate to ourselves and others is affected by experiences of being bullied or not, and what helps to facilitate compassion and what gets in the way. This knowledge would be beneficial to highlight the potential long-term impact of school experiences. Increasing understanding of what helps us, and what gets in the way of being compassionate to ourselves and others, could help clinicians to provide appropriate support and identify barriers to helping people they are working with to reduce emotional distress.

Ethical Considerations

This study was approved by the Faculty Research Ethics Committee (FREC) at the University of Southampton (Ethics/ERGO Number: 79374).

What will happen to me if I take part?

This study involves completing an anonymous survey which should take approximately 40 minutes of your time. If you are happy to complete this survey, you will need to tick (check) the box below to show your consent. As this survey is anonymous, researchers will not be able to identify which answers you provided if you agree to take part.

Why have I been asked to participate?

You have been asked to take part because we are interested in individuals who have had a range of experiences relating to being bullied in childhood, from no experience to more frequent or severe bullying. Therefore, the only requirements for taking part in this study is that you are 18 years old or over, that you currently live in the UK, that you have attended secondary school in the UK for a period of time (between the ages of 11-18), are able to read in English and have access to a device connected to the internet.

I am aiming to recruit a minimum of 128 participants for this study.

What information will be collected?

The questions in this survey ask for general information in relation to your demographics, (for example, your age, gender, ethnicity, and sexuality), your experience of being bullied or not being bullying during secondary school, your mental well-being (anxiety and depression), and your levels of compassion. Some of the questionnaires in the research may explore sensitive or personal issues and therefore there may be the possibility that you experience some psychological discomfort or distress.

What are the possible benefits of taking part?

If you decide to take part in this study, the main benefit will be to help improve our current understanding of the long-term impacts of childhood experiences on wellbeing and components of compassion and to inform potential treatment approaches. You will also be able enter a prize draw with the chance to win one of 5 x £50 Amazon vouchers. Please note the chance to enter the prize draw is only available on completion of the study and you are only able to complete the survey once.

Are there any risks involved?

There is a possibility that taking part in this study could cause you some psychological discomfort and/or distress. If this happens, you can contact the following resources for support:

• **Your registered GP** – We recommend you contact your registered GP to discuss any concerns and seek advice. Your GP should be able to either signpost you to a helpful service or make a referral.

• **Samaritans** - Samaritans is a registered charity aimed at providing emotional support to anyone in emotional distress, struggling to cope, or at risk of suicide throughout Great Britain and Ireland. Telephone: 116 123 Website: www.samaritans.org

• **The National Bullying Helpline**- The National Bullying Helpline is a registered charity in the United Kingdom that offer information and advice for anyone dealing with bullying. Telephone: 0300 323 0169 (helpline), 0845 225 5787 (general line) Website: www.nationalbullyinghelpline.co.uk

If you feel you are in a crisis and need urgent support, please call 999 or go straight to your local A&E department.

What will happen to the information collected?

All information collected for this study will be stored securely on a password protected computer and hard drive. In addition, all data will be pooled and only compiled into data summaries or summary reports. Your participation and the information we collect about you during the research will therefore be kept strictly confidential.

As I will not be asking for any identifiable information before or whilst you complete the questionnaires, all your data will be unidentifiable and anonymous. If you would like to be entered into the prize draw, then you will be asked to provide your email address for us to contact you should you win. These email addresses will be stored in a file separate to your data; therefore, it will be impossible to link your email address with your questionnaires and your data will remain anonymous. Only the researcher and their supervisors will have access to this information.

The information collected will be analysed and written up as part of the thesis. The research project will also be put forward for publishing meaning that the results may be published in a journal and/or

forum for people to access. The University of Southampton conducts research to the highest standards of ethics and research integrity. In accordance with our Research Data Management Policy, data will be held for 10 years after the study has finished when it will be securely destroyed.

What happens if there is a problem?

If you are unhappy about any aspect of this study and would like to make a formal complaint, you can contact the Head of Research Integrity and Governance, University of Southampton, on the following contact details: Email: egoinfo@soton.ac.uk, phone: + 44 2380 595058. Please quote the Ethics/ERGO number above. Please note that by making a complaint you might be no longer anonymous.

More information on your rights as a study participant is available via this link: www.southampton.ac.uk/about/governance/participant-information.page

Thank you for reading this information sheet and considering taking part in this research.

Appendix H Measures Used in the Survey

H.1 RBQ

Q22

The following questions are about bullying.

Bullying is intentional hurtful behaviour. It can be physical or psychological. It is often repeated and characterized by an inequality of power so that it is difficult for the victim to defend him/ herself.

This part deals with your experiences at SECONDARY SCHOOL (11–18 years).

The next questions are about physical forms of bullying – *hitting and kicking, and having things stolen from you.*

Q23

1. Did this happen?

Never	Rarely	Sometimes	Frequently	Constantly
○	○	○	○	○

Q24

2. How serious did you consider these bullying-attacks to be?

I wasn't bullied	Not at all	Only a bit	Quite serious	Extremely serious
○	○	○	○	○

Q25

The next questions are about verbal forms of bullying *- being called nasty names and being threatened.*

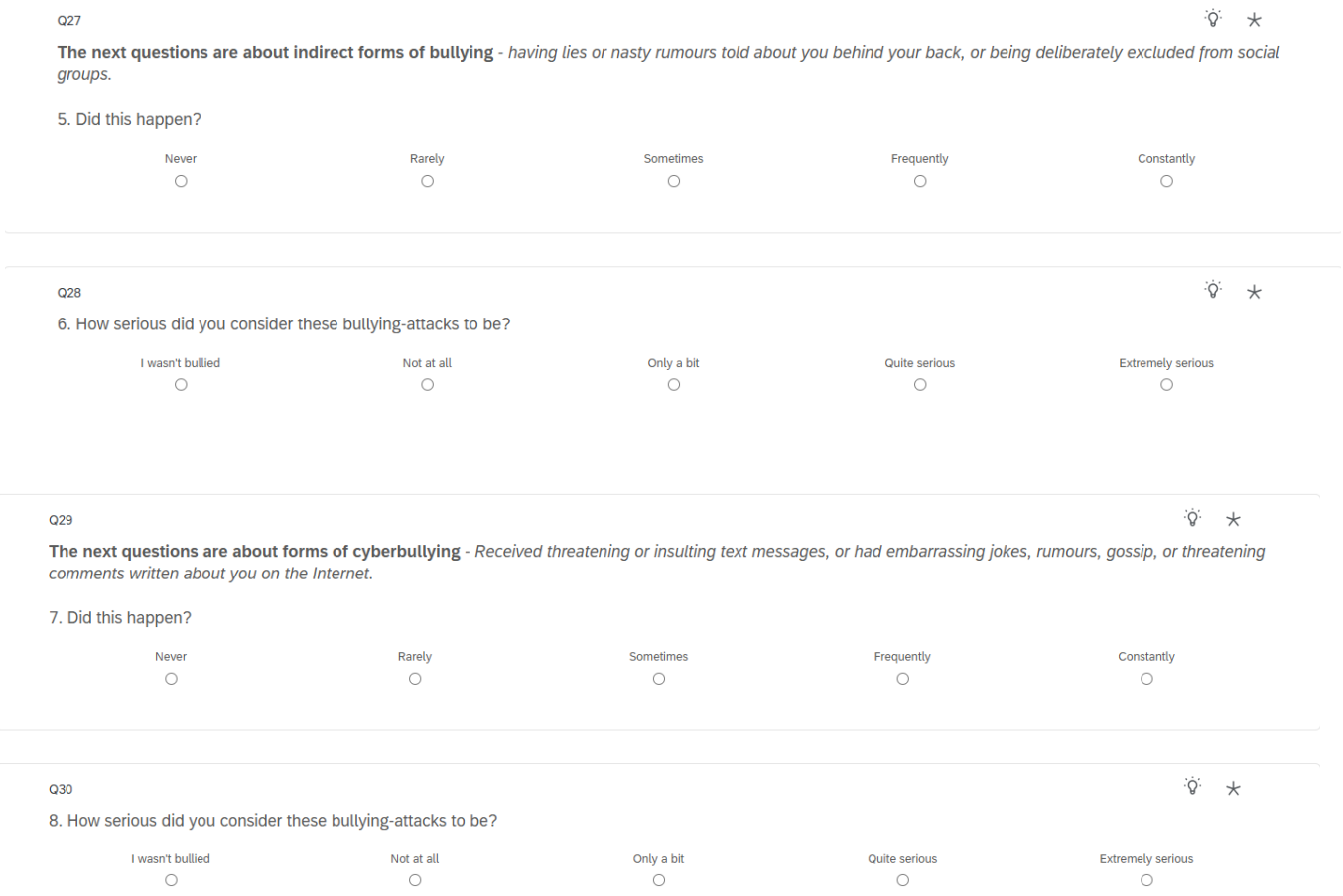
3. Did this happen?

Never	Rarely	Sometimes	Frequently	Constantly
○	○	○	○	○

Q26

4. How serious did you consider these bullying-attacks to be?

I wasn't bullied	Not at all	Only a bit	Quite serious	Extremely serious
○	○	○	○	○



Scoring Instructions:

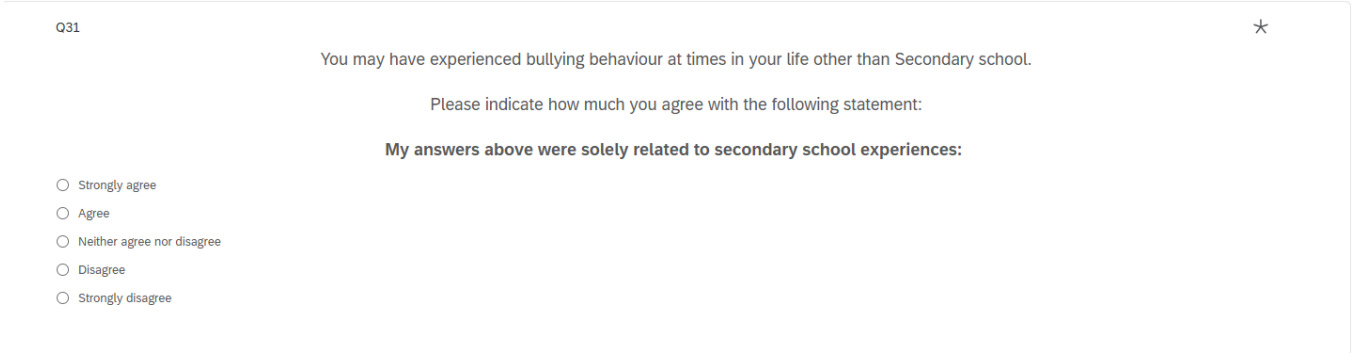
Victims are identified from their responses about frequency and intensity of reported physical, verbal, and indirect bullying. A respondent is considered a victim if they report being bullied in one or more ways “sometimes” (3+) or more often (frequency) AND classified the experience as “quite serious” (4+) or “extremely serious” (intensity).

References

Schäfer, M., Korn, S., Smith, P. K., Hunter, S. C., Mora-Merchán, J. A., Singer, M. M., & Meulen, K. (2004). Lonely in the crowd: Recollections of bullying. *British Journal of Developmental Psychology*, *22*(3), 379–394. https://doi.org/10.1348/0261510041552756

Mitchell, S. M., Seegan, P. L., Roush, J. F., Brown, S. L., Sustaíta, M. A., & Cukrowicz, K. C. (2016). Retrospective Cyberbullying and Suicide Ideation: The Mediating Roles of Depressive Symptoms, Perceived Burdensomeness, and Thwarted Belongingness. *Journal of Interpersonal Violence*, *33*(16), 2602–2620. https://doi.org/10.1177/0886260516628291

H.2 REQ


Q31
You may have experienced bullying behaviour at times in your life other than Secondary school.
Please indicate how much you agree with the following statement:
My answers above were solely related to secondary school experiences:
Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree

H.3 CEAS

THE Compassionate Mind FOUNDATION

THE COMPASSIONATE ENGAGEMENT AND ACTION SCALES

Self-compassion

When things go wrong for us and we become distressed by setbacks, failures, disappointments or losses, we may cope with these in different ways. We are interested in the degree to which people can **be compassionate with themselves**. We define compassion as "a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it." This means there are two aspects to compassion. The *first* is the ability to be motivated to engage with things/feelings that are difficult as opposed to trying to avoid or supress them. The *second* aspect of compassion is the ability to focus on what is helpful to us. Just like a doctor with his/her patient. The first is to be motivated and able to pay attention to the pain and (learn how to) make sense of it. The second is to be able to take the action that will be helpful. Below is a series of questions that ask you about these two aspects of compassion. Therefore read each statement carefully and think about how it applies to you if you become distressed. Please rate the items using the following rating scale:

Never **Always**
1 2 3 4 5 6 7 8 9 10

Section 1 – These are questions that ask you about how motivated you are, and able to engage with distress when you experience it. So:

When I'm distressed or upset by things…

1. I am *motivated* to engage and work with my distress when it arises.
Never **Always**
1 2 3 4 5 6 7 8 9 10

2. I *notice,* and am *sensitive* to my distressed feelings when they arise in me.
Never **Always**
1 2 3 4 5 6 7 8 9 10

(r)3. I avoid thinking about my distress and try to distract myself and put it out of my mind.
Never **Always**
1 2 3 4 5 6 7 8 9 10

4. I am *emotionally moved* by my distressed feelings or situations.
Never **Always**
1 2 3 4 5 6 7 8 9 10

5. I *tolerate* the various feelings that are part of my distress.
Never **Always**
1 2 3 4 5 6 7 8 9 10

THE Compassionate Mind FOUNDATION

6. I *reflect on* and *make sense* of my feelings of distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)7 I do not tolerate being distressed.

Never **Always**

1 2 3 4 5 6 7 8 9 10

8. I am *accepting, non-critical and non-judgemental* of my feelings of distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

Section 2 – These questions relate to how you actively cope in compassionate ways with emotions, thoughts and situations that distress you. So:

When I'm distressed or upset by things…

1. I direct my *attention* to what is likely to be helpful to me.

Never **Always**

1 2 3 4 5 6 7 8 9 10

2. I *think* about and come up with helpful ways to cope with my distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)3. I don't know how to help myself.

Never **Always**

1 2 3 4 5 6 7 8 9 10

4. I take the *actions* and do the things that will be helpful to me.

Never **Always**

1 2 3 4 5 6 7 8 9 10

5. I create inner feelings of *support, helpfulness and encouragement*.

Never **Always**

1 2 3 4 5 6 7 8 9 10

NOTE FOR USERS: REVERSE ITEMS (r) ARE NOT INCLUDED IN THE SCORING

THE Compassionate Mind FOUNDATION

Compassion to others

When things go wrong for other people and they become distressed by setbacks, failures, disappointments or losses, we may cope with their distress in different ways. We are interested in the degree to which people can be **compassionate to others**. We define compassion as "a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it." This means there are two aspects to compassion. The *first* is the ability to be motivated to engage with things/feelings that are difficult as opposed to trying to avoid or supress them. The *second* aspect of compassion is the ability to focus on what is helpful. Just like a doctor with his/her patient. The first is to be motivated and able to pay attention to the pain and (learn how to) make sense of it. The second is to be able to take the action that will be helpful. Below is a series of questions that ask you about these two aspects of compassion. Therefore read each statement carefully and think about how it applies to you when **people in your life** become distressed. Please rate the items using the following rating scale:

Never **Always**
1 2 3 4 5 6 7 8 9 10

Section 1 – These are questions that ask you about how motivated you are, and able to engage with other people's distress when they are experiencing it. So:

When others are distressed or upset by things…

1. I am *motivated* to engage and work with other peoples' distress when it arises.
Never **Always**
1 2 3 4 5 6 7 8 9 10

2. I *notice* and *am sensitive* to distress in others when it arises.
Never **Always**
1 2 3 4 5 6 7 8 9 10

(r)3. I avoid thinking about other peoples' distress, try to distract myself and put it out of my mind.
Never **Always**
1 2 3 4 5 6 7 8 9 10

4. I am *emotionally moved* by expressions of distress in others.
Never **Always**
1 2 3 4 5 6 7 8 9 10

5. I *tolerate* the various feelings that are part of other people's distress.
Never **Always**
1 2 3 4 5 6 7 8 9 10

THE Compassionate Mind FOUNDATION

6. I *reflect on* and *make sense* of other people's distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)7 I do not tolerate other peoples' distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

8. I am *accepting, non-critical and non-judgemental* of others people's distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

Section 2 – These questions relate to how you actively respond in compassionate ways when other people are distressed. So:

When others are distressed or upset by things…

1. I direct *attention* to what is likely to be helpful to others.

Never **Always**

1 2 3 4 5 6 7 8 9 10

2. I *think about and come up* with helpful ways for them to cope with their distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)3. I don't know how to help other people when they are distressed.

Never **Always**

1 2 3 4 5 6 7 8 9 10

4. I take the *actions* and *do the things* that will be helpful to others.

Never **Always**

1 2 3 4 5 6 7 8 9 10

5. I express feelings of *support, helpfulness and encouragement* to others.

Never **Always**

1 2 3 4 5 6 7 8 9 10

NOTE FOR USERS: REVERSE ITEMS (r) ARE NOT INCLUDED IN THE SCORING

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Compassion from others

When things go wrong for us and we become distressed by setbacks, failures, disappointments or losses, others may cope with our distress in different ways. We are interested in the degree to which you feel that **important people in your life can be compassionate to your distress**. We define compassion as "a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it." This means there are two aspects to compassion. The *first* is the ability to be motivated to engage with things/feelings that are difficult as opposed to trying to avoid or supress them. The *second* aspect of compassion is the ability to focus on what is helpful to us or others. Just like a doctor with his/her patient. The first is to be motivated and able to pay attention to the pain and (learn how to) make sense of it. The second is to be able to take the action that will be helpful. Below is a series of questions that ask you about these two aspects of compassion. Therefore read each statement carefully and think about how it applies to the **important people in your life** when you become distressed. Please rate the items using the following rating scale:

Never									**Always**
1	2	3	4	5	6	7	8	9	10

Section 1 – These are questions that ask you about how motivated you think others are, and how much they engage with your distress when you experience it. So:

When I'm distressed or upset by things…

1. Other people are actively *motivated* to engage and work with my distress when it arises.

Never									**Always**
1	2	3	4	5	6	7	8	9	10

2. Others *notice* and *are sensitive* to my distressed feelings when they arise in me.

Never									**Always**
1	2	3	4	5	6	7	8	9	10

(r)3 Others avoid thinking about my distress, try to distract themselves and put it out of their mind.

Never									**Always**
1	2	3	4	5	6	7	8	9	10

4. Others are *emotionally moved* by my distressed feelings.

Never									**Always**
1	2	3	4	5	6	7	8	9	10

5. Others *tolerate* my various feelings that are part of my distress.

Never									**Always**
1	2	3	4	5	6	7	8	9	10

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6. Others *reflect on* and *make sense* of my feelings of distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)7. Others do not tolerate my distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

8. Others are *accepting, non-critical and non-judgemental* of my feelings of distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

Section 2 – These questions relate to how others actively cope in compassionate ways with emotions and situations that distress you. So:

When I'm distressed or upset by things…

1. Others direct their *attention* to what is likely to be helpful to me.

Never **Always**

1 2 3 4 5 6 7 8 9 10

2. Others *think about* and come up with helpful ways for me to cope with my distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)3. Others don't know how to help me when I am distressed

Never **Always**

1 2 3 4 5 6 7 8 9 10

4. Others take the *actions* and do the things that will be helpful to me.

Never **Always**

1 2 3 4 5 6 7 8 9 10

5. Others treat me with feelings of *support, helpfulness and encouragement*.

Never **Always**

1 2 3 4 5 6 7 8 9 10

NOTE FOR USERS: REVERSE ITEMS (r) ARE NOT INCLUDED IN THE SCORING

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SCORING

The three scales – *Compassion for others*, *compassion from others*, *compassion for self* are scored separately.
For each scale two subscales can be calculated: Engagement (items 1, 2, 4, 5, 6, 8) and Actions (1, 2, 4, 5).
For the *Compassion for self* scale, two dimensions may be analysed in the Engagement subscale (sum of items 2 and 4, and sum of items 1, 5, 6, and 8).
A total score can be calculated (sum of items of the Engagement and Actions subscales) for each scale – *Compassion for others*, *compassion from others*, *compassion for self*.
Please note that reverse items (r) are not included in the scoring.

DESCRIPTION

The Compassionate Engagement and Action Scales

The Compassionate Engagement and Action Scales are three scales which measure self-compassion ("I am motivated to engage and work with my distress when it arises"), the ability to be compassionate to distressed others ("I am motivated to engage and work with other peoples' distress when it arises") and the ability to receive compassion from key persons in the respondent's life ("Other people are actively motivated to engage and work with my distress when it arises"). In the first section of each scale, six items are formulated to reflect the six compassion attributes in the CFT model: sensitivity to suffering, sympathy, non-judgemental, empathy, distress tolerance and care for wellbeing. These sections also include two reversed filler items. The second section of the scale has four more items which reflect specific compassionate actions to deal with distress and an extra reversed filler item. Participants are asked to rate each statement according to how frequently it occurs on a scale of 1 to 10 (1 = Never; 10= Always).

REFERENCE

Gilbert, P., Catarino, F., Duarte, C., Matos, M., Kolts, R., Stubbs, J., ... & Basran, J. (2017). The development of compassionate engagement and action scales for self and others. *Journal of Compassionate Health Care*, *4*(1), 4.

H.4 FOCS

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FEARS OF COMPASSION SCALE

Different people have different views of compassion and kindness. While some people believe that it is important to show compassion and kindness in all situations and contexts, others believe we should be more cautious and can worry about showing it too much to ourselves and to others. We are interested in your thoughts and beliefs in regard to kindness and compassion in three areas of your life:

1. Expressing compassion for others
2. Responding to compassion from others
3. Expressing kindness and compassion towards yourself

Below are a series of statements that we would like you to think carefully about and then circle the number that best describes how each statement fits you.

SCALE

Please use this scale to rate the extent that you agree with each statement

Don't agree at all 0 1 2 3 4 Completely agree

Somewhat agree

Scale 1: Expressing compassion for others

1.	People will take advantage of me if they see me as too compassionate	0	1	2	3	4
2.	Being compassionate towards people who have done bad things is letting them off the hook	0	1	2	3	4
3.	There are some people in life who don't deserve compassion	0	1	2	3	4
4.	I fear that being too compassionate makes people an easy target	0	1	2	3	4
5.	People will take advantage of you if you are too forgiving and compassionate	0	1	2	3	4
6.	I worry that if I am compassionate, vulnerable people can be drawn to me and drain my emotional resources	0	1	2	3	4
7.	People need to help themselves rather than waiting for others to help them	0	1	2	3	4
8.	I fear that if I am compassionate, some people will become too dependent upon me	0	1	2	3	4
9.	Being too compassionate makes people soft and easy to take advantage of	0	1	2	3	4
10.	For some people, I think discipline and proper punishments are more helpful than being compassionate to them	0	1	2	3	4

1

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Scale 2: Responding to the expression of compassion from others

1.	Wanting others to be kind to oneself is a weakness	0	1	2	3	4
2.	I fear that when I need people to be kind and understanding they won't be	0	1	2	3	4
3.	I'm fearful of becoming dependent on the care from others because they might not always be available or willing to give it	0	1	2	3	4
4.	I often wonder whether displays of warmth and kindness from others are genuine	0	1	2	3	4
5.	Feelings of kindness from others are somehow frightening	0	1	2	3	4
6.	When people are kind and compassionate towards me I feel anxious or embarrassed	0	1	2	3	4
7.	If people are friendly and kind I worry they will find out something bad about me that will change their mind	0	1	2	3	4
8.	I worry that people are only kind and compassionate if they want something from me	0	1	2	3	4
9.	When people are kind and compassionate towards me I feel empty and sad	0	1	2	3	4
10.	If people are kind I feel they are getting too close	0	1	2	3	4
11.	Even though other people are kind to me, I have rarely felt warmth from my relationships with others	0	1	2	3	4
12.	I try to keep my distance from others even if I know they are kind	0	1	2	3	4
13.	If I think someone is being kind and caring towards me, I 'put up a barrier'	0	1	2	3	4

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Scale 3: Expressing kindness and compassion towards yourself

1.	I feel that I don't deserve to be kind and forgiving to myself	0	1	2	3	4
2.	If I really think about being kind and gentle with myself it makes me sad	0	1	2	3	4
3.	Getting on in life is about being tough rather than compassionate	0	1	2	3	4
4.	I would rather not know what being 'kind and compassionate to myself' feels like	0	1	2	3	4
5.	When I try and feel kind and warm to myself I just feel kind of empty	0	1	2	3	4
6.	I fear that if I start to feel compassion and warmth for myself, I will feel overcome with a sense of loss/grief	0	1	2	3	4
7.	I fear that if I become kinder and less self-critical to myself then my standards will drop	0	1	2	3	4
8.	I fear that if I am more self compassionate I will become a weak person	0	1	2	3	4
9.	I have never felt compassion for myself, so I would not know where to begin to develop these feelings	0	1	2	3	4
10.	I worry that if I start to develop compassion for myself I will become dependent on it	0	1	2	3	4
11.	I fear that if I become too compassionate to myself I will lose my self-criticism and my flaws will show	0	1	2	3	4
12.	I fear that if I develop compassion for myself, I will become someone I do not want to be	0	1	2	3	4
13.	I fear that if I become too compassionate to myself others will reject me	0	1	2	3	4
14.	I find it easier to be critical towards myself rather than compassionate	0	1	2	3	4
15.	I fear that if I am too compassionate towards myself, bad things will happen	0	1	2	3	4

SCORING

Simply sum the items for each of the 3 scales

DESCRIPTION

Compassion Evaluation Scales

We developed three scales for this study, measuring *Fear of compassion for self* (compassion we have for ourselves when we make mistakes or things go wrong in our lives), *Fear of compassion from others* (the compassion that we experience from others and flowing into the self) and *Fear of compassion for others* (the compassion we feel for others, related to our sensitivity to other people's thoughts and feelings). We generated a series of items based on various fears of compassion for each of these scales. Many of these items were inspired by PGs discussions with patients, ideas generated in the psychotherapy literature (e.g. Arieti & Bemporad, 1980) and in the attachment literature (Bowlby, 1969, 1973, 1980).

We generated twenty items for each domain and then asked the research team to rank the items according to face validity and selected the items which were rated to be the most valid. Those items for which there was general agreement that they had low face validity or were difficult to understand were rejected. The final subscales consisted of: Compassion *for Self* comprised 15 items (e.g. "I worry that if I start to develop compassion for myself I will become dependent on it"); compassion *from others* comprised 13 items (e.g. "I try to keep my distance from others even if I know they are kind"); compassion *for Others* comprised 10 items (e.g. "Being too compassionate makes people soft and easy to take advantage of"). The items were rated on a five-point Likert scale (0 = Don't agree at all, 4 = Completely agree). The Cronbach's alphas for this scale are 0.85 for fear of compassion for self; 0.87 for fear of compassion from others and 0.78 for fear of compassion for others.

REFERENCES

Gilbert, P., McEwan, K., Catarino, F., & Baião, R. (2014). Fears of compassion in a depressed population: Implications for psychotherapy. *Journal of Depression and Anxiety*, http://dx.doi.org/10.4172/2167-1044.S2-003

Gilbert, P., McEwan, K., Catarino, F., & Baião, R. (2014). Fears of negative emotions in relation to fears of happiness, compassion, alexithymia and psychopathology in a depressed population: A preliminary study. *Journal of Depression and Anxiety*, http://dx.doi.org/10.4172/2167-1044.S2-004

Gilbert, P., McEwan, K., Gibbons, L., Chotai, S., Duarte, J., & Matos, M. (2012). Fears of compassion and happiness in relation to alexithymia, mindfulness and self-criticism. *Psychology and Psychotherapy*, *85*, 374–390. DOI:10.1111/j.2044-8341.2011.02046.x

H.5 EISS

EISS

(C. Ferreira, M. Moura-Ramos, M. Matos & A. Galhardo, 2020)

Below are a series of statements about feelings people may usually have, but that might be experienced by each person in a different way. Please read each statement carefully and circle the number that best indicates how often you feel what is described in each item.

Please use the following rating scale

0 = Never	1 = Rarely	2 = Sometimes	3 = Often	4 = Always

	In relation to several aspects of my life, I FEEL THAT:	0	1	2	3	4
1	other people see me as not being up to their standards	0	1	2	3	4
2	I am isolated	0	1	2	3	4
3	other people don't understand me	0	1	2	3	4
4	I am different and inferior to others	0	1	2	3	4
5	other people are judgmental and critical of me	0	1	2	3	4
6	other people see me as uninteresting	0	1	2	3	4
7	I am unworthy as a person	0	1	2	3	4
8	I am judgmental and critical of myself	0	1	2	3	4

H.6 FSCRS

THE FORMS OF SELF-CRITICISING/ATTACKING &

SELF-REASSURING SCALE (FSCRS)

When things go wrong in our lives or don't work out as we hoped, and we feel we could have done better, we sometimes have *negative and self-critical thoughts and feelings*. These may take the form of feeling worthless, useless or inferior etc. However, people can also try to be supportive of them selves. Below are a series of thoughts and feelings that people sometimes have. Read each statement carefully and circle the number that best describes how much each statement is true for you.

Please use the scale below.

Not at all like me	A little bit like me	Moderately like me	Quite a bit like me	Extremely like me
0	1	2	3	4

When things go wrong for me:

1.	I am easily disappointed with myself.	0	1	2	3	4
2.	There is a part of me that puts me down.	0	1	2	3	4
3.	I am able to remind myself of positive things about myself.	0	1	2	3	4
4.	I find it difficult to control my anger and frustration at myself.	0	1	2	3	4
5.	I find it easy to forgive myself.	0	1	2	3	4
6.	There is a part of me that feels I am not good enough.	0	1	2	3	4
7.	I feel beaten down by my own self-critical thoughts.	0	1	2	3	4
8.	I still like being me.	0	1	2	3	4
9.	I have become so angry with myself that I want to hurt or injure myself.	0	1	2	3	4
10.	I have a sense of disgust with myself.	0	1	2	3	4
11.	I can still feel lovable and acceptable.	0	1	2	3	4
12.	I stop caring about myself.	0	1	2	3	4
13.	I find it easy to like myself.	0	1	2	3	4
14.	I remember and dwell on my failings.	0	1	2	3	4
15.	I call myself names.	0	1	2	3	4

1

16.	I am gentle and supportive with myself.	0	1	2	3	4
17.	I can't accept failures and setbacks without feeling inadequate.	0	1	2	3	4
18.	I think I deserve my self-criticism.	0	1	2	3	4
19.	I am able to care and look after myself.	0	1	2	3	4
20.	There is a part of me that wants to get rid of the bits I don't like.	0	1	2	3	4
21.	I encourage myself for the future.	0	1	2	3	4
22.	I do not like being me.	0	1	2	3	4

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THE FORMS OF SELF-CRITICISING/ATTACKING & SELF-REASSURING SCALE (FSCRS)

SCORING

1. **is**	I am easily disappointed with myself.	0	1	2	3	4
2. **is**	There is a part of me that puts me down.	0	1	2	3	4
3. **rs**	I am able to remind myself of positive things about myself.	0	1	2	3	4
4. **is**	I find it difficult to control my anger and frustration at myself.	0	1	2	3	4
5. **rs**	I find it easy to forgive myself.	0	1	2	3	4
6. **is**	There is a part of me that feels I am not good enough.	0	1	2	3	4
7. **is**	I feel beaten down by my own self-critical thoughts.	0	1	2	3	4
8. **rs**	I still like being me.	0	1	2	3	4
9. **hs**	I have become so angry with myself that I want to hurt or injure myself.	0	1	2	3	4
10.**hs**	I have a sense of disgust with myself.	0	1	2	3	4
11.**rs**	I can still feel lovable and acceptable.	0	1	2	3	4
12.**hs**	I stop caring about myself.	0	1	2	3	4
13.**rs**	I find it easy to like myself.	0	1	2	3	4
14.**is**	I remember and dwell on my failings.	0	1	2	3	4
15.**hs**	I call myself names.	0	1	2	3	4
16.**rs**	I am gentle and supportive with myself.	0	1	2	3	4
17.**is**	I can't accept failures and setbacks without feeling inadequate.	0	1	2	3	4
18.**is**	I think I deserve my self-criticism.	0	1	2	3	4
19.**rs**	I am able to care and look after myself.	0	1	2	3	4
20.**is**	There is a part of me that wants to get rid of the bits I don't like.	0	1	2	3	4
21.**rs**	I encourage myself for the future.	0	1	2	3	4
22.**hs**	I do not like being me.	0	1	2	3	4

KEY FOR SUBSCALES:

is = inadequate self,
rs = reassured self,
hs = hated self

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DESCRIPTION

This scale was developed by Gilbert, Clarke, Hempel, Miles and Irons (2004). It was developed to measure self-criticism and the ability to self-reassure. It is a 22-item scale, which measures different ways people think and feel about themselves when things go wrong for them. The items make up three components, there are two forms of self-criticalness; inadequate self, which focuses on a sense of personal inadequacy ('I am easily disappointed with myself'), and hated self, this measures the desire to hurt or persecute the self ('I have become so angry with myself that I want to hurt or injury myself'), and one form to self-reassure, reassured self ('I am able to remind myself of positive things about myself'). The responses are given on a 5-point Likert scale (ranging from 0 = 'not at all like me', to 4 = 'extremely like me'). Cronbach alphas were .90 for inadequate self and .86 for hated self and reassured self respectively.

REFERENCE

Gilbert, P., Clark, M., Hempel, S., Miles, J.N.V. & Irons, C. (2004). Criticising and reassuring oneself: An exploration of forms, styles and reasons in female students. *British Journal of Clinical Psychology, 43*, 31-50.

It has been used in a number of other studies

H.7 EMWSS

EARLY MEMORIES OF WARMTH AND SAFENESS SCALE

This scale explores some of your emotional memories of your childhood. Below is a set of questions that tap various feelings you may have experienced when you were young. Please read each item carefully and circle the number to the right of the statement that best describes your feelings during childhood. Use the scale below.

0 = No, never	1 = Yes, but rarely	2 = Yes, sometimes	3 = Yes, often	4 = Yes, most of the time

1. I felt safe and secure	0 1 2 3 4
2. I felt appreciated the way I was	0 1 2 3 4
3. I felt understood	0 1 2 3 4
4. I felt a sense of warmth with those around me	0 1 2 3 4
5. I felt comfortable sharing my feelings and thoughts with those around me	0 1 2 3 4
6. I felt people enjoyed my company	0 1 2 3 4
7. I knew that I could count on empathy and understanding from people close to me when I was unhappy	0 1 2 3 4
8. I felt peaceful and calm	0 1 2 3 4
9. I felt that I was a cherished member of my family	0 1 2 3 4
10. I could easily be soothed by people close to me when I was unhappy	0 1 2 3 4
11. I felt loved	0 1 2 3 4
12. I felt comfortable turning to people important to me for help and advice	0 1 2 3 4
13. I felt part of those around me.	0 1 2 3 4
14. I felt loved even when people were upset about something I had done	0 1 2 3 4
15. I felt happy	0 1 2 3 4
16. I had feelings of connectedness	0 1 2 3 4
17. I knew I could rely on people close to me to console me when I was upset	0 1 2 3 4
18. I felt cared about	0 1 2 3 4
19. I had a sense of belonging	0 1 2 3 4
20. I knew that I could count on help from people close to me when I was unhappy	0 1 2 3 4
21. I felt at ease	0 1 2 3 4

1

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SCORING

Simply sum the scale items

DESCRIPTION

Early Memories of Warmth and Safeness Scale (EMWSS)

This scale was designed to measure recall of feeling warm, safe and cared for in childhood. The 21 items included statements such as "I felt cared about", "I felt appreciated the way I was" and "I felt part of those around me". The response measure consisted of a Likert-type scale with participants required to rate how frequently each statement applied to them in their childhood (0 = No, never; 1 = Yes, but rarely, 2 = Yes, sometimes, 3 = Yes, often, 4 = Yes, most of the time). The scale contained the following instruction: "This scale explores positive and pleasant emotional memories of childhood. Please read each item carefully and circle the number to the right of the statement that best describes your own emotional memories from childhood. Use the scale below". The scale had a Cronbach's alpha of 0.97 (Richter et al., 2009).

REFERENCE

Richter, A., Gilbert, P. & McEwan, K. (2009). Development of an early memories of warmth and safeness scale and its relationship to psychopathology. *Psychology and Psychotherapy: Theory, Research and Practice*, 82, 171-184.

H.8 GAD7

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

H.9 PHQ9

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

Appendix I Debrief statement

Study Title: Exploring the Impact of Bullying in Childhood on Compassion, and Barriers and Facilitators of Compassion in Adulthood.

Researcher(s): Lauren Hewitt, Dr Margo Ononaiye, Dr Alison Bennetts, Dr Chris Ions

University email: lh8n21@soton.ac.uk

Ethics/ERGO no: 79374 Version and date: Version 3- 24.04.2023

Thank you for taking part in our research project. Your contribution is very valuable and greatly appreciated.

Purpose of the study

The aim of this research was to explore the impact of being bullied or not being bullied in secondary school on anxiety, low mood, and components of compassion in adulthood. The study also aimed to explore what helps to facilitate compassion and what gets in the way.

It was expected that people who had experienced bullying of one type or more (physical, verbal, indirect or cyber bullying) during secondary school, that they considered to be serious, would have lower levels of self-compassion, less ability to self-reassure and fewer early memories of warmth and safeness than those who had not experienced bullying during secondary school. Those who had experienced bullying were also expected to have higher levels of self-criticism, shame, and anxiety and depression than those who had not experienced bullying in secondary school that they considered to be severe.

Confidentiality

Results of this study will not include your name or any other identifying characteristics.

Prize Draw

If you would like to be entered into the prize draw to win one of 5 x £50 Amazon vouchers, please tick the checkbox 'I would like to be entered for the prize draw' at the bottom of this form which will take you to separate survey to collect your contact details. Please note that by providing your contact details, your participation in the study might be no longer anonymous, but the researcher will not know what information you provided. Please make sure to click the submit button after entering your email address.

Study results

If you would like to receive a copy of the final report when research is complete, please email Lauren Hewitt at lh8n21@soton.ac.uk. It is up to you whether you would like to receive study results. Please note that by providing your contact details, your participation in the study might be no longer anonymous, but the researcher will not know what information you provided.

Further support

If taking part in this study has caused you discomfort or distress, you can contact the following organisations for support:

- **Your registered GP** – We recommend you contact your registered GP to discuss any concerns and seek advice. Your GP should be able to either signpost you to a helpful service or make a referral.

- **Samaritans** - Samaritans is a registered charity aimed at providing emotional support to anyone in emotional distress, struggling to cope, or at risk of suicide throughout Great Britain and Ireland. Telephone: 116 123 Website: www.samaritans.org

- **The National Bullying Helpline**- The National Bullying Helpline is a registered charity in the United Kingdom that offer information and advice for anyone dealing with bullying. Telephone: 0300 323 0169 (helpline), 0845 225 5787 (general line) Website: www.nationalbullyinghelpline.co.uk If you feel you are in a crisis and need urgent support, please call 999 or go straight to your local A&E department.

If you feel you are in a crisis and need urgent support, please call 999 or go straight to your local A&E department.

Supplementary materials

Supplementary sensitivity analysis

Analysis of covariance (ANCOVA) were carried out as supplementary sensitivity analysis for all variables that were found to have a significant difference between VB and NVB groups (see table S.1.). Bootstrap procedures were used based on 1000 samples as age violated assumptions of normality and groups were unequal in size (Field, 2024). Sexuality and recollections of bullying occurring during or outside of secondary school were not included as covariates as these variables violated the parametric assumptions for this analysis (Field, 2024). Significant differences between VB and NVB remained between all variables after controlling for age, gender and ethnicity separately. Findings suggest that VB experienced significantly greater barriers to compassion (FoCtO, FoCfO, FoCtS, shame, IS, HS) and anxiety and depression and significantly lower ability to receive CfO and facilitators of compassion (SR and EMWS) than NVB, while controlling for differences in age, gender and ethnicity separately.

Table S.1.

ANCOVAs exploring differences of variables between VB and NVB groups, while controlling for demographic covariates separately.

	VB	NVB	Age covariate			Gender covariate			Ethnicity covariate		
Measure	M (SD)	M (SD)	*F*	*p*	η_p^2	*F*	*p*	η_p^2	*F*	*p*	η_p^2
Compassion from others	58.55 (16.28)	63.52 (14.68)	9.24	.006	.02	7.85	.004	.02	9.3	.003	.02
Fear of compassion to others	28.52 (8.09)	25.55 (7.16)	16.62	<.001	.04	14.74	<.001	.04	15.83	<.001	.04
Fear of compassion from others	33.63 (10.32)	28.43 (9.51)	26.51	<.001	.07	21.65	<.001	.06	25.31	<.001	.06
Fear of compassion to self	36.036 (13.37)	30.55 (11.14)	19.58	<.001	.05	15.72	<.001	.04	18.92	<.001	.05
Internal external shame	25.51 (5.73)	22.18 (5.74)	30.37	<.001	.08	27.24	<.001	.07	29.61	<.001	.07
Reassured self	24.35 (6.09)	25.87 (6.06)	5.74	.012	.02	4.26	.039	.01	5.49	.015	.01
Inadequate self	32.27 (7.60)	28.33 (8.05)	23.68	<.001	.06	19.95	<.001	.05	22.07	<.001	.06
Hated self	11.4 (4.77)	9.93 (4.69)	9.02	.003	.02	7.03	.014	.02	8.46	.007	.02
Early memories of warmth and safeness	67.63 (19.17)	77.48 (20.85)	20.02	<.001	.05	17.35	<.001	.05	21.68	<.001	.06
Generalised anxiety	17.29 (5.62)	14.83 (4.95)	21.91	<.001	.06	19.1	<.001	.05	19.74	<.001	.05
Depression	19.13 (6.07)	16.63 (5.47)	18.83	<.001	.05	14.45	<.001	.04	17.04	.002	.04

Note. η_p^2 effect size= small effect size = .01, medium effect size = .06, large effect size = .14.