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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

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involves relating to one's suffering with a loving-kind, nonjudgmental attitude from the perspective of Hiraoka et al., Hiraoka et al., ctive that suffering is part of the larger human experience (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, & Ravis, 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, & Borairi, 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

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