Barriers to self-compassion for female survivors of childhood maltreatment: The roles of fear of self-compassion and psychological inflexibility

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ABSTRACT

Preliminary evidence has demonstrated the benefits of targeting self-compassion in the treatment of posttraumatic stress disorder (PTSD). However, survivors of childhood maltreatment may present with unique challenges that compromise the effectiveness of these and other PTSD treatments. Specifically, childhood maltreatment victims often exhibit a marked fear and active resistance of self-kindness and warmth (i.e., fear of self-compassion). Victims may also attempt to control distressing internal experiences in a way that hinders engagement in value-based actions (i.e., psychological inflexibility). Research suggests that psychological inflexibility exacerbates the negative effects of fear of self-compassion. The present study expanded on previous research by examining the relations among childhood maltreatment, fear of self-compassion, psychological inflexibility, and PTSD symptom severity in 288 college women. As expected, moderate to severe levels of childhood maltreatment were associated with greater fear of self-compassion, psychological inflexibility, and PTSD symptom severity compared to minimal or no childhood maltreatment. A mediation analysis showed that childhood maltreatment had a significant indirect effect on PTSD symptom severity via fear of self-compassion, although a conditional process analysis did not support psychological inflexibility as a moderator of this indirect effect. A post hoc multiple mediator analysis showed a significant indirect effect of childhood maltreatment on PTSD symptom severity via psychological inflexibility, but not fear of self-compassion. These findings highlight the importance of addressing fear of self-compassion and psychological inflexibility as barriers to treatment for female survivors of childhood maltreatment.

1. Introduction

Posttraumatic stress disorder (PTSD) is a debilitating psychiatric condition that affects up to one-fourth of individuals exposed to a potentially traumatic event (Breslau et al., 1998; Kessler, Sonnega, Hughes, & Nelson, 1995; North, Nixon, McMillen, Spitznagel, & Smith, 1999; Shalev et al., 1998). Recently, there has been increasing interest in self-compassion as a therapeutic target for PTSD treatment (Dahm et al., 2015; Hiraoka et al., 2015; Kearney et al., 2013; Thompson & Waltz, 2008; Zeller, Yuval, Nitzan-Assayag, & Bernstein, 2015) and preliminary results from clinical trials are promising (Au et al., 2017; Kearney et al., 2013). Self-compassion...
involves relating to one’s suffering with a loving-kind, nonjudgmental attitude from the perspective of compassion (Neff, 2003). It is believed to confer positive health benefits by building one’s ability to withstand distress through improved emotion regulation. According to Gilbert’s tripartite model of emotion regulation, humans have three evolved emotion systems that interact and regulate one another (Gilbert, 2014). The threat system is sensitive to external and internal threats, activating defense mechanisms whenever threats are perceived. The drive system is associated with attempts to seek and acquire rewarding stimuli. Self-compassionate behaviors are driven by the contentment system, which is responsible for downregulating the threat system and, to a lesser extent, the drive system. As theorized by Gilbert and Procter (2006), early attachment experiences play a formative role in the maturation of the contentment system. Secure attachment to caregivers during childhood facilitates a sense of security and support from others. This, in turn, creates positive emotional memories of being comforted that become available during times of stress to promote self-soothing. Comparatively, parental neglect and abuse serves as a source of threat, and when emotional memories of these experiences are activated, they elicit withdrawal, submission, or avoidance (Gilbert, McEwan, Matos, & Rivis, 2011). In other words, childhood maltreatment disrupts the balance of the regulatory systems by producing overactivity in the threat system (Gilbert & Procter, 2006). Survivors of childhood maltreatment may experience unique challenges that interfere with their ability to access their contentment system and compromise the effectiveness of compassion-based treatments (e.g., Compassion-Focused Therapy, Mindful Self-Compassion Program; Gilbert, 2014; Neff & Germer, 2013).

Early in life, maltreated children are deprived of opportunities to feel safe and reassured by caregivers at a time when parents play an integral role in providing emotion regulation. Consequently, maltreated children acquire an increased sensitivity to potential sources of threat and become less emotionally regulated due to their inability to calm their threat system with self-soothing behaviors (Gilbert, 2014). Instead, they may adopt a rejecting, self-critical perspective of their inadequacies that mirrors the rejection and abuse expressed by their perpetrators. They may also develop internal working models of themselves as undeserving of love, concerns of inevitable rejection from others, and beliefs that compassion is indicative of weakness. Therefore, receiving compassion from oneself or others triggers a threat/fear response that these victims have a limited capacity to regulate. This conditioned response of marked fear toward self-kindness is known as fear of self-compassion (Gilbert, 2014; Gilbert et al., 2011). Fear of self-compassion is conceptually distinct from a lack of self-compassion, which may manifest as a ruminative preoccupation with negative self-relevant thoughts (e.g., “I’m a failure”) and emotions that result in feeling disconnected from the larger society (Neff, 2003). Research supports that self-compassion and fear of self-compassion are unique constructs that yield different health outcomes (Gilbert et al., 2011; Kelly, Carter, Zuroff, & Boraira, 2013; Miron, Seligowski, Boykin, & Orcutt, 2016; Miron, Sherrill, & Orcutt, 2015; Xavier, Cunha, & Pinto Gouveia, 2015). Fear of self-compassion has been linked with pathological trauma reactions, including PTSD symptoms, depression, anxiety, self-criticism, and self-injurious behavior (Gilbert et al., 2011; Miron et al., 2015, 2016; Xavier et al., 2015).

While research is lacking, fear of self-compassion is likely associated with long-term functional impairments. For example, maltreatment survivors may find it difficult to form meaningful relationships with others, especially their children. It remains debatable as to whether maltreatment begets maltreatment (see Thornberry, Knight, & Lovegrove, 2012 for a review); however, fear of self-compassion may increase the likelihood that adult survivors of childhood maltreatment will mistreat their children. Their personal abuse histories have conditioned them to instinctively resist any expression of compassion due to concerns of being rejected, harshly criticized, or feeling undeserving. This could manifest in becoming emotionally unavailable or neglectful of their children in a way that resembles their childhood experiences. Additionally, parental neglect may not directly contribute to offspring victimization per se (Berlin, Appleyard, & Dodge, 2011), but correlates of fear of self-compassion (e.g., psychopathology, increased stress) are risk factors for parental maltreatment (Dixon, Browne, & Hamilton-Giachritsis, 2005; Dixon, Browne, & Hamilton-Giachritsis, 2009). Thus, targeting fear of self-compassion directly or as a therapy-interfering behavior could have the added benefit of preventing the continuation of intergenerational maltreatment, although research is warranted.

Recent findings from Miron et al. (2015) suggest that the negative effects of fear of self-compassion are exacerbated among trauma survivors who are psychologically inflexible. Psychological inflexibility describes individuals who limit their engagement in value-based actions due to rigid rule following and attempts to avoid, control, or suppress difficult private experiences, such as thoughts, feelings, memories, or bodily sensations (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). It has been linked with several negative psychological outcomes, including (but not limited to) lower overall life satisfaction, poorer overall well-being, and increased pathology (see Kashdan & Rottenberg, 2010 for a review; see also Lilly & Allen, 2015; Seligowski, Miron, & Orcutt, 2014; Van Dam, Sheppard, Forsyth, & Earleywine, 2011; Woodruff et al., 2014). Theorists suggest that psychological inflexibility is conditioned through language acquisition and social context. From early in development, humans have the extraordinary ability to derive complex relations among events (e.g., touch hot stove → burn finger), even without direct experience (e.g., being told that touching a hot stove will burn one’s fingers). Verbal information can be combined to create rules (e.g., “Boys don’t cry”, “Girls don’t get angry”) that govern behavior. Consequently, suffering arises when rigid adherence to verbal rules produces automated responses that are insensitive to environmental changes and apart from natural contingencies. Another process by which language and context influence psychological inflexibility involves the interplay between actual experiences (e.g., physical, emotional) and verbal understanding of events. For example, remembering the details of a traumatic experience invokes psychological and physical processes akin to those experienced at the time of the incident. As illustrated by this example, being verbally aware of aversive events is aversive itself. A natural and, at times, appropriate response to aversive experiences is to avoid, deny, or suppress distressing thoughts, feelings, memories, and bodily sensations (also known as experiential avoidance). However, indiscriminate, rigid use of experiential avoidance narrows engagement in value-based actions and exacerbates suffering (Hayes, Strosahl, & Wilson, 2012).

Childhood maltreatment survivors may be particularly vulnerable to becoming psychologically inflexible, though the degree of inflexibility will depend on abuse characteristics (e.g., age at onset of abuse, duration, severity). Growing up in a hostile childhood
environment can cultivate experiential avoidance, which becomes a strategy for “mentally escaping” aversive thoughts, feelings, and sensations when physical escape is not possible (Reddy, Pickett, & Orcutt, 2006). As language matures, maltreatment can also foster critical self-views (e.g., “I am unlovable”, “I’m a bad person”) that become fused with victims’ conceptualizations of themselves, leading to behaviors that confirm derived rules (e.g., “I don’t deserve love”, “I should be punished”). Hayes et al. (2012) argue that “once we think about things in a particular way, that way of thinking remains irremediably in our relational repertoire, even if it rarely occurs” (p. 52). Consequently, any events that contradict these rules seem threatening. For example, maltreated individuals who perceive themselves as unlovable will resist self-compassion because it conflicts with their internalized negative self-views. Miron et al. (2015) further speculate that fear of self-compassion may emerge from objectifying one’s suffering as “unacceptable” and that unconditional self-compassion is threatening because it undermines this function. For these reasons, it is believed that the combination of psychological inflexibility and fear of self-compassion poses a serious threat to the functioning and treatment of childhood maltreatment survivors.

Although a link between fear of self-compassion, psychological inflexibility, and trauma pathology has been established (Miron et al., 2015), the associations among these variables relative to childhood maltreatment has yet to be examined. Thus, the present study utilized a trauma-exposed sample of college women to assess these relations. It was hypothesized that women with a history of moderate to severe childhood maltreatment would demonstrate greater fear of self-compassion than those with minimal or no history of maltreatment. It was also predicted that fear of self-compassion would indirectly influence the relationship between childhood maltreatment and PTSD symptoms (Miron et al., 2016). Moreover, the magnitude of this indirect effect was assumed to be contingent upon the degree to which individuals were psychologically inflexible (Miron et al., 2015). That is, women with a history of moderate to severe childhood maltreatment were expected to endorse a greater fear of self-compassion that would yield greater PTSD symptoms, especially among those women who demonstrated inflexibility. For a graphical depiction of study hypotheses, see Fig. 1.

2. Method

2.1. Participants and procedure

The sample was comprised of 311 college women who were at least 18 years old and fluent in English. Twenty-three participants were removed for missing data on all variables of interest. Four additional participants were removed as extreme outliers on age, leaving a final sample of 288. The mean age was 19.22 (SD = 1.46) years old with the majority of the sample self-identifying as White (60.1%) followed by Black (21.9%), “other/multiparacial” (9.7%), Asian or South-Asian (3.1%), and Native Hawaiian or Pacific Islander (1.0%) with 4.2% preferred not to respond. Most participants self-identified as non-Hispanic (80.9%); 18.8% Hispanic, 0.3% preferred not to respond. Regarding educational status, participants were primarily in their first (56.9%) or second undergraduate year (21.5%) with some students having completed three or more undergraduate years (16.0% juniors, 4.5% seniors, 1.0% “other”).

Prospective participants were recruited from introductory and upper-level psychology courses at a large Midwestern university via an online research sign-up system, flyers, and classroom announcements. Participants completed an online survey following informed consent to determine eligibility for a larger study examining the effectiveness of a brief self-compassion intervention. Participants were entered into a drawing for two $50 awards, and those participants who were also introductory psychology students had the additional option of receiving partial course credit. All study procedures were approved by the university’s institutional review board.

2.2. Measures

2.2.1. Childhood trauma questionnaire (CTQ: Bernstein & Fink, 1998)

The CTQ is a measure of exposure to five types of childhood maltreatment — emotional abuse (e.g., “I believe I was emotionally abused”), physical abuse (e.g., “I got hit so hard by someone in my family that I had to see a doctor or go to the hospital”), sexual abuse (e.g., “Someone touched me in a sexual way, or tried to make me touch them”), emotional neglect (e.g., “People in my family called me
things like ‘stupid,’ ‘lazy,’ or ‘ugly’

4. Results

4.1. Fear of Compassion Scale

The Fear of Compassion Scale consists of three subscales: Fear of Compassion for Self, Fear of Compassion from Others and Fear of Compassion for Others. To measure fear of self-compassion, the Fear of Compassion for Self subscale was utilized in this study. This subscale consists of 18 items with participants indicating the extent to which they expressed kindness and compassion toward themselves (e.g., “I feel that I don’t deserve to be kind and forgiving to myself”) on a 5-point Likert-like scale (0 = don’t agree at all to 4 = completely agree). Items were summed to create a total score of self-compassion, which showed excellent internal consistency (α = 0.95). Other studies have shown that the Fear of Compassion for Self subscale shows adequate internal consistency and can be used without compromising its psychometric integrity (Gilbert et al., 2011; Miron et al., 2015).

4.2. Acceptance and Action Questionnaire (AAQ-II; Bond et al., 2011)

The AAQ-II is a measure of psychological inflexibility. Participants indicated the extent to which they avoid or attempt to control internal experiences (e.g., “I worry about not being able to control my worries and feelings”) on a 7-point Likert-like scale (1 = never true to 7 = always true). Items were averaged to compute a mean score, which showed adequate internal consistency (α = 0.69). Overall, the AAQ-II has good psychometric properties, including good test-retest reliability, internal consistency, and validity (Bond et al., 2011).

4.3. PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013)

The PCL-5 is a measure of perceived PTSD symptom severity in the past month. Symptoms are based on DSM-5 diagnostic criteria (APA, 2013). Participants rated the extent they have been bothered by PTSD symptoms on a 5-point Likert-like scale (0 = not at all to 4 = extremely). Items were summed to compute a PTSD symptom severity score, which showed excellent internal consistency (α = 0.95). Overall, the PCL-5 has demonstrated strong psychometric properties, including high internal consistency, acceptable test-retest reliability, and adequate validity (Blevins, Weathers, Davis, Witte, & Domino, 2015).

5. Data Analytic Plan

Study hypotheses were assessed in Mplus 6.0, which utilizes full-information maximum likelihood estimation (MLE). MLE is arguably a better approach for handling data missing at random than other imputation methods (e.g., multiple imputation, Allison, 2012). First, data were examined for accuracy. Less than 10% of data were missing at random on PTSD symptom severity. Four extreme outliers (± 3 SDs) on age were detected and removed from further analysis (Tabachnick & Fidell, 2007). No multivariate outliers were detected. Next, a simple mediation model was tested to examine the indirect effect of childhood maltreatment on PTSD symptom severity through fear of self-compassion. Bootstrapping was used to approximate the sampling distributions of population-specific indirect effects. This widely-used resampling method yields bias-corrected confidence intervals (CIs) that are percentile-based and empirically-derived (Preacher & Hayes, 2008), which are an improvement upon the percentile bootstrap CIs. Finally, a conditional process analysis, as described by Hayes (2013), was performed by adding psychological inflexibility as a moderator of the indirect effect. Mplus syntax for the conditional process model was adapted from Stride, Gardner, Catley, & Thomas (2015). An interaction term was created from the product of fear of self-compassion and psychological inflexibility (mean-centered). A significant interaction effect implies a significant conditional indirect effect. Both a significant interaction effect and significant conditional interaction effect can be assessed using simple slopes analysis to probe these interactions at two levels (−1 SD, +1 SD) of psychological flexibility.

3. Results

A high percentage of the sample endorsed a history of moderate to severe childhood maltreatment (n = 120; 41.7%). Of those participants, 25.8% (n = 31) endorsed physical abuse, 35.0% (n = 42) physical neglect, 61.7% (n = 74) emotional abuse, 60.0% (n = 72) emotional neglect, and 26.7% (n = 32) sexual abuse. It is worth noting that these categories were not mutually exclusive. Significant between-group differences were observed on fear of self-compassion (t[202.44] = −4.81, p < 0.001, Cohen’s d = −0.58), psychological inflexibility (t[218.21] = −3.32, p = 0.001, d = −0.40), and PTSD symptom severity (t[172.43] = −3.67, p < 0.001, d = −0.44). Specifically, participants reporting moderate to severe childhood maltreatment endorsed significantly higher levels of fear of self-compassion (M = 16.47, SD = 14.57), psychological inflexibility (M = 3.48, SD = 1.08), and
PTSD symptom severity ($M = 10.78$, $SD = 12.60$) as compared to participants with minimal to no childhood maltreatment (fear of self-compassion, $M = 8.94$, $SD = 10.42$; psychological inflexibility, $M = 3.09$, $SD = 0.85$; PTSD symptom severity, $M = 5.64$, $SD = 8.60$). No between-group differences were observed for demographic variables. Table 1 shows the means, standard deviations, ranges, and zero-order correlations of study variables and potential covariates (i.e., age, race/ethnicity, sex, education level). No covariates were significantly associated with any variables of interest and, thus, not included in subsequent analyses.

Results of the simple mediation analysis are shown in the top panel of Fig. 2. As expected, participants with a history of moderate to severe childhood maltreatment reported greater fear of self-compassion than participants with minimal to no history of childhood maltreatment. Childhood maltreatment and fear of self-compassion were significantly associated with PTSD symptom severity. In addition, childhood maltreatment had a significant indirect effect on PTSD symptom severity through fear of self-compassion (Indirect Effect: $B = 1.51$, $p = 0.013$, 95% CI [0.556, 2.978], $\beta = 0.07$).

Results from the conditional process analysis are shown in the bottom panel of Fig. 2. Childhood maltreatment was significantly associated with fear of self-compassion (FSC; top panel) and psychological inflexibility (PIF) added as a moderator (bottom panel).

Table 1
Bivariate Correlations, Means, Standard Deviations, and Range among Study Variables.

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<td>3. Education</td>
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<td>4. Childhood Maltreatmentb</td>
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<td>5. Fear of Self-Compassionc</td>
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<td>6. Psychological Inflexibilityd</td>
<td>0.01</td>
<td>-0.01</td>
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<td>0.24</td>
<td>0.28</td>
<td>0.37</td>
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<td>7. PTSD Symptom Severity</td>
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<td>$M$</td>
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<td>$SD$</td>
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<td>$Max$</td>
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Note. $N = 288$. Bolded values are significance at $p < 0.05$.

a $n = 283$.
b $n = 282$.
c $n = 286$.
d $n = 266$.

Fig. 2. Results of simple mediation model testing the indirect effect of childhood maltreatment on posttraumatic stress disorder (PTSD) symptom severity via fear of self-compassion (FSC; top panel) and the conditional process model with psychological inflexibility (PIF) added as a moderator (bottom panel).
Fig. 3. Post hoc multiple mediation results of the hypothesized indirect effect of a history of childhood maltreatment on posttraumatic stress disorder (PTSD) severity through fear of self-compassion and psychological inflexibility.

associated with fear of self-compassion and PTSD symptom severity. Interestingly, fear of self-compassion no longer predicted PTSD symptom severity with psychological inflexibility added to the model. Bootstrapping was used to determine the conditional indirect effects. The conditional indirect effects refer to the effect of childhood maltreatment on PTSD symptom severity via fear of self-compassion at different levels (−1 SD, +1 SD) of psychological inflexibility. The conditional indirect effects were non-significant (ps < 0.100). Contrary to expectation, psychological inflexibility did not moderate the indirect effect, as evidenced by a non-significant interaction effect.

In light of the significant between-group difference in psychological inflexibility and its significant direct effect on PTSD symptom severity, a post hoc analysis examining the indirect effects of psychological inflexibility and fear of self-compassion on childhood maltreatment and PTSD symptom severity was tested as an alternative model (see Fig. 3). Results showed that the indirect effect of childhood maltreatment on PTSD symptom severity via psychological inflexibility (Indirect Effect: $B = 1.38$, $p = 0.012$, 95% CI [0.521, 2.715], $\beta = 0.06$) was statistically significant while this indirect effect via fear of self-compassion was not (Indirect Effect: $B = 0.60$, $p = 0.328$, 95% CI [-0.439, 2.025], $\beta = 0.03$).

4. Discussion

The current study sought to replicate and extend previous research by examining the relationships among childhood maltreatment, fear of self-compassion, psychological inflexibility, and PTSD symptom severity in a sample of women with varying levels of childhood maltreatment. As expected, women with a history of moderate to severe childhood maltreatment endorsed a greater fear of self-compassion compared to women with minimal to no history of maltreatment. As stated above, rejection and abuse from early attachment figures, such as parents, conditions children to respond to themselves in a harsh, rejecting manner rather than with warmth and reassurance. They can develop a self-directed hostility that permeates self-criticism and facilitates self-deprecating beliefs, such as that self-compassion is not deserved, is a sign of weakness, or that desiring love and kindness will only be met with rejection. Thus, individuals reared in families characterized by abuse and low affection may not only be unfamiliar with compassion (from others and themselves), but may also find it aversive. Because of the abuse and neglect, victims develop overactive threat system (and to a lesser degree the drive system) and underactive contentment system (Gilbert, 2014; Gilbert & Procter, 2006). This increased sensitivity to potential threats (and lack of emotion regulatory capacity) likely contributes to pathological reactions to childhood maltreatment, specifically PTSD symptoms. In this study, fear of self-compassion was associated with greater PTSD symptom severity and has been linked with other adverse outcomes elsewhere (e.g., depression, anxiety, self-criticism, self-injurious behaviors; Gilbert et al., 2011; Miron et al., 2015, 2016; Xavier et al., 2015). Moreover, childhood maltreatment had an indirect effect on PTSD symptom severity via fear of self-compassion. Miron et al. (2016) had a similar finding, although the indirect effect was specific to a history of childhood sexual abuse (CSA) and not childhood physical abuse (CPA). The unique effects of different childhood maltreatment types (e.g., sexual, physical, emotional) were not examined in this study; however, it seems plausible that certain forms of maltreatment would more strongly elicit a fearful response to self-compassion and more symptom severity. Altogether, these findings support fear of self-compassion as a separate construct than simply lacking self-compassion. Additionally, they implicate fear of self-compassion as a risk factor for adverse reactions to trauma exposure, especially childhood adversity.

Future research would benefit from exploring the functional implications of fear of self-compassion. Although present data were insufficient for testing the assumption that maltreatment begets maltreatment, we have already raised the point that fear of self-compassion may increase the likelihood that adult survivors of childhood maltreatment will mistreat their children. Self-compassion is cultivated within early attachment relationships and maltreated children are often deprived of positive caregiver-child experiences that promote secure attachment. Evidence suggests that insecurely attached parents may adopt a parenting style that is characterized by distance and reduced availability (Moreira, Carona, Silva, Nunes, & Canavarro, 2015). This is likely due to limited internal working models for forming meaningful relationships with others, especially with their children. Although parental neglect does not directly contribute to offspring victimization (Berlin et al., 2011), fear of self-compassion is associated with known risk factors for
parental maltreatment (e.g., psychopathology, increased stress; Dixon et al., 2005, 2009). Toward this end, addressing fear of self-compassion as a therapeutic target might not only improve overall well-being, but also reduce the likelihood that maltreatment victims will mistreat their own offspring. Clarifying the role that fear of self-compassion plays in determining risk for parental abuse among previous victims would be an invaluable first step in testing this presumption.

As previous research suggested (Miron et al., 2015), psychological inflexibility was expected to exacerbate the negative effects of fear of self-compassion for childhood maltreatment survivors. Specifically, it was hypothesized that a history of maltreatment would be associated with a heightened fear of self-compassion and, therefore, greater PTSD symptom severity, especially among women who were psychologically inflexible. Present data did not support this hypothesis. This contradicts the findings of Miron et al. (2015), who showed that higher fear of self-compassion was only predictive of increased PTSD symptom severity among participants with high psychological inflexibility. The differences in sample characteristics (i.e., all-female sample with varying histories of childhood maltreatment vs. mixed-gender sample of trauma survivors with various types of exposure) could have contributed to the discrepant findings. Miron et al. were also able to control for the potential influence of negative affect while these data were not available for inclusion in the present study. Additional research is warranted to determine if and under which circumstances (e.g., type of trauma history) fear of self-compassion and psychological inflexibility interact to influence trauma-related outcomes.

Results indicated that psychological inflexibility was more strongly related to PTSD symptom severity than fear of self-compassion. Several studies have documented a link between psychological inflexibility and psychological distress among survivors of childhood adversity (Marx & Sloan, 2002; Polusny, Rosenthal, Aben, & Follette, 2004; Reddy et al., 2006; Shenk, Putnam, & Noll, 2012). Not surprisingly, a post hoc analysis showed that psychological inflexibility had a significant indirect effect on childhood maltreatment and PTSD symptom severity while fear of self-compassion no longer did. This implies that childhood maltreatment experiences that foster rigid rule following and indiscriminate use of avoidance for aversive internal experiences are potentially more detrimental than experiences that simply cultivate a fear response to compassion. Thus, future research may investigate which maltreatment characteristics are more likely to reinforce the internalization of critical self-views that govern subsequent behavior. For example, a victim that believes he or she is unlovable may act in a way that conforms to this negative self-conceptualization, such as isolating from others. Maltreatment characteristics of interest include (but are not limited to) relation to perpetrator(s), duration of maltreatment, age of first occurrence, and severity and/or type of maltreatment (e.g., sexual abuse, physical abuse, neglect). Knowing this information will advance our understanding of the development of psychological inflexibility among childhood maltreatment survivors and better inform appropriate treatment planning. Many compassion-based treatments target self-compassion and fear of self-compassion directly (e.g., Compassion-Focused Therapy, Mindful Self-Compassion program; Gilbert, 2014; Neff & Germer, 2013). These treatments may also address psychological inflexibility; however, a more appropriate therapeutic option is Acceptance and Commitment Therapy (ACT). ACT is based on the psychological flexibility model and teaches skills that increases one’s ability to remain engaged with the present moment while acting in accordance with chosen values (Hayes et al., 2006). ACT also has preliminary support as an effective treatment for PTSD through several case studies (Batten & Hayes, 2005; Burrows, 2013; Cad, Twohig, Crosby, & Enno, 2011; Hermann, Meyer, Schnurr, Batten, & Walser, 2016; Jansen & Morris, 2017; Orsillo & Batten, 2005; Thompson, Luoma, & Lejeune, 2013; Twohig, 2009).

This study was not without its limitations. An all-female sample was utilized, thus, limiting the ability to generalize findings to male survivors of childhood maltreatment. Fear of self-compassion may be particularly prevalent in men due to differences in gender socialization, highlighting the need for similar research using this population. Similarly, the current study used a college sample that may not be representative of the broader adult population. Using self-report measures to assess constructs of interest could have introduced confounding factors, such as bias, personality differences, or state mood, which could not be adjusted for in the present study. Researchers have expressed concerns about the accuracy with which psychological inflexible individuals are able to report their internal states (Gratz, Bornovalova, Delany-Brumsey, Nick, & Lejeuz, 2007). Finally, causal inferences cannot be made from a cross-sectional design study such as this, underscoring the importance of longitudinal designs to delineate the exact relationships among childhood maltreatment, fear of self-compassion, psychological inflexibility, and PTSD symptom severity.

Despite these limitations, the current study expanded upon previous research by examining the potential links among childhood maltreatment, fear of self-compassion, psychological inflexibility, and PTSD symptoms. As expected, a history of moderate to severe childhood maltreatment (as opposed to minimal or no childhood maltreatment) was associated with greater fear of self-compassion and psychological inflexibility. Interestingly, present data suggested that psychological inflexibility may be more detrimental to subsequent functioning following childhood maltreatment than fear of self-compassion. While additional research is warranted, it may be beneficial to examine the impact of certain maltreatment experiences (e.g., relationship to perpetrator(s), severity and frequency of maltreatment, age at onset). Our data did not support an interaction effect between fear of self-compassion and psychological inflexibility on PTSD symptom severity, but this interaction effect has been found elsewhere (Miron et al., 2015). Thus, replicating and extending this research, preferably using longitudinal studies with maltreatment survivors from demographically diverse backgrounds, will better inform the nature of the association between these two constructs within this trauma subpopulation.

Overall, childhood maltreatment survivors can present with unique challenges that compromise the effectiveness of PTSD treatments. For example, survivors with a marked fear of compassion (not just self-compassion) may struggle to form a genuine therapeutic alliance. Furthermore, psychological inflexible clients may be unwilling to engage with standard PTSD treatments, such as exposure-based therapy, because they involve repeated, prolonged engagement with distressing private experiences. Consequently, these clients may be more likely to prematurely drop out from these treatments. Clinicians may consider ACT as an appropriate treatment option for childhood maltreatment survivors that present as highly inflexible. ACT cultivates a willingness to engage with intense private experiences, such as aversive emotional reactivity, while also reducing PTSD symptom severity. Alternatively, compassion-based treatments (e.g., Compassion-Focused Therapy, Mindful Self-Compassion program) not only increase self-
compassion, but also address fear of self-compassion by helping clients to normalize, process, and work through any aversion to compassion. Similar to ACT, preliminary evidence shows that treatments increasing self-compassion are associated with clinically meaningful reductions in PTSD symptoms (Au et al., 2017; Kearney et al., 2013). These findings underscore the utility of exploring alternative PTSD treatment approaches.

Conflict of interest

The authors declare that they have no conflicts of interest.

Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional research committee and the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

References


