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Fear of Compassion: Links to Interpersonal and Intrapsychic Behavior, Personality Variables, and Mental Health Outcomes

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FEAR OF COMPASSION: LINKS TO INTERPERSONAL AND INTRAPSYCHIC BEHAVIOR, PERSONALITY VARIABLES, AND MENTAL HEALTH OUTCOMES

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Compassion and self-compassion have significant benefits for wellbeing and mental health (e.g. Neff, 2003a, 2003b). Recent literature has demonstrated that some individuals can come to experience fear when receiving compassion from oneself or others (Gilbert, McEwan, Matos, & Rivis, 2011). The present study examines how fear of compassion for others, fear of compassion from others, and fear of self-compassion are related to interpersonal and introjected behavior, stable personality traits, and various facets of mental health. Undergraduate participants completed self-report survey measures in a laboratory setting, including the fear of compassion scales, the Structural Analysis of Social Behavior (SASB), NEO Five Factor Inventory, and Counseling Center Assessment of Psychological Symptoms (CCAPS-62). Bivariate correlational analyses revealed fear of self-compassion to demonstrate inverse associations with levels of affiliation with a focus on oneself and others in interpersonal and introjected interactions, with fear of compassion from others inversely associated with affiliation towards others and with oneself. Fears of compassion were further found to be correlated positively with neuroticism and negatively with extraversion, agreeableness, and conscientiousness. Consistent with previous literature, fears of compassion were also associated with various negative mental health outcomes like depression, generalized anxiety, social anxiety, and eating concerns. Fear of self-compassion and fear of compassion for others were correlated to measures of academic distress, substance use, family problems, and hostility. These findings add to the literature on the challenges faced by individuals fearing compassion, while

further research is needed to better understand the processes by which fears of compassion operate and contribute to these challenges.

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INTRODUCTION

Background

Compassion has long been conceptualized as vital to physical and mental health by various cultures and has recently received empirical attention (e.g. Davidson & Harrington, 2002; Gallagher & Shear, 1999). From an evolutionary perspective, a specialized affect regulation system has developed to emphasize the importance of compassion on caregiving and attachment behavior (Gilbert, 2005). Compassionate behavior stimulates feelings of warmth, soothing, contentment, and social safeness, which also serve to inhibit senses of both physical and social threat and danger. These emotions are affiliative in nature; they encourage interpersonal closeness and foster meaningful relationships with others.

Some individuals, however, are unable to access the health benefits associated with compassion. Clinical and empirical evidence has suggested that people can come to fear certain emotions, including positive ones (Arieti, S. & Bemporad, 1980; Gilbert et al., 2011). Specifically, a fear of affiliative emotions can produce an aversive reaction to compassion. People may associate compassion with feared outcomes like a drop in personal standards, being taken advantage of, a threat of abuse, or a reliance on compassion that may be inaccessible in the future. Gilbert et al. (2011) created measures for fear of compassion from others, fear of compassion for others, and fear of compassion for self. Fears of compassion have been linked to various forms of psychopathology (Gilbert et al., 2011; Kelly, Carter, Zuroff, & Borairi, 2012; Miron, Sherrill, & Orcutt, 2015) and other variables associated with negative mental health outcomes like attachment insecurity, difficulties with mindfulness, and alexithymia (Gilbert et al., 2011; 2012).

Further study is needed to understand fear of compassion. Little is known about the interpersonal and intrapsychic experiences of those fearing compassion. One avenue for further study may be pursued through the use of the Structural Analysis of Social Behavior (SASB; Benjamin, 1974). The SASB is a model that can be applied to measure interpersonal transactions on three dimensions: focus, affiliation, and autonomy. Each of these dimensions reflects a critical domain of relating to oneself and other individuals. The focus dimension identifies the person towards whom an interaction is directed. The affiliation dimension uses a continuum from love to hate to assess the extent to which an interaction serves to facilitate affiliation or interpersonal closeness, considered to be a primary motivator of human behavior. The autonomy dimension measures the degree to which a transaction encourages independent and self-directed behavior on the high end of the spectrum, where the low end reflects a transaction intended to exert control. Healthy interpersonal behaviors are characterized by high levels of affiliation and autonomy on the SASB. Individuals who fear compassion may exhibit behavior reflecting lower levels of affiliation and autonomy towards themselves and others.

The present study employed the SASB to assess how individuals fearing compassion behave intrapsychically and interpersonally. It also examined the relationship between fears of compassion and stable personality traits. To do so, the Five Factor Model (FFM; McCrae & Costa, 1987) of personality was used. The FFM identifies five overarching and independent personality dimensions: extraversion, neuroticism, agreeableness, conscientiousness, and openness to experience. Analysis of these variables may further elucidate the nature of fears of compassion and inform intervention. This project attempted to further the existing literature by examining the personality variables and interpersonal and intrapsychic patterns of interaction demonstrated by those who fear compassion.

CHAPTER 2

LITERATURE REVIEW

Compassion

Individuals from both Eastern and Western traditions have defined compassion in various ways. The Dalai Lama (1995), for instance, provides the following definition for compassion: “an openness to the suffering of others with a commitment to relieve it.” He identifies its roots in prosocial behavior, loving kindness, and desire to alleviate suffering. Eastern traditions have considered compassion to be vital to the liberation from aversive emotions like fear, anger, jealousy, and hatred (Goleman, 2003). Attributes of compassion include motivation to care, capacity for sympathy, ability to tolerate unpleasant emotions, capacity for empathic understanding, and nonjudging (Gilbert, 2005). It further involves recognition that humans are imperfect by nature and equally prone to mistakes. While Buddhist tradition sees compassion as central to wellbeing, Western psychology has only relatively recently begun to study compassion as a scientific variable affecting outcomes of psychological health and wellbeing (Davidson & Harrington, 2002; Gallagher & Shear, 1999). Compassion has been linked to related notions of affiliative behavior, attachment, sympathy, prosocial behavior, and types of love (Gilbert, 2005).

Compassion can be differentiated from these similar concepts. It has been differentiated from similar variables like efficacy, self-esteem, power, and love (Goetz, Keltner, & Simon-Thomas, 2010; Shiota, Keltner, & John, 2006). Compassion can be considered a form of prosocial behavior intended to improve the circumstances of the recipient (Bierhoff, 2005). Whereas terms like helping behavior, prosocial behavior, and altruism describe actions, compassion describes "the motivational framework that leads to such actions" (Bierhoff, 2005; pg 148). Compassion involves an empathic understanding of others' thoughts, feelings, and behavior without judging or condemning. It fosters a concern for others' suffering and a desire to engage in helpful action. It stimulates affiliative emotion in both the provider and the receiver (Gilbert, 2010). Affiliative emotions by nature are positive and drive interpersonal closeness. They have qualities of soothing, calming, and producing contentment. Among compassion's key influences is the stimulation of these emotions.

An accumulation of evidence has illustrated the importance of building compassion for oneself and for others, as well as receiving compassion (e.g., Gilbert, 2005). The ensuing discussion reviews evidence of the importance of compassion to mental health and wellbeing. Compassion has been studied in three different forms with regard to application and directionality. It can be experienced for others, from others, and for ourselves (self-compassion), especially when faced with hardship (Gilbert, 2009; Neff, 2003).

Compassion From Others

Receiving compassion from others in the form of social support has been tied to protection from disease and death (Broadhead et al., 1983), whereas lower levels of social support have been linked to heightened risks of morbidity and mortality (Hawkley, Masi, Berry, & Cacioppo, 2006; House, Landis, & Umberson, 1988). From an evolutionary perspective, receiving compassion via social support can be expected to improve prospects of survival.

Social support can both directly improve wellbeing and serve as protection from the detrimental effects of stress (Cohen & Wills, 1985). It fosters interconnectedness and the formation and maintenance of valued social relationships. Social contact consistently demonstrates robust associations with wellbeing (House et al., 1988). Perceived social support has been linked to lower levels of depression (Peirce, Frone, Russell, Cooper, & Mudar, 2000) and anxiety (Zimet, Dahlem, Zimet, & Farley, 1988). Compassion from others appears to regulate negative emotions like shame (Warren, 2015). Its benefits are widespread and generally beneficial to the recipient.

Compassion For Others

Compassion for others generally appears to benefit the provider (Axelrod & Dion, 1988; Rusbult & Van Lange, 2003). It appears to reduce mortality and has been suggested to be more influential than receiving support from others (Brown, Nesse, Vinokur, & Smith, 2003). Building compassion for others can increase personal resources like mindfulness, purpose in life, and social support from others (Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008). Enhancement of these resources in turn predicts greater life satisfaction and reductions in depressive symptoms. Moreover, increases in compassion for others have predicted increased perceptions of others as compassionate in reciprocation, feelings of closeness, connectedness and trust (Crocker & Canevello, 2008). In light of our fundamental need for interpersonal relationships (Baumeister & Leary, 1995), compassionate behavior may be useful in forming and maintaining social connectedness that could help fulfill this need. Additionally, the practice of compassion for others through altruism (Midlarsky & Kahana, 1994; Weinstein & Ryan, 2010) and volunteerism (Oman, Thoresen, & McMahon, 1999) is associated with physical and physiological health benefits.

Loving-Kindness Meditation (LKM) can be used to foster compassion for self and others. This practice involves directing compassion and wishes for wellbeing toward real or imagined others. LKM is designed to produce emotional, motivational, and behavioral benefits so as to stimulate positive feelings towards oneself and others (Salzberg, 1995). Evidence suggests that it further promotes heightened feelings of connectedness to others (Hutcherson, Seppala, & Gross, 2008), which may improve both psychological and physical wellbeing (Brown et al., 2003). Using LKM to cultivate compassion also appears to activate the mental circuitry associated with empathic responses to another's pain (Lutz, Brefczynski-Lewis, Johnstone, & Davidson, 2008). Additionally, those more versed in LKM exhibited greater detection of emotional sounds and active mentation following auditory emotional cues, suggesting greater capacity to be attuned to emotion.

The importance of compassion for others can be further understood through an evolutionary lens. The evolutionary function of altruistic behavior has been hotly debated ever since Darwin published his *Origin of Species*. Helping others at the expense of oneself did not initially appear to enhance the individual's own prospects of survival. Thus, altruistic behavior did not appear to fit with evolutionary theory. A more recent emphasis on the survival of one's *genes*, however, has shed new light on how altruism may indeed be understood within the context of Darwin's theory (Geary, 2000). Altruism is believed to have evolved because such behavior may benefit the group, and perhaps thereby benefit the individual. When one helps the kin group, inclusive fitness, the chances of shared genes being passed on (Geary, 2000), is improved. This can occur in two forms: kin and reciprocal altruism. Kin altruism is performed for members of the same ingroup and may foster the individual's inclusiveness within the group. It also improves the chances of shared genes being passed on (Sober, 2002). Reciprocal altruism is performed to aid someone from a separate group, and it may improve the individual's group via the return of those favors at a later time (Sober, 2002). In each case, the likelihood of individual or shared genes being passed on is improved. These forms of altruism statistically boost the probability of shared genes being furthered through reproduction. Even if say, the individual dies in the process of saving a member of his or her kin, that member's chances of passing on genetic material are increased through the surviving kin. While the link between this focus on genes and the evolution of the drivers of human behavior is not well understood, it does appear that humans are motivated to partake in actions like pursuing a mate or taking care of children that will enhance the prospects of inclusive fitness over the long term (Sober, 2002).

Self-Compassion

Self-compassion involves adopting a caring and compassionate attitude towards the self in the face of hardship or perceived personal failure (Neff, 2003a). Neff (2003a) identified three vital components to self-compassion: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification. Self-compassion is a style of positive attitude towards oneself that may prevent maladaptive outcomes like isolation, rumination, and depression (Neff, 2003a). Because a generalized compassionate orientation deems all humans as deserving of compassion, individuals should treat themselves compassionately as well. Self-compassion is thus considered a fundamental component of compassion (Neff, 2003b).

Self-compassionate individuals first exhibit the ability to recognize when they are suffering (mindfulness), then respond by treating themselves with feelings of warmth, kindness, nonjudgmental understanding, and interconnectedness (Neff, 2003a). Those low in self-compassion on the other hand are likely to treat themselves harshly and feel isolated. They tend to over-identify with their suffering or inadequacy rather than mindfully experience it as a momentary setback or hardship common to the human experience. Negative experiences are neither suppressed nor exaggerated among those high in self-compassion. Neff notes that self-compassion cannot occur without the appropriate acknowledgement of one's feelings (2003b). Neff therefore considers self-compassion to subsume a mindful perspective, characterized by nonjudgmental receptiveness of one's thoughts and feelings (Hayes, Strosahl, & Wilson, 1999). Self-compassionate individuals are able to employ these skills to prevent the onset of suffering in the first place (Neff, 2003b) and ameliorate negative emotional states so as to appropriately guide their thinking and take actions to navigate the environment (Folkman & Moskowitz, 2000; Salovey & Mayer, 1990).

Self-compassion can serve as a protective factor against psychopathology and promote emotional resilience (Neff, 2003a, 2003b). It provides perspective to one's suffering and is a distinct concept from self-pity (Kornfield & Goldstein, 1987). Self-compassion is negatively associated with self-criticism, depression, anxiety, rumination, thought suppression, performance goals, disordered eating behavior, and neurotic perfectionism while positively associated with life-satisfaction, social connectedness, and emotional intelligence (Adams & Leary, 2007; Neff, 2003a; Neff, Hsieh, & Dejitterat, 2005; K. D. Neff, Kirkpatrick, & Rude, 2007). Notably, the aforementioned benefits are prosocial in nature and may lend themselves to affiliative behavior. Neff et al. (2007) found positive associations between self-compassion and reflective and affective wisdom, personal initiative, curiosity and exploration, happiness, optimism, and positive affect. It has been suggested to promote wellbeing through stimulation of feelings of care, connectedness, and contentment (Gilbert, 2005). Moreover, its soothing qualities may deactivate feelings of threat (Johnson & O'Brien, 2013).

Individuals practicing self-compassion should be predisposed to treat themselves with kindness rather than self-criticism under shame-provoking circumstances. Self-compassion may interrupt the process by which negative thoughts about the self incur negative consequences. Samaie & Farahani (2011) found self-compassion to moderate the association between stress and rumination, while Wong & Mak (2013) found it to moderate that between depressogenic personality variables and the experience of depression. One study has identified self-compassion to be a partial mediator of the relationship between childhood maltreatment and emotion regulation difficulties later in adolescence (Vettese, Dyer, Li, & Wekerle, 2011). Self-compassion seems to prevent negative experiences from resulting in negative mental health outcomes.

Self-compassion has also been shown to accelerate decreases in eating disorder outcome and moderate decreases in body shame/dissatisfaction following compassion-based meditation interventions (Kelly, Carter, & Borairi, 2014). Self-compassion moderates the relationship between a focus on one's body and body shame (Liss & Erchull, 2015), a crucial mediator of the relationship between body surveillance and psychiatric symptomatology (eating or depressive symptoms; Moradi, Dirks, & Matteson, 2005). Liss & Erchul (2015) wondered whether those experiencing body shame could employ self-compassion to localize it rather than globalize it into generalized depression. This idea resembles the findings of Johnson & O'Brien (2013), whereby participants recalling a shameful memory with a self-compassionate attitude (as opposed to without said attitude) were less likely to experience depression. Self-compassion, after all drives acceptance of the self, even in moments of threat to self-esteem, such as shame (Neff, 2003a, 2003b).

Self-Compassion vs. Self-Esteem

Self-compassion and self-esteem are separate but related constructs (Neff, 2003a). Both are ways of relating to oneself considered to improve wellbeing and reduce psychopathology. Neff has suggested that self-esteem in individualistic society reflects the degree to which one stands out from others. Efforts to build self-esteem may require people to consider themselves above average. Raising self-esteem can therefore have downfalls. It may lead people to engage in egotistical or narcissistic behavior in order to confirm this superior valuation. People can feel and act defensively when faced with threats to their self-esteem (Blaine & Crocker, 1993; Taylor & Brown, 1988), often resulting in displays of anger or aggression. Self-esteem involves a judgment of one's worth, often subject to fluctuation based on the most recent success or failure (Crocker, Luhtanen, Cooper, & Bouvrette, 2003). Self-compassion, unlike self-esteem, does not involve self-comparison or self-evaluation; rather, it describes a way of relating to oneself. Whereas self-esteem may rely on a judgment as to whether one meets external criteria (like appearance standards), self-compassion involves unconditional kindness and love directed towards the self (Neff & Vonk, 2009). Specifically, the *mindfulness* and *common humanity* components of self-compassion encourage non-judgment and acceptance of the self. Compassion for the self is derived from the recognition that all individuals deserve compassion and understanding regardless of any evaluation of their worth, whereas self-esteem may be associated with feelings of superiority to others and social rank (Gilbert, 2005). Self-compassion is dependent neither on external circumstances nor on a competitive comparison to others (Neff, 2003a). It may be more stable than self-esteem in the face of feedback (Neff & Vonk, 2009).

Moreover, self-compassion appears related to distinct thoughts, feelings, and behaviors from self-esteem (Leary, Tate, Adams, Allen, & Hancock, 2007). Leary et al. (2007) found self-compassion but not self-esteem to be related to lower negative affect not only at baseline but also upon receipt of unflattering feedback, as well as more favorable ratings of other people. People high in self-compassion were more willing to attribute negative events to their own personality than people high in self-esteem. Leary et al. (2007) suggest defensiveness and self-serving biases to account for these features of self-esteem but not self-compassion, as these strategies make people feel better about themselves (Blaine & Crocker, 1993; Taylor & Brown, 1988).

There may be downfalls to the cognitive styles unique to self-esteem, unlike self-compassion. Self-serving illusions interfere with accurate self-perception and may not be sustainable when one is confronted with clear evidence of his or her limitations or inadequacies (Leary, 2004, 2007). Self-compassion, alternatively, may lend itself to a more realistic perception of one's strengths and weaknesses with nonjudging acceptance of those weaknesses. Importantly, self-compassion appears especially advantageous for those individuals with lower self-esteem (Leary et al., 2007). Leary et al. (2007) further found self-compassion to account for more of the unique variance than self-esteem in several positive outcomes previously attributed to the effects of self-esteem, including lower levels of anxiety, depression, embarrassment, and hurt feelings. The same authors found self-compassion to be a better predictor of emotional stability and resilience than self-esteem, where self-esteem may only offer emotional resilience following positive feedback, as opposed to both negative and neutral feedback. Neff & Vonk (2009) found self-compassion a better buffer than self-esteem against social comparison, self-consciousness, and self-rumination. Self-esteem, but not self-compassion was found related to contingent self-worth, a sense of self-worth dependent on outcomes being successful. Self-compassion appears to provide a more stable sense of positive self-regard than self-esteem (Neff & Vonk, 2009). The same authors also observed a significant relationship between narcissism and self-esteem, but not with self-compassion. Self-compassion may be more conducive to affiliative behavior than self-esteem (Crocker & Canevello, 2008).

Individual Differences in Capacity for Compassion

The effects of compassion may not be universally beneficial, however. Depending on support from others can cause guilt and anxiety (Lu & Argyle, 1992). Individual differences in compassion for others among a female sample appear to moderate the effects of social support received from another on acute stress reactivity (Cosley, McCoy, Saslow, & Epel, 2010). Those higher in compassion were better able to experience decreases in stress, measured by blood pressure, salivary cortisol, and heart rate variability, in response to social support. Others (e.g. Crocker & Canevello, 2008) have postulated that more compassionate individuals also perceive others as more compassionate. In addition, only participants low in cynicism (Lepore, 1995) and defensiveness (Westmaas & Jamner, 2006) exhibited benefits from social support. Westmaas & Jamner (2006) found social support to lower blood pressure only among those low in defensiveness. Individuals with low self-esteem appear less receptive to social support, something that may be perceived by social support providers (Marigold, Cavallo, Holmes, & Wood, 2014). Indeed, social support providers were shown less likely to offer emotional validation to those with low self-esteem. Further evidence suggests that some people may not respond positively to the affiliative emotions signaled by compassion from others, and may even respond aversively (Arieti & Bemporad, 1980; Gilbert, McEwan, Matos, & Rivis, 2011; Hayes & Feldman, 2004).

Self-compassion specifically may not work in the presence of certain psychological barriers. When shame is high enough, it can be overwhelming and perhaps incompatible with self-compassion. Building self-compassion appears a challenge for men who adhere to masculine norms or experience high shame (Reilly, Rochlen, & Awad, 2014). Reilly et al. (2014) suggest that self-criticism, feelings of inadequacy, and restricted emotional expression do not lend themselves to the willingness to develop and utilize self-compassionate abilities in many men.

Those unable to benefit from compassion not only miss a core evolutionary emotion regulation strategy but also suffer unwanted psychological outcomes. Deficits in the capacity to experience affiliative emotion can be indicative of underdeveloped inner emotion regulation (Gilbert, 2005). These individuals might experience higher levels of distress while also lacking the means of coping with such distress. Important to understanding individual differences in compassion are the core systems of affect regulation. The development of compassionate abilities and deficits can be further understood through processing systems evolved to value compassion. The work of Gilbert in particular has illuminated the value of building compassion in people with difficulties experiencing the effects of compassion and was heavily utilized in the ensuing discussion.

Affect Regulation Systems

Compassion plays a vital role in affect regulation. Research has suggested that a specialized affect regulation system concerned with feelings of reassurance, safeness, and wellbeing evolved with attachment systems (Depue & Morrone-Strupinsky, 2005). These authors have identified three distinct types of emotion regulation systems: (1) threat and protection systems, (2) drive, resource-seeking, and excitement systems, and (3) contentment, soothing, and safeness systems. Each type of threat warrants a system to detect it and to employ one or more coping strategies in response (Gilbert, 2005) Each system can also respond to social or nonsocial (e.g. physical, biological) threats. The first system serves to detect threats quickly through selective focus of attention and stimulate feelings of anxiety, fear, anger, or disgust. The intent of these feelings is to take action that will result in protection from threat (e.g. fight or flight). It therefore confers numerous advantages associated with self-protection. However, this system operates so as to be "better safe than sorry" (Gilbert, 1998). Therefore, it is thought to underpin psychopathology when easily conditioned and overactive in response to less dangerous threats (Rosen & Schulkin, 1998). For example, the threat of social evaluation from another may be perceived with greater danger than warranted in individuals with heightened levels of social anxiety. The threat system is also associated with defensiveness and feelings of insecurity that can be manifested in psychopathology.

The motivational system for drive and excitement leads people to seek resources and rewards: food, sex, relationships, etc. This system thus underpins some forms of positive affect, but not others (Gilbert, et al., 2009). Recent work has distinguished three unique categories of positive affect: feeling excited and motivated, feeling relaxed, and feeling soothed and content (Gilbert et al., 2008). This system energizes and activates people, and may be most closely tied to dopaminergic systems (Depue & Morrone-Strupinsky, 2005). The emotions associated with this system are those that increase arousal, such as excitement and pleasure. In social contexts, it stimulates behaviors of achievement and status seeking (Depue & Morrone-Strupinsky, 2005). Buddhist psychology, however, notes that while such positive feelings may satisfy desires and produce pleasure, they do not necessarily result in happiness. The Buddhist notion of happiness is derived from the development of a calm mind focused on mindfulness and compassion rather than striving for rewards (Dalai Lama, 2001). Gilbert (2005) proposed that this system is more closely tied to self-esteem than self-compassion. Self-compassion appears more related to the third system in its inhibition of threat-based processing and activation of soothing feelings.

The third system produces feelings of contentment, soothing, and social safeness. It operates when the needs to acquire sufficient resources and to be vigilant of threats are satisfied (Depue & Morrone-Strupinsky, 2005). Contentment is achieved not only through the suppression of the other two motivation systems, but also through a third system that regulates feelings of social safeness and wellbeing. Depue & Morrone-Stupinsky (2005) have discussed how this system has evolved alongside attachment behavior. Caring behavior is a powerful stimulator of soothing and safeness and regulator of threat and arousal. It operates via opiate and oxytocin systems. Oxytocin produces feelings of affiliation, trust, soothing, and calmness within the context of close relationships (Depue & Morrone-Strupinsky, 2005; Carter, 1998).

An important distinction should be made between the systems of threat and protection and that of contentment and social safeness. Safety can be considered a desired result of behaviors encouraged by the threat protection system. Gilbert (1993) has differentiated safety from *safeness*. Safety can be sought through many different avenues. Numerous defensive behaviors, like aggression, avoidance, and social withdrawal, can be utilized to achieve safety from some threat. While effective in many cases, this defensive style of threat reduction can, however, be turned towards the self in a self-attacking manner (Gilbert, 2005). The desire to seek safety differs from the actual feeling experienced while safe. Gilbert (2005) has thus used the term *safeness* in order to describe the way the mind is allowed to operate when allowed to feel safe. People experiencing safeness are typically relaxed, openly attentive, and explorative in a non-defensive manner (Gilbert, 1993). Recent evidence is accumulating to suggest a crucial role of attachment experiences, to be further discussed below, in stimulating social safeness and interconnectedness, and thereby emotion regulation (Cozolino, 2014). Insecure competitiveness and feeling inferior to others via social comparison, each strongly associated with depression in both clinical and nonclinical populations (Allan & Gilbert, 1997; Gilbert, Allan, Brough, Melley, & Miles, 2002; Gilbert & Allan, 1998; Gilbert, McEwan, Bellew, Mills, & Gale, 2009), may impede access to feelings of contentment and social safeness (Gilbert et al., 2009; Gilbert et al., 2008).

Each motivation system can be activated or deactivated, dysregulated or undermined. Balance among the three motivation systems is often a goal of therapy. Gilbert's compassion-focused therapy (2009) holds the assumption that the three systems can become imbalanced. It seeks to realign them in order to return the client to a sort of equilibrium. For instance, Gilbert suggests that compassion operates so as to deactivate the ego threat system and activate the soothing and contentment system (2005). Therapeutic interventions appear helpful when targeting the soothing and contentment system (Gilbert & Procter, 2006; Mayhew & Gilbert, 2008).

One common imbalance arises from oversensitivity and excessive activity of the threat protection and/or drive systems, which is often related to heightened levels of shame and self-criticism (Gilbert, 2009). Such individuals may experience difficulties in feeling contentment and safeness in their relationships with others. The contentment system can be considered less available or accessible as a result. In some, this system may have been insufficiently stimulated and utilized throughout development. Those who received little soothing from their primary caregivers may not develop the adequate capacity to soothe themselves later in life. Compassion for self and others is easier to learn when one has memories of being treated compassionately and values compassion (Gillath, Shaver, & Mikulincer, 2005). Difficulties accessing the contentment and social safeness system may be a risk factor for various unwanted mental health outcomes (Gilbert, McEwan, et al., 2009; Gilbert, 2000, 2005).

One line of evidence illustrating the reduced availability of the contentment and social safeness system is that regarding oxytocin. Oxytocin appears to influence numerous affiliative behaviors (Meyer-Lindenberg, 2008), including trust (Baumgartner, Heinrichs, Vonlanthen, Fischbacher, & Fehr, 2008; Kosfeld, Heinrichs, Zak, Fischbacher, & Fehr, 2005), empathy (Bartz et al., 2010), and social memory (Rimmele, Hediger, Heinrichs, & Klaver, 2009). Some individuals, however, are less receptive to the benefits associated with oxytocin, such as social threat regulation (Depue & Morrone-Strupinsky, 2005). Notably, those with low levels of social safeness and self-reassurance, high levels of self-criticism, and greater attachment insecurity were found to experience less benefit from intranasal oxytocin (Rockliff et al., 2011).

Some factors appear to preclude the receptivity to and capacity to benefit from compassion. Two key theories are discussed in light of their importance to understanding the variability in how individuals respond to compassion: (1) social mentality theory, which demonstrates how the brain responds to internal and external displays of compassion, and (2) attachment theory, which provides further insight into how the contentment and soothing system can be underdeveloped or even associated with fear.

Social Mentality Theory

Social mentality theory (Gilbert, 1989) can characterize self-compassion as a form of self-to-self relating, similarly conceptualized by (Neff, 2003b). It suggests that humans have evolved to develop different role relationships. Distinct role relationships include attachment, sexual, dominate-subordinate, etc. (Gilbert, 2005). Each role relationship is associated with a unique processing system. The appropriate processing system is activated in response to the relevant social stimuli. An aggressive demonstration from one individual can activate another's processing systems of fear and submission. Likewise, a parent's display of warmth and care can activate their infant's processing system of safeness and attachment. Different social signals are responsible for both developing and activating corresponding neurobiological systems. Signals of aggression stimulate the release of cortisol, whereas signals of warmth and safeness stimulate the release of oxytocin (Depue & Morrone-Strupinsky, 2005; Carter, 1998).

Social mentality theory proposes that not only do individuals respond to external social signals but also produce *internal* signal-response systems that work off of one another (Paul Gilbert, 1989, 2005). That is, internal cues also stimulate the same processing responses as external cues. Importantly, individuals do not discriminate between external and internal systems in how they are processed. A sexual stimulus may activate pituitary systems in the same or similar manner whether the stimulus was an external image or an internal fantasy. Responses to internal signals can vary as do responses to external social signals. One may be too highly aroused to respond appropriately to an internal signal of sexual arousal activated by fantasy and imagination. Conversely, one may be too low in arousal to respond to the same signal (Gilbert, 2005).

Social mentality theory suggests that individuals develop self-to-self relationships. An understanding of these social mentalities can be used to highlight the importance of compassion to mental health. Those who experience more frequent internal signals of compassion perceive the world differently from those who experience less frequent inner compassion. Both compassion from others (Woods & Proeve, 2014) and self-compassion (Gilbert, 1989) may be employed to deactivate threat-based processing, supporting the proposed similarity between external relationships and internal ones. Furthermore, some are more likely to experience self-created signals of social threat, characteristic of self-criticism. Hostile self-to-self relationships can be tied to recurring patterns of self-criticism. Self-criticism can therefore be considered an inner social relationship in which one part of the self identifies fault, makes accusations, and condemns the self (Gilbert, 2005).

Compassionate mind training (Gilbert & Procter, 2006) examines the nature of responses to self-criticism. It treats the cognitive and emotional responses to criticism from another person similar to those of internal self-criticism. Self-criticism is viewed as a *social* threat requiring a coping response. Responses may then include feelings of inadequacy, anxiety, or stress. The impact of these responses is further magnified by deficits in abilities to self-generate feelings of warmth, soothing, and reassurance among self-critical individuals (Gilbert, 2000; Neff, 2003a; Whelton & Greenberg, 2005). Greenberg et al. (1990) have theorized that people are more vulnerable to depression when they cannot defend themselves against their own attacks. Ideas of self-processing systems functioning similarly to social relationships are exemplified in numerous theories, especially regarding how they can contribute to psychopathology. Mental representations about the self and others underpin various therapeutic traditions. Cognitive therapies describe multiple schemata that structure information about the self and others. Automatic thoughts may be maladaptive or self-critical. Various dynamic and gestalt therapies have also illuminated self-to-self relationships to help clients identify emotions and clarify the meaning associated with self-criticism. Self-criticism can take the form of suggestions, commands, condemnations, and emotions like contempt (Gilbert, 2000; Whelton & Greenberg, 2005). Compassionate mind training often focuses on the dominate-subordinate social mentality, whereby a self-attack yields a submissive or anxious/depressive response (Gilbert & Procter, 2006). It seeks to cultivate warm and compassionate inner relationships rather than self-critical and shaming ones.

Compassion Focused Therapy (CFT; Gilbert, 2009) also draws from social mentality theory in its conceptualization of compassion. It stresses the evolutionary importance of caring, in addition to things like sex and aggression. Major changes in the peripheral and central nervous system facilitated the regulation of fight and flight responses in order to build and maintain social closeness. Oxytocin, for instance, serves to inhibit fight/flight/freeze processing and promote caring (Bell, 2001; Wang, 2005). Soothing effects thus arise from physical closeness with others. The evolution of the myelinated vagus nerve allowed for the soothing of infants through parental caregiving behaviors (Carter, 1998; Depue & Morrone-Strupinsky, 2005).

The myelinated vagus nerve is involved in the suppression of the hypothalamic pituitary-adrenal (HPA) axis, thereby regulating threat-driven behaviors like fight or flight and inducing a calmer physiological state (Gilbert, 2010). This lower level of physiological arousal facilitates socially affiliative behaviors. Feelings of safeness generally promote openness and flexibility in response to one's environment (Porges, 2007), as evidenced by the link between heart rate variability (HRV) resulting from the balance between sympathetic and parasympathetic nervous systems and feelings of interpersonal safeness. Porges (2007) has also demonstrated a link between HRV and one's capacity to inhibit threat-based processing and engage in self-soothing during times of stress. These links support the role of another's soothing behaviors on one's own development of self-soothing abilities. In combination with attachment theory, these findings suggest a mode through which those with deficits in the processing of affiliative stimuli may come to experience discomfort with compassionate behavior.

Attachment Theory

Bowlby's (1969, 1982) attachment theory describes innate systems of attachment and caregiving behaviors, in addition to other behavioral systems of threat regulation. Emotional attachment to caregivers evolved because it improved chances of survival and reproduction. Bowlby has identified the function of the attachment system to be protection from harm through the maintenance of closeness to caring and supportive others (attachment figures). These attachment figures are valued because they offer physical safety, support, and respite from adversity. The attachment system is shaped as early as infancy and continues to be adjusted by interpersonal experiences with attachment figures. The resulting product is a largely stable attachment style, a pattern of expectations of others and corresponding emotions and behaviors associated with the individual's attachment style (Fraley & Shaver, 2000; Hazan & Shaver, 1987).

Individuals vary in attachment style along two orthogonal dimensions: attachment-related avoidance and attachment-related anxiety (Brennan, Clark, & Shaver, 1998). One's position on the avoidant dimension is determined by the extent to which one "distrusts relationship partners' goodwill and strives to maintain behavioral independence and emotional distance from partners" (Mikulincer, Shaver, Gillath, & Nitzberg, 2005a). The anxious dimension represents the extent to which one "worries that a partner will not be available and responsive in times of need" (Mikulincer et al., 2005a). Attachment anxiety has been negatively correlated with self-compassion (Wei, Liao, Ku, & Shaffer, 2011). Scoring low on both dimensions reflects secure attachment, significantly correlated with self-compassion (Neff & McGehee, 2010).

As reviewed by various authors (e.g. Mikulincer & Shaver, 2003; Shaver & Clark, 1994; Shaver & Hazan, 1993), attachment style is considered a strong predictor of various aspects of mental health and wellbeing, including self- and social-schemas, emotion regulation, coping abilities, quality of intimate relationships, motivations for sexual behavior, and recovery from loss. Attachment security facilitates social safeness, trust in the availability of others, and confidence to explore the environment and interact with others (Bowlby, 1988). Early attachment experiences exhibit strong associations with internal working models of self and others and psychopathology (Mikulincer & Shaver, 2004, 2007).

Early attachment figures in particular appear to play a vital role in stimulating a child's emotional development through the provision of openness and validation (Fonagy & Luyton, 2009). Regular displays of compassion from important others allow for the maturation of abilities in engagement with, understanding of, and processing of one's emotions. Problematic attachment (i.e. higher levels on avoidant or anxious dimensions), including early trauma in these relationships, has been associated with various difficulties processing emotions (e.g. Aust, Alkan Härtwig, Heuser, & Bajbouj, 2012; Thomas, DiLillo, Walsh, & Polusny, 2011; Troisi, D'Argenio, Peracchio, & Petti, 2001; Wearden, Lamberton, Crook, & Walsh, 2005) like *alexithymia*. Alexithymia is a term used to describe interconnected difficulties in the processing of emotion (Sifneos, 1973). Among these difficulties are problems identifying and distinguishing between feelings and their corresponding bodily sensations, challenges assigning labels to emotions and describing them to other people, and a bias towards external cognitive processing with limited imagination. One reason that individuals may struggle to process emotions is that emotions are feared and avoided. Fear of the more negative emotions, like anger, guilt, or sadness, is linked to problematic emotion regulation. People may avoid their emotions rather than engaging them when their emotions are generally experienced as threatening (Chawla & Ostafin, 2007).

This avoidance is not exclusive to negative emotions. The literature has demonstrated that some individuals harbor a fear of positive emotions (e.g., Arieti & Bemporad, 1980). Fear of positive emotions has been studied through clinical observation (Arieti & Bemporad, 1980; Gilbert, 2009), and attachment theory (Bowlby, 1969, 1973). Positive emotions can be conditioned to become associated with negative outcomes (Ferster, 1973; Gilbert, 1992). Moments of happiness may trigger senses of fear or loss of control. Additionally, children experiencing happiness amidst an unhealthy family structure may feel guilt over their fortunate circumstances or pleasure (Arieti & Bemporad, 1980). More recently, some depressed individuals have been shown not only to be incapable of experiencing pleasure and joy (anhedonia) but also exhibit this actual fear of experiencing (Gilbert et al., 2012; Hayes & Feldman, 2004) or unwillingness to experience (Beblo et al., 2012) positive emotions. Gilbert et al. (2012) found strong links between fear of happiness and alexithymia, self-criticism, anxiety, stress, and depression.

One subset of positive emotion is that related to affiliation. Affiliation is driven by the emotions of soothing, calming, and contentment as opposed to the affective system tied to excitement and interest (Depue & Morrone-Strupinsky, 2005). Gilbert noted that these positive affiliative emotions associated with interpersonal closeness may be associated with aversive outcomes (2010). He furthered the work of Bowlby (1969, 1973) by linking a sense of capacity for compassion to the development of the attachment system, whereby some individuals with insecure attachment styles can have their affiliative motivation shut down or essentially stowed away. Reactivating such a system may reactivate the memories of emotional conflict, abuse, or neglect that originally played a part in the system deactivating. Gilbert, McEwan, Matos, & Rivis (2011) proposed that the re-emergence of these difficult emotions could underlie fears of compassion and block the acceptance of compassion from the self or others. On the other hand, recall of childhood emotional memories of warmth and safeness appears associated with self-compassion as a mechanism of emotion regulation (Cunha, Martinho, Xavier, & Espírito Santo, 2013).

Individuals who come to fear these affiliative feelings risk consequences of negative mental health outcomes. Bowlby (1969, 1973) has conceptualized attachment behavior as crucial to threat regulation, the capacity for which develops with early caregiving experiences. Cozolino (2014) has detailed the significant range of effects of affection and care on infants' physiological development. Those with little or no experiences of warmth and care from important others may therefore have deficits in their abilities to identify and apply affect regulation strategies crucial to coping with internal and external threats. A fear of affiliation impedes access to the immense benefits (e.g. calming and emotion regulation) associated with the abilities to give and receive compassion (Cozolino, 2014; Mikulincer & Shaver, 2007). It precludes the effects of the affect system specifically evolved for the receptivity of compassion and support, as suggested by Gilbert (2009). Compassion Focused Therapy, rooted not only in social mentality theory, but also in Bowlby's work on attachment, suggests that one's perception of compassion depends on the nature and quality of the care received from others. Some adults may experience compassion from others as threatening rather than soothing if they cannot call upon prior memories of soothing. People may view compassion as a weakness, may feel undeserving of compassion from the self or others, or may experience the reactivation of memories of people who treated them with both kindness and abuse.

Gilbert et al. (2011) used self-report data from a student population to create three measures of fear of compassion, each tapping a separate variable: fear of receiving compassion from oneself, fear of compassion from others, and fear of compassion for others. These three constructs are separate but related (Gilbert et al., 2011). Their relationship is supported by findings of Mikulincer et al. (2005a). These authors found insecure attachment style to be associated with limited capacity or ineffective strategies for empathic engagement with others. Specifically, avoidant attachment style is associated with deficits in the ability to experience compassion, while anxious attachment style is associated with difficulties tolerating and regulating distress, thereby resulting in either emotional over-involvement or withdrawal from the individual needing compassion. Those who fear self-compassion and compassion from others appear to be less comfortable and skilled in providing care for others. Experimentally manipulated increases in attachment security were shown to increase displays of compassion towards others (Mikulincer et al., 2005a). Thus, a decrease in fear of compassion from others appears to produce a behavioral decrease in fear of compassion for others. Fears of compassion have been strongly linked to self-criticism, depression, anxiety, and stress in both student and clinical samples (Gilbert et al., 2012; Gilbert et al., 2011).

Review of Fear of Compassion

Fear of Compassion From Others

Despite the critical importance of affection, care, and warmth on physical and mental health (Depue & Morrone-Strupinsky, 2005; Gilbert, 2009), some individuals find affiliative emotion unpleasant. Rockliff, Gilbert, McEwan, Lightman, & Glover (2008) found that those high in self-criticism responded to imagery of compassionate expression from another with reduction in heart rate variability, indicating an increased sense of threat. Those low in self-criticism instead responded with increased HRV, expectedly reflecting a suppression of threat-based processing accompanied by activation of the affiliative system responsible for feelings of social safeness and soothing. Clinical observation has provided evidence that compassion from a therapist can activate feelings of grief from wanting affection from important others but not receiving it (Gilbert, 2010). Displays of compassion from others might be foreign, and this grief may be too overwhelming or painful to tolerate. Those from insecure backgrounds may distrust the availability or quality of compassion from others, which can result in withdrawal, avoidance, or anxious clinging to attachment figures without feeling soothed. Attachment anxiety may override one's ability to reap the psychological benefits of social support. Those from secure attachment backgrounds, on the other hand, are more likely to employ coping strategies that involve seeking social support and to feel helped by these strategies (Collins & Read, 1990; Collins, 1996; Gilbert et al., 2011; Kobak, Cole, Ferenz-Gillies, Fleming, & Gamble, 1993; Mikulincer & Florian, 1995). Gilbert et al.'s (2011) fear of compassion from others scale was designed to capture these features. They found fear of compassion from others to be associated with depression, anxiety, stress, and self-criticism. They further found a negative relationship with secure attachment style and a positive relationship with both anxious and avoidant attachment styles.

Fear of Self-Compassion

Self-compassion is linked to numerous health benefits and appears to predict some aspects of wellbeing better than self-esteem (e.g. Neff & Vonk, 2009). Self-compassion appears particularly beneficial for coping with failure and hardship. Writing a compassionate letter to oneself can boost coping with life events and reduce depressive symptomatology (Leary et al., 2007). Reports from a clinically depressed population suggest that higher levels of depression and anxiety within subjects were associated with greater difficulty developing self-compassion (Pauley & McPherson, 2010). Interestingly the same individuals reported experiencing the exact opposite of compassion the more depressed and/or anxious they felt. This finding is consistent with literature on self-criticism and depression (e.g. Zuroff & Mongrain, 1987). Those high in self-criticism have marked difficulties developing and utilizing self-compassion (Gilbert & Procter, 2006; Rockliff et al., 2008), especially when coming from abusive backgrounds (Mikulincer & Shaver, 2007).

Fear of compassion can be distinguished from low levels of compassion (Kelly, Carter, et al., 2012). Among a clinical population, self-compassion and fear of self-compassion demonstrated a negative correlation, with less than 40% of the variance shared (Kelly, Carter, et al., 2012). Fears of affiliative emotion can lead people to actively resist feeling, providing, and receiving compassion. Reasons for fearing self-compassion include fears of making oneself vulnerable to emotional pain and rejection, fears of losing one's motivation or competitive edge, fears of becoming too dependent on self-compassion, fears of losing an important aspect of one's identity, fears of losing an oft used coping strategy, fears of becoming less likeable, and feelings of inadequacy, shame, and unworthiness (Gilbert et al., 2011).

People may view themselves as undeserving of self-compassion or weak for practicing self-compassion. Indeed, fear of self-compassion is linked positively to avoidant and anxious (most strongly) attachment styles and negatively to secure attachment style (Gilbert et al., 2011), supporting in particular the suggestions of Mikulincer & Shaver (2007) that anxious attachment may involve an actual fear of affiliation. High fear of self-compassion is also associated with heightened levels of self-criticism, depression, and anxiety (Gilbert et al., 2011).

Fear of Compassion For Others

Secure attachment is associated with a heightened capacity for empathic, caring, and compassionate behavior towards others (Gillath et al., 2005; Mikulincer et al., 2005a). Individuals with an avoidant attachment style are more likely to view compassion as a weakness or experience contempt for others seeking support (Collins & Read, 1994; Mikulincer et al., 2005a). Those with an anxious attachment style are more likely to engage in submissive helping behavior, while experiencing anxiety and personal distress themselves. They may not therefore experience the positive affiliative emotion from compassion for others. Compassion for others may even lead to unpleasantness, distress, and isolation among these individuals, resulting in aversion to compassion. They also may be too vulnerable to their own distress to engage in compassionate behavior in the first place (Collins & Read, 1994; Mikulincer et al., 2005a). Attachment insecurity can block the activation of other behavioral systems, like that of caregiving and compassion.

Gilbert et al. (2011) found fear of compassion for others to be associated with secure (negatively) and anxious and avoidant (positively) attachment styles.

Altruistic compassion may be viewed as a weakness or as a means of letting someone off the hook, especially among those with avoidant attachment (Collins & Read, 1994; Zehr & Mika, 2003). People may fear compassion for others due to risk of being taken advantage of or being seen as submissive (Zehr & Mika, 2003). Aspects of personal identity, especially high masculinity associated with a loss of poise in helping, have been found to inhibit helping behavior (Tice & Baumeister, 1985). Compassion has also been deemed an evolutionarily expensive resource, often dictating who should receive compassion and who should not (Burnstein, Crandall, & Kitayama, 1994). Compassion towards kin is adaptive, whereas compassion towards non-kin is not, and may at times be considered detrimental to self-interest. Those motivated by social dominance, especially favoring the superiority of their in-group, can hold non-compassionate attitudes towards out-groups (Pratto, Sidanius, Stallworth, & Malle, 1994). Certain motives and personality features appear at odds with compassionate behavior.

Fear of Compassion

Accumulating evidence supports the role of compassion in coping with setbacks and promoting psychological adjustment, appropriate interdependence with others, and wellbeing (Barnard & Curry, 2011; Gilbert & Procter, 2006). Affiliative emotions are vitally involved in the regulation of feelings of threat and social isolation (Depue & Morrone-Strupinsy, 2005), but those who experience affiliative emotions as threatening rather than soothing or pleasant are unlikely to benefit from the compassion of others and may even have aversive reactions to it (Gilbert, 2000). The initial response to compassion from the self or another is fear, which serves as a protective factor against experiencing further vulnerability to pain. Fear of compassion may thus operate as a gatekeeper to compassion and its psychological benefits, especially among those who experienced insecure attachments as children. Fear of compassion is strongly linked to high shame and self-criticism, often seen in individuals from harsher backgrounds (Gilbert et al., 2011; Gilbert & Procter, 2006; Gilbert, 2010). Fear of self-compassion in particular appears related to backgrounds of low affection, abuse, neglect, and high criticism (Gilbert, 2010).

Fear of compassion research has also enhanced our understanding of self-criticism. Self-criticism involves both feelings of inadequacy and self-hating emotion (contempt and self-loathing; Gilbert, 2000; Whelton & Greenberg, 2005). Its strong link to fear of self-compassion goes further to suggest that self-criticism is not just about self-hatred, feelings of inadequacy, or simply negative attitudes towards the self but involves the type of "fear-based orientation towards affiliation" characteristic of fear of self-compassion (Gilbert et al., 2011). Similarly, fear of self-compassion may be characterized by a hostile affective self-to-self relationship and challenges accessing systems of warmth and self-soothing. Given the importance of affiliative emotions in regulating affect in response to threat, this is important for symptom severity and psychological intervention.

Fears of compassion have recently been linked to alexithymia and issues with abilities in mindfulness, empathy, social safeness, and self-reassurance (Gilbert et al., 2012). It seems that fearing compassion coincides with poor emotional awareness, emotion regulation, and understanding of others' experiences, combining to make compassion difficult. These fears may further hinder the development of compassionate experiences and memories and the social safeness system that underlies compassionate behavior towards the self or others (Gilbert, 2010).

Results of path analysis has suggested that fear of self-compassion, along with a fear of happiness, to mediate the relationship between alexithymia and depression (Gilbert, McEwan, Catarino, Baiao, & Palmeira, 2014). Gilbert et al. (2014) speculated that the ability to feel reassured by positive emotions, thereby allowing the potential for safeness, may be necessary in order to be able to openly explore and process emotions. These authors additionally linked fear of compassion to insecure attachment in adulthood. Individuals with insecure attachment style may have memories of seeking support from others as unsuccessful, futile, unreliable, or carrying threat, making the prospect of compassion frightening. Fear of compassion from others was also inversely correlated with feelings of social safeness. A relationship between insecure attachment and a fear of happiness was also found, but the link disappeared when controlling for a fear of compassion from others (Gilbert et al., 2014). These findings illustrate the importance of affiliative emotions of social safeness, soothing, and contentment. While it may be difficult to disentangle the interactions between various forms of positive emotion, fears of compassion appear to be vital variables.

Xavier, Cunha, & Gouveia (2015) have found evidence of a relationship between feeling threatened, submissive, and undervalued during childhood and greater levels of fear of compassion later in adolescence. They also supported an association between fear of self-compassion and both negative affect and self-harm, a highly shame-based behavior. The severity of self-harm was predicted independently by fear of compassion and negative affect. Fear of compassion may therefore be an outcome of negative experiences with affiliative emotion earlier in life. It appears a manifestation of emotion regulation and self-soothing difficulties (Xavier et al., 2015).

Fear of self-compassion also appears to be associated with posttraumatic stress disorder symptomatology (Miron et al., 2015). Baseline levels of self-compassion have been found to longitudinally predict PTSD symptom severity, even when controlling for baseline PTSD and combat exposure (Hiraoka et al., 2015). This finding is particularly important as abilities in self-compassion appear to relieve the effects of trauma exposure (Kearney et al., 2013). Fear of self-compassion may interfere with this avenue for improvement, while also resulting in greater symptom severity. Miron et al. (2015) found both high self-reported fear of self-compassion and experiential avoidance to be associated with heightened PTSD symptomatology. Both may impair individuals with PTSD further and interfere with treatment response.

Fear of self-compassion may also be a classically conditioned response to invalidating and abusive childhood environments (Gilbert, 2010). Following this evidence, Miron, Seligowski, Boykin, & Orcutt (2016) examined the relationship between fear of self-compassion in adulthood and childhood abuse type, comparing physical to sexual abuse. They found that adults who experienced both childhood physical and sexual abuse showed greater fear of self-compassion than adults having experienced a single form of abuse, as well as those without abuse histories. Furthermore, path modeling revealed an indirect effect of child sexual abuse history on symptoms of depression and PTSD through fear of self-compassion, but not self-compassion (Miron et al., 2016). Fear of self-compassion exhibited this relationship for childhood sexual abuse, but not for childhood physical abuse. Miron et al. (2016) speculated that fear of self-compassion may represent a vulnerability to PTSD unique to sexual abuse due to survivors' perception of blame. Childhood sexual abuse is more likely to bring about strong negative beliefs about the self, self-blame, and shame than childhood physical abuse (Feiring, 2005).

These results align with an explanation offered by Noll (2008), who suggested that the blame in childhood physical abuse can easily be attributed to the perpetrator, whereas survivors of childhood sexual abuse are likely to experience conflict, confusion, and often self-blame over their perceived degree of willing participation. She noted the differences in coercion in each abuse type: physical for physical abuse as opposed to psychological for sexual abuse. Psychological coercion could be less apparent or could be perceived as less legitimate. Liotti (2010) noted that compassion from others and from oneself can be perceived as threatening for those with emotional memories of having been abused, neglected, and/or shamed by caregiver figures. Survivors of early sexual abuse may later in life associate friendliness with the threat of abuse or a need to meet others' sexual demands. Miron et al. (2016) further suggest that a child's experience of their environment as inconsistent may foster a distrust of affection and compassion and a learned association between compassion and threat. Caution should still be taken when evaluating these suggestions, however, as they have not yet been empirically tested. Overall, fear of compassion appears strongly related to childhood backgrounds of abuse and/or neglect.

In some instances, a fear of developing compassion for oneself can be more detrimental than mere limitations in self-compassionate abilities. Among a clinical population of individuals with eating disorders controlled for self-esteem and body mass index (BMI), high fear of self-compassion was a stronger predictor of eating disorder symptoms than low levels of self-compassion (Kelly, Vimalakanthan, & Carter, 2014). Each construct was additionally found to contribute more than self-esteem and shame. Among college students, however, self-compassion was a stronger predictor of eating disorder symptoms than fear of self-compassion. Kelly et al. (2012) further found the combination of low self-compassion and high fear of self-compassion to predict both higher baseline severity of eating disorder symptomatology and poorer response to intervention. Thus, it may be the *combination* of low abilities in self-compassion and high fear of self-compassion that is most pathological. Those individuals with this combination failed to show significant change in self-reported shame and eating disorder symptoms after 12 weeks of inpatient treatment. Fear of self-compassion may therefore be especially harmful among individuals low in self-compassion. These individuals may be especially predisposed to greater psychopathology. It may further be important for therapists to consider each variable uniquely when seeking to build self-compassion in their clients. Interpersonally, fear of compassion may interfere with therapists' attempts to treat such clients with compassion, thereby impeding treatment progress. Some treatment barriers may be unique to fear of self-compassion, rather than a mere lack of self-compassion.

Among Kelly et al.'s (2012) clinical population, lower fear of self-compassion was associated with greater decreases in shame. Higher self-compassion on the other hand, was related to negligible change in shame, and this relationship was especially true for those with low trait self-compassion. Kelly et al. (2012) speculated that individuals experiencing greater levels of fear of self-compassion might have been “more reluctant to acknowledge and share their feelings with co-patients and therapists during treatment.” Perhaps this prevented them from receiving the compassion from others that could have ameliorated shame. In addition, these missed experiences might have helped by instilling memories of warmth that could facilitate self-compassion (Gilbert, 2005; Irons, Gilbert, Baldwin, Bacchus, & Palmer, 2006).

Gilbert et al. (2011) have noted that fear of self-compassion coincides with beliefs that reacting to one’s distress with more compassion would make one weak, expose one’s flaws, and lead to a drop in personal standards. In Kelly et al.’s sample (2013), when faced with the fear and shame frequently triggered by treatment procedures (eating more, gaining weight), individuals who are both fearful of and low in self-compassion may feel stuck. They are being asked to let go of the only tools they have employed to cope with these emotions. Clinging to their eating disorder might offer a means of emotion regulation and/or self-punishment for the difficulties they are undergoing. Resistance to support from others may also offer a mechanism by which these individuals did not benefit from treatment. These individuals may further resist supportive behaviors outside the context of psychological treatment.

Further Study

More research is needed on fear of compassion. While evidence has mounted to show its relation to various negative mental health outcomes and forms of psychopathology, less is known about other realms of functioning. Specifically, the interpersonal functioning and inner experiences of individuals with fear of compassion has not been investigated to this author’s knowledge. Little is known about the general personality variables found among these individuals or the behavioral effects of fears of compassion in interpersonal interaction. The present study therefore aimed to shed light on these processes by comparing measures of fear of compassion to those known to evaluate personality and interpersonal and intrapsychic behavior. This study may be a valuable addition to the previous literature on fears of compassion.

Little research has investigated the translation of fear of compassion into interpersonal behavior. Furthermore, some have argued that intrapsychic motives are underemphasized relative to interpersonal ones (Leary, Raimi, Jongman-Sereno, & Diebels, 2015). An examination of both interpersonal and intrapsychic relations may thus shed light on the experiences of individuals who fear compassion. The relational patterns associated with fears of compassion have not previously been studied.

Additionally, while Compassion Focused Therapy has been found to benefit individuals resistant to affiliation (Barnard & Curry, 2011; Gilbert & Procter, 2006; Gilbert, 2009), it has little quality empirical support as a stand-alone intervention (Leaviss & Uttley, 2015). It is presently unclear whether CFT will be found to be an empirically supported treatment that could rival other major theories or a compilation of adjunct techniques to be incorporated into therapy. The present study may lend support to the theoretical underpinnings (e.g. social mentality theory, attachment theory) of CFT by validating the interpersonal and intrapsychic effects of fear of compassion. CFT employs the therapeutic relationship in order to stimulate affect regulation and affiliative emotions (Gilbert, 2010). The current study could also support this therapeutic process while suggesting issue with that of other treatment modalities. For instance, Lee, (2005) noted that patients undergoing Cognitive Behavioral Therapy could understand the harm caused by self-critical thoughts and even generate alternatives but rarely felt reassured by this process. The present study could be used to emphasize the need for clinical detection of fears of compassion when treating this vulnerable population.

Structural Analysis of Social Behavior

One avenue for further investigation of the impact of fear of compassion is the assessment of critical social interactions. Interpersonal manifestations of fear of compassion could be measured using the Structural Analysis of Social Behavior (SASB; Benjamin, 1974). The SASB was developed to specifically measure interpersonal and intrapsychic relations via self-report or as perceived by an independent rater (Benjamin, 2003). Its origins draw from behavioral, dynamic, and interpersonal theory. Object relations theory sees humans as fundamentally driven toward social behavior (Greenberg, 1983). The notion of adult personality is considered a culmination of their perceptions, experiences, and early representations of social learning. The behavioral perspective proposes that learning is drawn from early social experiences so as to create a template for later patterns of social behavior. The SASB is rooted in these theoretical perspectives and manifests into a circumplex model of interpersonal and intrapsychic behavior.

The concept of a two-dimensional interpersonal circle was first proposed by Freedman, Leary, Ossorio, & Goffey (1951) to measure interpersonal dynamics. Leary (1957) developed the Interpersonal Circle, a conceptualization from which Benjamin designed the SASB. Leary attempted to study the nature by which biological drives and social experiences interact to yield a personality, as identified by Freedman et al. (1951). The SASB is further grounded in the Interpersonal Adjective Scales (Wiggins, 1995), a measure intended to characterize interpersonal traits based on the circumplex model of personality (Trapnell & Wiggins, 1990). Sullivan's (1953) notion of the introject, suggesting that we treat ourselves the way that important others have treated us, was also added to Benjamin's model, culminating in a single tool capable of describing both interpersonal and intrapsychic behavior.

The SASB focuses on an interpersonal dyad to characterize transactional behaviors on three dimensions: (a) the focus (the self for intrapsychic behaviors; the self or other for interpersonal behaviors), (b) the level of affiliation (a continuum from love to hostility), and (c) the level of interdependence (on a continuum from autonomy to control). Each dimension is central to describing the interpersonal transactions in which fear of compassion might be exhibited.

The focus dimension of an interpersonal transaction is identified between two interactants of a dyad on one of three levels (Benjamin, 1996b). First, focus on the self can be considered intransitive interaction. One's focus is directed towards the self when the interpersonal transaction concerns "what is happening to, for, or about X" (Benjamin, 1996b). This may occur when, for instance, one is asking another for guidance, telling a story about oneself, or seeking social support for oneself. In each example, the person's action is oriented towards him- or herself rather than towards someone else. Second, focus on others can be considered transitive action (Benjamin, 1974). One's focus is directed towards another when acting for, towards, or about another person. It may be helpful to consider a parent taking action for their child. Lastly, an introjected focus characterizes an intrapsychic transaction in which one typically treats oneself as he or she was treated by important others in the past. One's focus is introjected when they act to, for, or about themself out of an intrapsychic representation of the self rather than in explicit reaction to another (Benjamin, 1996b). In this way, focus of a person is a reaction to an inner representation of him- or herself rather than that to a second person. Focus is represented on Figure 1 by the three types of print. The bold font represents the intransitive focus, or focus on another. The underlined font represents the transitive focus, or focus on the self. The italicized font represents the introjected focus.

The remaining dimensions of affiliation and autonomy are respectively represented on the horizontal and vertical axes of the model (see Figure 1). Affiliation (horizontal) ranges along a continuum from hate to love. The more affiliative the action, the closer it is placed to the "love" end of the axis. Autonomy (vertical) ranges along a continuum from enmeshment to differentiation. The more the action supports or fosters autonomy, the closer it is placed to the "differentiation" end of the axis. The orthogonal structure allows each dimension to be measured and studied separately. This structure has accumulated significant empirical support for its circular order (Alpher, 1988; Benjamin, 1996a, 1996b; Henry, 1994) and factor structure (Benjamin, 1974; Tscheulin & Glossner, 1993). Further, the octant model also incorporates four additional points represented at the intersecting midpoints of the affiliation and autonomy axes (Benjamin, Rothweiler, & Critchfield, 2006). For example, on the transitive surface, the midpoint of "emancipate" and "active love" is identified as "affirm." The corresponding octants to "affirm" on the intransitive and introject surfaces are "disclose" and "self-affirm," respectively.

The SASB offers several advantages in capturing and measuring behaviors within multiple dimensions (Benjamin, 1996b). It helps keep researchers from oversimplifying complex social interactions. In addition, the ability of the SASB to focus on a single dimension allows for the disentanglement of confounded interpersonal behaviors.

(Beveridge & Berg, 2007). Furthermore, individual behaviors within an interpersonal transaction tend to complement one another “in a predictable and meaningful way” (Benjamin, 1974). She has suggested that one person’s interpersonal style tends to produce a predictable complementary reaction in another. Benjamin describes “complementarity” as a phenomenon in which one individual is focused on the self and the second individual is focused on the other, such that both are focused on the same person. Complementarity occurs when their behaviors align on both the affiliation and interdependence dimensions (1974). For example, the complement of “control” on the intransitive surface is “submit” on the transitive surface. Another predictive principle of SASB is opposition. Psychological opposites are displayed at 180-degree angles on a shared surface. For example, the opposite of “ignore” on the intransitive surface is “protect.” This feature allows for the identification of conflict or ambivalence in an interpersonal transaction (Benjamin, 1996b). Similarity, in contrast, occurs when two people are placed on the same point on the same surface in the model. Lastly, antithesis can be considered the complement of the opposite (Benjamin, 1974). It occurs when one individual acts at one point on the affiliation and autonomy dimensions on one surface (e.g. affirm on the transitive surface), and another acts at the corresponding 180-degree angle on a different surface (e.g. sulk on the intransitive surface).

Three different interpersonal foci are defined along the axes of attack-love and control-emancipate. At each of the four endpoints, focus on another person is first described. Next comes focus on the self when engaged interpersonally, followed by the introject, describing a focus on the other turned inwards whereby one treats the self the way that important others have treated them (Benjamin, 1995). The introject surface ties interpersonal experience to the self-concept, which demonstrates strong correlations with psychopathology (Benjamin, 1994a, 1994b; Henry, 1994).

Research & Clinical Utility of the SASB

The SASB has been used to frame markers of wellbeing and psychopathology in an interpersonal context. For example, descriptions of personality disorders as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994) have been linked to the SASB model and predictive principles (Benjamin, 1996c).

The SASB has additionally been linked to maladaptive and recurrent interpersonal patterns (Henry, 1994). For example, Rorschach responses have predicted interpersonal behavior within marital interactions as assessed by the SASB (Blake, Humphrey, & Feldman, 1994). The SASB has been applied as a predictor of therapeutic match between therapist and client (Talley, Strupp, & Morey, 1990) and the quality of psychotherapeutic process (Henry, Schacht, & Strupp, 1986). The SASB appears to have high utility in the processes of clinical diagnosis and treatment planning (Florsheim, Tolan, & Gorman-Smith, 1996; Pincus & Ruiz, 1997).

The SASB introject surface has been used to measure self-image and predict psychological treatment outcome (Ryum, Vogel, Walderhaug, & Stiles, 2015). Specifically, clients with higher levels of Self-ignore and Self-blame reported experiencing less benefit from therapy. Similarly, increases in Self-love and decreases in Self-blame predicted symptom reduction, while decreases in Self-attack and Self-control, along with increases in Self-affirm predicted alleviation of interpersonal problems (Ryum et al., 2015). Gezelius, Wahlund, Carlsson, & Wiberg (2016) have also used the SASB introject surface to predict treatment outcome among adolescents with eating disorders.

The SASB introject surface has previously been employed to study self-image in patients with personality disorders (Granberg & Armelius, 2003). SASB affiliation showed improvement in response to therapy, whereas SASB autonomy exhibited no change over the course of treatment. The sample used was high in neurotic and borderline personality features and showed high levels of Self-attack at the initial measurement. It is therefore quite possible that the individuals in this sample would have endorsed fears of compassion. Self-attack appears theoretically similar to low self-compassion, which may further suggest a fear of self-compassion in some. The same authors previously found patients with borderline personality disorder to have more negative images of their parents in addition to themselves (Armelius & Granberg, 2000). These findings taken together suggest a suitability of the SASB to assess the interpersonal dynamics of individuals who fear compassion.

Among another sample of individuals diagnosed with borderline personality disorder, higher levels of "dialectical behavior," characterized by the authors as high levels of both affiliation and autonomy, among therapists using Dialectical Behavior Therapy has been linked to subsequent improvements in SASB introject (Bedics, Atkins, Comtois, & Linehan, 2012). Clients with borderline personality disorder treated themselves with a more positive self-to-self relationship after therapists treated them with higher levels of affiliation and autonomy. This finding appears to align with the theoretical (Gilbert & Procter, 2006; Gilbert, 2009) and empirical (Leaviss & Uttley, 2015; Mayhew & Gilbert, 2008) basis for Compassion Focused Therapy, in which self-critical individuals benefit from therapist compassion. Bedics et al. (2012) found that therapists perceived themselves acting more therapeutically (i.e. with higher affiliation and higher autonomy) towards patients whom the therapists themselves rated as having more affiliative (rather than hostile) introject the previous week. The therapists tended to perceive their patients' friendly behavior as indicative of improved introject. Thus, it appears that these therapists displayed more prosocial behavior to those clients with a healthier introject. It could, in turn, be expected that those with a more hostile introject receive less affiliative and more hostile treatment from important others as a result. It is reasonable to suggest that individuals who fear self-compassion even invite, possibly without an intention of doing so, less compassionate response from others. Notably, the sample used by Bedics et al. (2012) is likely to represent a population with high shame and self-criticism and is therefore likely to fear compassion. Indeed, Lucre & Corten (2013) have found CFT to decrease these same barriers to self-compassion among a similar sample of individuals with personality disorders. The present study seeks to add to the SASB literature on interpersonal and intrapsychic dynamics by extending it to a fear of compassion.

Attachment Theory & the SASB

The SASB has been both theoretically and empirically linked to attachment theory (Benjamin, 1994; Florsheim et al., 1996; Pincus, Dickinson, Schut, Castonguay, & Bedics, 1999). Benjamin (1993; 1996a) has suggested that young children have strong needs to maintain proximity to attachment figures and develop beliefs about themselves, their needs, and their wishes through these relationships. Children then internalize the representations of these relationships and even give these representations priority over new relationships so as to preserve closeness to attachment figures, even if the attachment relationship consisted of abuse or neglect. Florsheim et al. (1996) suggested that securely attached individuals should recall early interactions with parents as higher in affiliation. They should also demonstrate more affiliative introjects. Attachment theory similarly conceptualizes interpersonal behavior; both theories crucially emphasize the ongoing importance of the early attachment relationship. Parallels are seen in the notion of SASB affiliation and attachment security. Furthermore, the SASB notion of autonomy reflects that of exploration in attachment theory (Bowlby, 1977).

Pincus, Dickinson, Schut, Castonguay, & Bedics (1999) found empirical support for convergence between these theories. SASB affiliation was inversely related to (1) fearful and preoccupied adult attachment styles, (2) perceptions of rejecting early attachment, and (3) current angry and dismissive states toward the caregiver. These relationships were represented on each surface of interpersonal focus within attachment relationships. Additionally, current introjected behavior was found more hostile among those with lower attachment security. SASB autonomy exhibited a negative relationship with perceptions of enmeshed early attachment. Findings regarding SASB autonomy and attachment appear inconsistent, however (Neumann & Tress, 2007).

Several have proposed using the SASB to measure symptomatology in an interpersonal light (Horowitz & Vitkus, 1986). Erickson & Pincus (2005) found anxious worry to distinguish individuals on self- and other-perceptions, with an inverse relationship to affiliation. In addition, attachment insecurity was associated with less affiliative self- and other-perceptions. Further support has indicated a close relationship between attachment security and SASB affiliation in both parental relationships during childhood and current romantic relationships (Neumann & Tress, 2007). It appears that attachment avoidance and anxiety correspond with SASB affiliation. Gallo, Smith, & Ruiz (2003) found SASB affiliation to be most closely related to an overall dimension of attachment security, representing features like recollections of early experiences with parents, self-representations, and social functioning, rather than separate dimensions of attachment anxiety or attachment avoidance. Given the association of fears of compassion with both anxious symptoms and insecure attachment, fears of compassion may be linked to SASB affiliation as well.

Using the SASB for Fear of Compassion

The SASB has been employed to examine the impact of parental self-criticism on female undergraduates' self-criticism, depression, and perceptions of romantic partners (Amitay, Mongrain, & Fazaa, 2008). Self-critical parents reported less loving and more controlling treatment of their daughters, predicting self-criticism among daughters. Self-critical daughters then exhibited heightened levels of depression and perceptions of their boyfriends as less loving and more controlling. In light of the role of self-criticism among individuals who fear compassion, one could suspect fear of compassion to be related to perceptions of important others as lower on SASB dimensions of affiliation and autonomy.

Integrating the SASB with the literature on fear of compassion could provide several benefits. First, it could build on the convergent and discriminant validity of each construct. Second, in light of the literature relating both the SASB and fear of compassion to attachment theory, the present study sought to expand on these relationships and lend support to existing theoretical models (e.g. social mentality theory).

Furthermore, the analysis of the interpersonal behavioral effects of fear of compassion could be used to inform therapeutic intervention. The relationship between fear of compassion and the affiliative dimension of the SASB could shed light on the interpersonal process patterns for those fearing compassion. More specifically, that process between a psychotherapist and a client who fears compassion from the therapist, him- or herself, or both, could be better understood when considering the relationship of fear of compassion to interpersonal behavior. The importance of attention to interpersonal process on therapeutic outcome has been extensively studied (e.g. Kiesler, 1973; Teyber, 1992; Benjamin & Critchfield, 2010). For example, Carson first described the SASB concept of complementarity as occurring when the behavior of one person is “inviting” the corresponding behavior of another (1969). This version of complementarity was originally represented on Leary’s interpersonal circle, in which someone exhibiting hostile-submissive behavior would incite hostile-dominant behavior in another (1957). In Leary’s model, these two relational styles were placed at complementary ends of the circle. Benjamin instead placed “Control” and “Submit” on corresponding points of separate surfaces (focus on another and focus on self, respectively) and specified “Emancipate” as the opposite of “Control” on a dimension of autonomy (1974). Her model still implements the notion of complementarity to suggest that controlling behavior from one individual invites submissive behavior in another. An individual fearing compassion on the other hand, may be more likely to respond to a therapist’s affiliative behavior with the antithesis “Recoil” rather than the complement “Reactive love.” The therapist may then be left wondering why his or her genuine compassion invoked a highly unexpected and unwanted response. Furthermore, the client may continue to treat him- or herself with “Self-attack” on the introject surface rather than the more desired “Self-love.” This process would interfere with treatment gains among those hoping to benefit from psychotherapy. Further, CFT aims to teach compassion for the self-critic, a process seen as a non-threatening way to engage the client and begin to cultivate acceptance of compassion. Perhaps therapies that do not incorporate this component would encounter problems among clients high in self-criticism due to the aforementioned mismatch of SASB surfaces. Importantly, higher frequencies of SASB complementarity in interactions between therapist and client seem linked to low attachment anxiety and positive treatment outcome among a sample of females with eating disorders (Maxwell et al., 2012). The present study could inform or highlight these types of dynamics.

More generally, dynamics of the psychotherapy relationship could be manifest in other important interpersonal relationships. People may interact with friends, family members, romantic partners, and coworkers with lower levels of affiliation. In turn, they would likely continue to experience minimal closeness, attachment security, and connection from their most important relationships. Experiences with compassion, eliciting a threat response, may contribute to tendencies to engage in Attack, Recoil, or Self-Attack, while important relationships characterized by low affiliation may contribute to the development and maintenance of fears of compassion.

Gilbert (2009) has described how a fearful orientation towards affiliative emotions could serve as a foundation for fears of compassion. Self-criticism and shame have been empirically identified as key features of fears of compassion, but little is known about the actual interpersonal and intrapsychic manifestations of the fear of compassion. Using the SASB could help illuminate the internal representations and patterns of self- and other-relation among individuals with fears of compassion by using empirically supported dimensions of intrapsychic and interpersonal activity. Henry (1996) proposed three concepts by which one might understand these underlying processes. First, *Identification* describes a process of imitating significant others in interactions. Second, *Internalization* describes a process of interpersonal expectancies being derived from abstract representations of a corresponding other. Third, *Introjection* (Sullivan, 1953) describes the child learning to treat themselves as important others have treated them. Feeling threatened, submissive, or undervalued by others during childhood (Xavier et al., 2015), for instance, may develop into fear of self-compassion through introjection, fear of compassion from others through internalization, and fear of compassion for others through identification. Studying fear of compassion with the SASB could lend empirical support to the proposed mechanisms by which individuals come to fear compassion, like the social mentality-based explanation of self-to-self relation or Gilbert's (2010) suggestion that one can be conditioned to associate affiliative emotion and behavior with fear.

In line with Sullivan's (1953) concept of the introject, those who have been conditioned to fear affiliation are likely to perceive others as more hostile and treat themselves with more hostility. Those without the opportunities to develop the abilities to detect the sources of their distress and be warm and soothing towards themselves tend to be more attuned to internal and external threat (Gilbert & Procter, 2006). They may show more self-attacking qualities in addition to lacking self-compassionate qualities. In the current study, fear of compassion is therefore predicted to show a negative association with SASB affiliation on all three surfaces (focus on the self, focus on another, and introjected focus). Attack, on the transitive focus, is expected to be associated with a fear of compassion for others. The opposite pole on the affiliative dimension, Active Love, is feared by nature. Fear of compassion from others may be most related to Recoil on the intransitive surface. A display of compassion from another is expected to engender fear, and as a result, behavioral withdrawal. Fear of self-compassion may be most related to Self-attack on the introject surface. The shaming and self-critical nature of fear of compassion can be expected to produce attacks in self-to-self relation.

The present study could also shed light on the interpersonal nature of fear of compassion with regard to control and autonomy. Predicting a direction of association on the dimension of SASB autonomy was difficult, as there is little evidence from which to base an estimate. Fear of compassion is generally considered detrimental to psychological health, especially given its relationships with various forms of psychopathology. Individuals with fears of compassion are likely motivated by systems of threat regulation to seek social safety (as opposed to seeking social safeness and soothing). They may anxiously avoid affiliative interaction or attempt to obtain control of their interactions with others in order to keep themselves safe from social threat. These drives and behaviors appear more indicative of control rather than emancipation. Similarly, fear of self-compassion may require self-control in order to avoid the experience of threatening emotions. Control of oneself may be an effective strategy to preemptively regulate the feared experience of compassion. Furthermore, the association between fear of self-compassion and alexithymia indicates that these individuals likely have generalized difficulties with the mindful experience of emotion. One may expect them to exert control over their inner experiences so as to refrain from engaging their emotions. They might, for example, use coping strategies like distraction, avoidance, or denial when faced with emotional distress. In an exploratory hypothesis, fear of compassion was predicted to be inversely related to SASB autonomy.

Five Factor Model

To this author's knowledge, the fear of compassion scales have not previously been compared to other empirically established personality traits. The present study therefore seeks to add to the literature by examining the personality variables associated with fears of compassion. Links to a well-established personality measure could lend support to the validation of the fear of compassion constructs and contribute to professional applications.

The Five Factor Model of personality (FFM; McCrae & Costa, 1987) hierarchically organizes personality traits on five dimensions: Extraversion (E), Agreeableness (A), Openness to Experience (O), Conscientiousness (C), and Neuroticism (N). This model constitutes a comprehensive integration of personality traits that can be employed across various fields. It uses a mere five scores to produce a global categorization of stable personality traits. It uses a dimensional, rather than categorical approach, and is widely thought to rather effectively capture the ranges of human normal and psychopathological personality (Widiger, 1993). The FFM can thus be applied to both normal and clinical populations, with personality disorders suggested to represent pathological degrees of common traits.

Using factor analysis, Costa & McCrae (1990) determined five factors to emerge across various rating scales. They considered these to be overarching dimensions of personality structure. They referred to E as sociability, liveliness, and cheerfulness, A as trust, altruism, and sympathy, O as aesthetic sensitivity, intellectual curiosity, and need for variety, C as disciplined goal-striving and adherence to one's principles, and N as a predisposing factor to psychological distress through affects like anxiety, anger, and depression (Costa & McCrae, 1990).

The NEO-PI and NEO-PI-R (Costa Jr & McCrae, 1992) are perhaps the most frequently used tool to measure the traits and facets of the FFM. Multiple versions of varying lengths have demonstrated sound reliability and validity (Aluja, Garcıa, Rossier, & Garcıa, 2005; McCrae & Costa, 2007). They have also been translated and used in various languages while retaining psychometric properties (e.g., McCrae, Costa, Del Pilar, Rolland, & Parker, 1998; Salgado & Rumbo, 1997; Yang et al., 1999). Their uses have been extended to the assessment of job performance and job satisfaction (Costa, McCrae, & Kay, 1995; Salgado, 1997; Salgado & Rumbo, 1997). They have also been applied to assess various health outcomes like exercise behavior, smoking, and impulsivity (Courneya & Hellsten, 1998; Terracciano & Costa, 2004; Whiteside & Lynam, 2001). Overall, these measures appear to demonstrate predictive and clinical utility across multiple domains.

Support for the convergent validity between the FFM and the SASB has been demonstrated (Benjamin, 1994; Pincus, Gurtman, & Ruiz, 1998). Both measures have been further linked to psychiatric symptomatology and the recognizable interpersonal features (Benjamin, 1994). Pincus et al. (1998) found SASB affiliation on the introject surface to be associated with facets of low neuroticism and high extraversion. Individuals with a more positive introject may experience greater levels of trait E and positive affect and lower levels of trait N and negative affect in relationships with others. They also may seek out affiliation more as a result. SASB autonomy on the introject surface was associated with facets of conscientiousness. SASB autonomy on the intransitive surface was associated with openness to experience. This may suggest that the trait O results in more willingness to engage in open and autonomous behavior, while the relation of Self-emancipation and trait C implies ego-mastery. Individuals fearing compassion may be expected to display the traits associated with more a negative introject and psychiatric symptoms, as well as those suggesting difficulties engaging and exploring their emotions.

Similar to the SASB, the FFM has also been tied to attachment theory (Shaver & Brennan, 1992). Attachment security was found related to higher extroversion and agreeableness, as well as lower neuroticism and conscientiousness. Anxious attachment was associated with lower agreeableness and higher neuroticism, while avoidant attachment was associated with lower agreeableness and extroversion and greater neuroticism. These findings suggest that securely attached individuals have more trusting and positive expectations from and experiences within their relationships, while those lower in attachment security may experience more distress and less closeness in their relationships. Individuals fearing compassion similarly experience discomfort and fright in such relationships. In light of its association with attachment insecurity, fears of compassion may be expected to relate to extroversion, agreeableness, and neuroticism.

Relationships have been found between high levels of self-compassion and extroversion and positive affect, agreeableness, and conscientiousness, as well as an inverse relationship between self-compassion and neuroticism and negative affect (Neff, Rude, & Kirkpatrick, 2007b). However, no study has yet examined the possibility of associations among fear of compassion and the core personality traits of the FFM. Fear of compassion is characterized by a fear of positive emotions that are likely to be represented in FFM dimensions (Arieti, S. & Bemporad, 1980; Gilbert, 2010; Rockliff et al., 2008). For example, the inhibition of positive emotions may be related to low scores on measures of the positive affect associated with extroversion. The suppression of emotion-expressive behavior has previously been linked to lower scores on trait extroversion (Gross & John, 2003). Gilbert et al. (2011) defined fear of compassion specifically as a fear of affiliative behavior, characteristic of extroverted individuals. Fear of compassion was therefore predicted to be negatively associated with trait extroversion.

Furthermore, fear of compassion is characterized by the presence of fearful emotions in place of affiliative emotions from the self or others (Gilbert et al., 2011). Fear of compassion produces a sense of threat rather than positive emotion. It was expected, then, that individuals who experience high fear of compassion also experience heightened levels of negative affect. Negative affect has been strongly linked to trait neuroticism. Fear of compassion is further associated with other facets of neuroticism, like anxiety and depression (Gilbert et al., 2011). Among the traits in the FFM, self-compassion has exhibited the strongest relationship with neuroticism, such that those high in self-compassion are low in neuroticism (Neff, Rude, & Kirkpatrick, 2007b). Fear of compassion was therefore hypothesized to correlate with neuroticism in the present study.

In addition to the likely associations among fear of compassion, extraversion and neuroticism, fear of compassion for self, from others, and for others are each interrelated (Gilbert et al., 2011). Those who fear compassion from the self and others also fear compassion for others. It can be expected that these individuals would yield lower scores on trait agreeableness. This prediction appears to align with the results of Neff et al. (2007b) who found a positive correlation between self-compassion and agreeableness. These authors propose that the kind, interconnected, and emotionally healthy orientation among self-compassionate individuals (Neff, 2003b) may be associated with abilities to get along well with others.

Lastly, self-compassion has been associated with conscientiousness (Neff et al., 2007b). These authors suggested that the emotional stability found among self-compassionate individuals may allow them to engage in more responsible behavior. Higher levels of conscientiousness may also predispose people to the practice of self-compassion. A meta-analysis of the Eastern perspective of mindfulness and the FFM has revealed significant association between mindfulness and conscientiousness (Giluk, 2009). Mindful abilities may be tied to the self-discipline and self-regulation found among conscientious individuals (Costa & McCrae, 1992; Masicampo & Baumeister, 2007). Western perspectives on mindfulness have more recently been linked to conscientiousness (Siegling & Petrides, 2014). Despite variation in the operationalization of mindfulness, the mindful component of self-compassion is likely related to conscientiousness as defined by the FFM. Fear of compassion is linked to low self-compassion (Gilbert et al., 2011) and low mindfulness (Gilbert et al., 2012). Difficulties identifying and describing feelings further appear negatively related to feelings of safeness, even more so than other forms of positive affect like relaxation and activity (Gilbert et al., 2012). As feelings of safeness are those most inhibited by fears of compassion, these findings suggest an expected negative relationship between fear of compassion and conscientiousness. This relationship was indeed hypothesized in the present study.

Fear of compassion was not expected to display a relationship with openness to experience, consistent with the previously demonstrated absence of a relationship between self-compassion and openness (Neff et al., 2007b). In sum, fear of compassion was predicted to exhibit a positive relationship with neuroticism, as well as negative relationships to conscientiousness, agreeableness, and extroversion. These potential linkages may help further illuminate the inner experience and functioning among those who harbor fears of compassion.

Hypotheses

Fears of compassion for others, from others, and for self were predicted to negatively correlate with SASB affiliation on the transitive, intransitive, and introject surfaces, respectively. Three bivariate correlations were run using two-tailed Pearson's coefficients to test these hypotheses. In addition, fears of compassion for others, from others, and for self were predicted to negatively correlate with SASB autonomy on the intransitive, transitive, and introject surfaces, respectively. Three bivariate correlations were run using two-tailed Pearson's coefficients to test these hypotheses.

Hypothesized relationships between fears of compassion and personality variables were also tested via bivariate correlations. Twelve correlations using two-tailed Pearson's coefficients were run to determine the predicted links between fears of compassion for others, from others, and for self with traits of neuroticism, conscientiousness, agreeableness, and extraversion. Negative correlations between fears of compassion for others, from others, and for self were predicted with extraversion, with conscientiousness, and with agreeableness, whereas positive correlations between fears of compassion for others, from others, and for self were predicted with neuroticism.

Two further measures were used to better understand the contextual relationships of fears of compassion. Fears of compassion were predicted to demonstrate positive correlations with variables capturing mental health symptoms. Eight scales of the Counseling Center Assessment of Psychological Symptoms (CCAPS-62; Locke et al., 2012) were analyzed. Fears of compassion for others, from others, and for self were each predicted to positively correlate with CCAPS-62 scales of depression, generalized anxiety, social anxiety, academic distress, family concerns, eating concerns, hostility, and substance use via two-tailed Pearson's coefficients.

Lastly, gender was explored with respect to fears of compassion. While no differences were predicted between male and female participants, it was hypothesized that men who identified more strongly with masculine gender norms would exhibit higher levels of fears of compassion than those male participants low in masculine gender norms. The Conformity to Masculine Norms Inventory (CMNI-22, Mahalik et al., 2003) has been used to study relationships between masculinity and shame (Reilly et al., 2014), with shame having been theoretically linked to fear of compassion. A bivariate correlation was conducted for each of the three fear of compassion scales with conformity to masculine norms among the male participants in the study.

CHAPTER 3

METHODS

Participants

University students (age 18-24) were used as participants for the present study. Based on power analysis, approximately 200 participants were sought. Study recruitment information was posted on the Psychology Research Participation System of Indiana University of Pennsylvania after obtaining approval by the Institutional Review Board (IRB). Participants were undergraduate students taking an introductory level psychology course and were able to earn credit towards the course's research requirement as a result of their participation in the study. This form of recruitment ensured all students in the course an equal opportunity to participate and gain credit. Given the age range of participants, this study chose to focus on parental relationships rather than romantic relationships or important friendships. Experiences in other types of relationships might not be consistent throughout the sample, whereas a focus on caregiver relationships was considered to be more consistently influential for this sample. Students were asked to provide relational information for a primary caregiver.

Procedure

Participants were scheduled to come to a laboratory setting. An online survey system, Qualtrics, was used to collect participant responses. Upon agreeing to participate, students completed a consent form, demographic measure, and study instruments. Participants followed an anonymous link to respond to the study's survey measures, which were counterbalanced. Following participation, they received a printed debriefing form and list of mental health resources. Information from respondents was stored anonymously and electronically.

Measures

The Structural Analysis of Social Behavior (SASB)

The SASB Intrex Questionnaire is a multidimensional self-report tool used to assess interpersonal and intrapsychic relations. The SASB Intrex Questionnaire offers a short form (8 items per surface), a medium form (16 items per surface), and a long form (36 items per surface). The present study chose the medium form in order to assess all dimensions while minimizing the length for respondents. While the SASB can be utilized to capture various dynamic relationships at various time points (e.g. from ages 5-10, over the last two years), participants in the present study were asked to rate a current relationship with a parent or primary caregiver "at best" and "at worst." They were asked to capture the relationship as is, rather than how it used to be or how one might hope for it to be. The medium form of the SASB Intrex has 2 items per each of the eight octants, yielding 16 items for ratings at best and at worst on each surface. Participants were asked to complete the transitive and intransitive, focus versions, each containing 32 items for "at best" and "at worst." The introject focus was measured with 16 items for "at best" and "at worst." A sample item indicating transitive control is, "He takes charge of everything and makes me follow his rules." Intransitive affiliation was assessed through items like "She happily, gently, very lovingly approaches me, and warmly invites me to be as close as I like." Items can be altered in order to assess present-day relationships along with relationships in the past. The present study used present-day relationships to ensure consistency with other measures.

The SASB Intrex Questionnaire shows comprehensive evidence of sound psychometric properties (e.g., Benjamin et al., 2006). Reliability is demonstrated through an average internal consistency of 0.82 for the medium form and 0.76 for the long form and a reported test-retest reliability of 0.78 for the short form, 0.84 for the medium form, and 0.87 for the long form over an interval of 6 weeks. Several forms of validity have been exemplified as well. Evidence of content validity has been reported through little deviation between data and theory on dimensions of affiliation and autonomy (Rothweiler, 2004) and participants' general agreement with their corresponding cluster scores (Benjamin et al., 2006). Construct validity has been supported by the SASB's use in differentiating among clinical groups like (externalizing) substance dependence and (internalizing) bulimia based on the assessed patterns of interpersonal relations between family members (Ratti, Humphrey, & Lyons, 1996). These findings demonstrated the SASB's clinical utility. Support for predictive validity has been accumulated through the SASB's ability to predict therapeutic outcome based on complementarity in the therapeutic relationship (Jørgensen, Hougaard, Rosenbaum, Valbak, & Rehfeld, 2000; Svartberg & Stiles, 1992). Support for concurrent validity can also be seen in the convergence between the SASB, Interpersonal Circumplex, and Five Factor Model (Pincus et al., 1998).

In the present study, an alternate scoring system was used. The system employed offered greater simplicity than the SASB's computerized scoring program while maintaining consistency with the original design and structure of the scoring program. Since the only measures used were the dimensions of autonomy and affiliation, the full octant cluster was not needed for analyses.

SASB item scores range from 0 to 100, allowing increments of 10. Each item was assigned a rating for both autonomy and affiliation, either -1, -0.5, 0, 0.5, or 1, by which to develop composite autonomy and affiliation scores. Each item represented only one of the three surfaces. For instance, the item, "I let them speak freely, and warmly try to understand them even if I disagree" represents the transitive surface, with focus on another. This item was given a multiplier of 0.5 each for transitive autonomy and transitive affiliation, capturing both dimensions in a positive direction. The item, "Without considering what might happen, I hatefully reject and destroy myself" represents hostility towards oneself without any determination of control on the introject surface. It was reverse scored in contributing to the composite score for affiliation and was not used to calculate the composite score for introject autonomy.

Fear of Compassion For Others

Fear of showing compassion for others is measured using a 10-item scale (Gilbert et al., 2011). Participants rate their degree of agreement with statements about expressing kindness and compassion towards others using a scale of 0 (don't agree at all) to 4 (completely agree). Sample items include, "Being too compassionate makes people soft and easy to take advantage of," and "I fear that if I am compassionate, some people will become too dependent on me." Good internal consistency for this scale has been demonstrated (Gilbert et al., 2011, 2012).

Fear of Compassion From Others

Fear of responding to the expression of compassion from others is measured using a 13-item scale (Gilbert et al., 2011). Participants rate their degree of agreement with statements about wanting and accepting kindness and compassion from others using a scale of 0 (don't agree at all) to 4 (completely agree). Sample items include, "Feelings of kindness from others are somehow frightening," and "When people are kind and compassionate towards me I feel anxious or embarrassed." This scale has received support for good internal consistency (Gilbert et al., 2011, 2014)

Fear of Self-Compassion Scale

The Fear of Self-Compassion scale contains a 15-item measure of fear of self-compassion (Gilbert et al., 2011). Participants rate their degree of agreement with statements about expressing kindness and compassion towards oneself using a scale of 0 (don't agree at all) to 4 (completely agree). Sample items include, "If I really think about being kind and gentle with myself it makes me sad," "I fear that if I am more self-compassionate I will become a weak person," and "I fear that if I become too compassionate to myself I will lose my self-criticism and my flaws will show." Prior studies have found good internal consistency of this measure (Gilbert et al., 2011, 2014).

Counseling Center Assessment of Psychological Symptoms

The Counseling Center Assessment of Psychological Symptoms (CCAPS; Locke et al., 2012) is a multidimensional measure of psychological symptoms and distress levels. It produces scores on 8 scales of psychological concerns relevant to a collegiate population: Depression (13 items), Generalized Anxiety (9 items), Social Anxiety (7 items), Academic Distress (5 items), Eating Concerns (9 items), Hostility (7 items), Substance Use (6 items), and Family Distress (6 items). It was normed on a large and diverse sample of college students and created for ease of implementation in college counseling centers across the country (Locke et al., 2011). It uses a Likert scale with responses ranging from zero, "Not at all like me" to four, "Extremely like me." The

CCAPS assesses for concerns like problematic substance use (“I drink alcohol frequently” and “I use drugs more than I should”) and body image (“I feel out of control when I eat”) problems specifically found among a college population, perhaps giving it an advantage over other outcome measures in collegiate settings. Its multiple dimensions may also be considered an advantage over other psychometrically sound outcome measures like the OQ-45 (Lambert et al., 1996), which is regarded as a unidimensional scale of distress.

Multiple versions of the CCAPS exist, with its most common clinical implementations a 62-item and 34-item version. Both forms received support for internal consistency, test-retest reliability, convergent validity, and construct validity (Locke et al., 2011, 2012). The CCAPS-34 was created to further enhance practicality and clinical utility and yields 7 of the 8 subscales produced by the CCAPS-62 (omitting Family Distress). Due to the items retained, its Substance Use scale is renamed Alcohol Use and does not assess for the use or abuse of other drugs. It retains acceptable psychometric properties with little decline compared to the CCAPS-62 while preserving the factor structure proposed by the CCAPS-62 (Locke et al., 2012). The present study employed the CCAPS-62 due to its inclusion of the family distress scale, deemed relevant to the fear of compassion literature.

While this measure is intended for students seeking services at college counseling centers, it was used in the current project to examine various problems among college students that may be associated with fear of compassion. The CCAPS-62 appears a highly relevant measure for this sample, though the differences between its intended use in college counseling and a broader collegiate sample should be noted as a potential limitation. The use of the CCAPS-62 may reveal specific mental health problems associated with fear of compassion in this sample.

NEO Five Factor Inventory

The NEO Five Factor Inventory (NEO-FFI; Costa & McCrae, 1992) was used to measure the personality traits of the Five Factor Model. It is a shortened 60-item version of the NEO-PI and was chosen to reduce time demand on participants. It has demonstrated good test-retest reliability (Robins, Fraley, Roberts, & Trzesniewski, 2001) and internal consistency (Costa & MacCrae, 1992). The NEO-FFI has been translated into different languages and has been among the most widely used measures of FFM traits (Zillig, Hemenover, & Dienstbier, 2002). It has further demonstrated strong internal consistency when applied to a sample of university students (Anisi, Majdiyan, Joshanloo, & Ghoharikamel, 2011). The NEO-FFI is a self-report measure that uses a five-point Likert scale for item response, ranging from one to five. Twelve items are used to measure each of the five traits. Sample items include “I often feel tense and jittery” and “I work hard to accomplish my goals” for Neuroticism and Conscientiousness, respectively.

Conformity to Masculine Norms Inventory

The Conformity to Masculine Norms Inventory (CMNI-22**;** Mahalik et al., 2003) was used to measure the degree to which individuals conform to masculine gender norms. It is a 22-item self-report scale that uses a five-point Likert scale for item response. It has demonstrated evidence of strong internal consistency, test-retest reliability, and convergent validity with related constructs (Mahalik et al., 2003). Sample items include

"My work is the most important part of my life" and "It bothers me when I have to ask for help" (Mahalik et al., 2003).

CHAPTER 4

RESULTS

Sample Demographics

This study had 204 undergraduate students at Indiana University of Pennsylvania participate. Among these participants, 115 identified as female (56.4%), 87 as male (42.6%), and 2 as other gender (1.0%). Fifty three were 18 years old (26.0%), 100 were 19 years old (49.0%), 25 were 20 years old (12.3%), 12 were 21 years old (5.9%), 4 were 22 years old (2.0%), 1 was 23 years old (.5%), 2 were 24 years old (1.0%), and 7 did not provide their age (3.4%). The mean age of the 197 participants who responded to this item was 19.11 (sd=1.073). All participants with complete data were included in the analysis on a scale by scale basis. For example, the data from a participant who omitted one or more items on the fear of compassion for others scale would not be included in the analysis, whereas completed data from the same participant on the fear of self-compassion scale would be included in the analysis.

Data Analysis

Identifying information was separated from participant responses to ensure confidentiality. Qualtrics responses were downloaded to an Excel file which is readable by the Statistical Package for the Social Sciences (SPSS), the software through which the final analyses were conducted. The SASB surface scores are generated by taking the average from the best and the worst form. Benjamin has recommended this mean computation as a way to minimize social desirability bias. Each SASB surface yields a weighted affiliation and autonomy score that is calculated based on the weighted average of all transitive and intransitive plane items (Benjamin, 1988). A series of bivariate correlations were then conducted using two-tailed Pearson's correlation coefficients. The weighted average scores in affiliation and autonomy were then correlated with the composite scores yielded by the three scales for fears of compassion.

In order to test hypotheses, each of the three fear of compassion scale scores were correlated with the t-scores of SASB dimensions of affiliation and autonomy. Fear of compassion for others, fear of compassion from others, and fear of self-compassion were each predicted to negatively correlate with both affiliation and autonomy. Specifically, fear of compassion for others was expected to show these relationships on the SASB intransitive surface (focus on other), as was fear of compassion from others on the transitive surface (focus on self) and fear of self-compassion on the introject surface. Thus, six bivariate correlations were used to test hypotheses concerning fears of compassion and interpersonal and intrapsychic relations.

All three fear of compassion scales were compared to the subscores produced by the CCAPS-62 in order to assess relationships with distress and psychopathology. The CCAPS-62 output provides percentile scores for each of the eight scale scores were converted to standard t scores and compared to fear of compassion scale scores via bivariate correlation. A total of 24 correlations were ultimately conducted using these measures. Fear of compassion scale scores were then correlated with those produced by NEO-FFI, also using bivariate correlation. Each of the three fear of compassion scores are predicted to show positive relationships with N and negative relationships with A, E, and C. No association was expected between fears of compassion and O. A total of 15 bivariate correlations were conducted to examine the link between fears of compassion and stable personality traits. Results of data analysis were summarized using SPSS output tables.

Descriptive Data

Table 1

Means, SD, & Reliability Coefficients of the Fear of Compassion Scales

Subscale	*N*	*M*	*SD*	*Cronbach's α*
FOC For Others	198	2.06	.74	.86
FOC From Others	189	1.32	.73	.90
FOSC	191	1.11	.82	.94

Note. FOC For=fear of compassion for others; FOC From=fear of compassion from others; FOSC=fear of self-compassion.

The subscale scores for the fear of compassion for others (see Table 1), fear of compassion from others, and fear of self-compassion were computed into sums and converted to mean scores. Reliabilities were found to be strong for each. Fear of compassion for others (see Table 1), fear of compassion from others, and fear of self-compassion all demonstrated acceptable internal consistencies, given that figures above .70 are generally considered acceptable. Means and standard deviations for this undergraduate sample were consistent with those previously reported (e.g., Gilbert et al., 2012; Gilbert et al., 2011).

Table 2

Means, SD, & Reliability Coefficients of the NEO-FFI-3

Subscale	*N*	*M*	*SD*	*Cronbach's α*
Neuroticism	197	2.13	.70	.834
Extraversion	191	2.37	.62	.845
Openness	195	2.44	.54	.729
Agreeableness	195	2.49	.57	.787
Conscientiousness	188	2.38	.56	.826

The subscale scores for neuroticism (see Table 2), extraversion, openness, agreeableness, and conscientiousness were computed into sums and converted to mean scores. Reliabilities were found to be strong for each. Neuroticism, extraversion, openness, agreeableness, and conscientiousness all demonstrated acceptable internal consistencies. Means and standard deviations for this undergraduate sample were consistent with those previously reported (e.g. Costa & McCrae, 1992).

Table 3

Means, SD, & Reliability Coefficients of the CCAPS-62

Subscale	*N*	*M*	*SD*	*Cronbach's α*
Depression	191	1.20	.84	.915
Generalized Anxiety	194	1.37	.87	.865
Social Anxiety	196	1.80	.84	.791
Academic Distress	196	1.54	.81	.739
Eating Concerns	197	1.12	.72	.781
Family Distress	198	1.03	.80	.797
Hostility	198	1.06	.81	.861
Substance Use	197	1.12	1.01	.872

The subscale scores for depression (see Table 3), generalized anxiety, social anxiety, academic distress, eating concerns, family distress, hostility, and substance use were computed into sums and converted to mean scores. Reliabilities were found to be strong for each. All eight subscales demonstrated acceptable internal consistencies (Table 3). Means and standard deviations for this undergraduate sample were consistent with those previously reported (e.g. Locke et al., 2011, 2012).

Table 4

Means, SD, & Reliability Coefficients of the CMNI-22

Scale	*N*	*M*	*SD*	*Cronbach's α*
CMNI	85	34.08	5.43	.473

Note. CMNI-22=Conformity to masculine norms inventory

The Conformity to Masculine Norms Inventory uses a single total score. This score was computed, and reliability was calculated for the male-identified participants in the sample. The internal consistency for this scale fell considerably below the acceptable range. Results using the CMNI should therefore be interpreted with caution.

Table 5

Means, SD, & Reliability Coefficients of SASB Autonomy

Subscale	*N*	*M*	*SD*	*Cronbach's α*
Transitive	116	217.82	131.86	.864
Intransitive	116	108.83	124.22	.866
Introject	157	47.07	60.78	.761

Total scores for SASB autonomy were computed for intransitive, transitive, and introject surfaces. SASB item scores range from 0 to 100, allowing increments of 10. Each item was assigned a rating for both autonomy and affiliation, either -1, -0.5, 0, 0.5, or 1, by which to develop composite autonomy and affiliation scores. Each item represented only one of the three surfaces. For instance, the item, "I let them speak freely, and warmly try to understand them even if I disagree" represents the transitive surface, with focus on another. This item was given a multiplier of 0.5 each for autonomy and affiliation, capturing both dimensions in a positive direction. The item, "Without considering what might happen, I hatefully reject and destroy myself" represents hostility towards oneself without any determination of control on the introject surface. It was reverse scored in contributing to the composite score for affiliation and was not used to calculate the composite score for autonomy. Scores on the derived total for transitive autonomy (see Table 5) ranged from 10.00 to 545.00. Scores on the derived total for intransitive autonomy ranged from -240.00 to 405.00. Scores on the derived total for introject autonomy ranged from -167.50 to 230.00. Higher scores reflected higher levels of autonomy (i.e. Emancipate rather than Control). Transitive, intransitive, and introject measures of autonomy all demonstrated acceptable internal consistencies (Table 5) consistent with those previously reported (e.g., Benjamin et al., 2006).

Table 6

Means, SD, & Reliability Coefficients of SASB Affiliation

Subscale	*N*	*M*	*SD*	*Cronbach's α*
Transitive	112	324.87	235.30	.873
Intransitive	117	318.75	245.94	.868
Introject	144	101.15	132.92	.760

SASB questionnaire items use a range of 0-100, with increments of 10. Scores on the derived total for transitive affiliation (see Table 6) ranged from -545.00 to 780.00. Scores on the derived total for intransitive affiliation ranged from -617.00 to 790.00. Scores on the derived total for introject affiliation ranged from -330.00 to 500.00. Higher scores represented higher levels of affiliation (i.e. Active-love rather than Attack). Intransitive, transitive, and introject measures of affiliation all demonstrated acceptable internal consistencies (Table 6) consistent with those previously reported (e.g., Benjamin et al., 2006). SASB subscales were later tested with corresponding fear of compassion scales. Bivariate correlations among fear of compassion scales were employed in order to test the extent to which the SASB concept of surfaces applies to the directionality of fears of compassion. The subsequent table demonstrates relationships among fear of compassion variables.

Table 7

Bivariate Correlations Among Fear of Compassion Scales

	FOC For	FOC From	FOSC
FOC For	1	.506 **	.377**
FOC From	.506**	1	.705**
FOSC	.377**	.705**	1

Note. *p<.05. **p<.01. FOC For=fear of compassion for others; FOC From=fear of compassion from others; FOSC=fear of self-compassion

Strong and moderate correlations were found among the fear of compassion scales. Fear of compassion for others correlated significantly and positively with fear of compassion from others and fear of self-compassion (see Table 7). Fear of compassion from others also exhibited a significant positive correlation with fear of self-compassion (Table 7). Consistent with prior research (Gilbert et al., 2011), these data suggest that each is a conceptually and empirically unique but related variable.

Hypotheses Testing

Table 8

Bivariate Correlations Among Fear of Compassion Scales and SASB Variables

	FOC For	FOC From	FOSC
Autonomy			
Transitive	-.046	-.016	.056
Intransitive	.007	-.141	-.148
Introject	-.071	-.063	.067
Affiliation			
Transitive	.051	-.235*	-.332*
Intransitive	.124	-.175	-.209*
Introject	-.130	-.340**	-.412**

Note. *p<.05. **p<.01. FOC For=fear of compassion for others; FOC From=fear of compassion from others; FOSC=fear of self-compassion

Bivariate correlations were used to test relationships between fear of compassion scales and SASB dimensions of autonomy and affiliation. None of the correlations between fears of compassion and autonomy were found to be statistically significant. Thus, the hypothesized associations between fear of compassion for others and autonomy with a focus on other, between fear of compassion from others and autonomy with a focus on self, and between fear of self-compassion and autonomy with an introjected focus were all not supported (see Table 8).

SASB affiliation exhibited several significant correlations with fears of compassion. Fear of compassion for others did not demonstrate the hypothesized relationship with affiliation with focus on other. Fear of compassion from others did not demonstrate the predicted relationship with affiliation with focus on self while it did show relationships with affiliation on the other two SASB surfaces: with focus on other and with introjected focus (see Table 8). Lastly, fear of self-compassion exhibited significant relationships with affiliation on all three surfaces: focus on other, focus on self, and introjected focus. Therefore, the hypothesized relationship between fear of self-compassion and introject affiliation was indeed supported in the predicted direction.

Table 9

Bivariate Correlations Among Fear of Compassion Scales and Factors of NEO-FFI-3

	FOC For	FOC From	FOSC
Neuroticism	.239**	.375**	.412**
Extraversion	-.070	-.215**	-.172**
Openness	-.041	.107	.096
Agreeableness	-.149*	-.260**	-.310**
Conscientiousness	.071	-.183*	-.257**

Note. *p<.05. **p<.01. FOC For=fear of compassion for others; FOC From=fear of compassion from others; FOSC=fear of self-compassion

To test hypotheses regarding the relationship between fears of compassion and personality variables, a series of Pearson’s correlations were performed (see Table 9). As predicted, neuroticism showed a significant positive association with fear of compassion for others, fear of compassion from others, and fear of self-compassion. Extroversion showed a significant negative association with fear of compassion from others and with fear of self-compassion, consistent with hypotheses. The hypothesized negative relationship between extroversion and fear of compassion for others, however, was not supported. No relationship was predicted between openness and the three fear of compassion scales, and indeed no significant association among them was found. Agreeableness demonstrated a significant negative association with fear of compassion for others, fear of compassion from others, and fear of self-compassion, consistent with hypotheses. Lastly, the hypothesized negative relationships between conscientiousness and fear of compassion from others and fear of self-compassion were supported, whereas that between conscientiousness and fear of compassion for others was not supported. Each of the significant correlations described above is considered small (Table 9).

Table 10

Bivariate Correlations Among Fear of Compassion Scales and Factors of CCAPS-62

	FOC For	FOC From	FOSC
Depression	.201**	.496**	.586**
GeneralizedAnxiety	.213**	.507**	.517**
Social Anxiety	.205**	.393**	.368**
Academic Distress	.126	.382**	.380**
Eating Concerns	.158*	.364**	.387**
Family Distress	-.006	.315**	.335**
Hostility	.222*	.296**	.410**
Substance Use	.142*	.243**	.376**

Note. *p<.05. **p<.01. FOC For=fear of compassion for others; FOC From=fear of compassion from others; FOSC=fear of self-compassion

Fear of compassion for others, fear of compassion from others, and fear of self-compassion were predicted to exhibit positive relationships with each of the eight factors in the CCAPS-62. A series of two-tailed Pearson's correlations were performed to test these hypotheses. Significant positive associations were found with fear of compassion for others and depression, generalized anxiety, social anxiety, eating concerns, hostility, and substance use (see Table 10), consistent with hypotheses. Fear of compassion for others did not, however, demonstrate significant associations with academic distress or family distress.

Hypotheses regarding fear of compassion from others and fear of self-compassion were fully supported, in that each displayed significant positive correlations with all eight of the CCAPS-62 variables. Fear of compassion from others was associated with depression, generalized anxiety, social anxiety, academic distress, eating concerns, family distress, substance use, and hostility (Table 10). Fear of self-compassion was also found to be associated with depression, generalized anxiety, social anxiety, academic distress, eating concerns, family distress, substance use, and hostility.

Table 11

Bivariate Correlations Among Fear of Compassion Scales and CMNI-22

	FOC For	FOC From	FOSC
CMNI Total	.188	.016	.037

Note. *p<.05. **p<.01. FOC For=fear of compassion for others; FOC From=fear of compassion from others; FOSC=fear of self-compassion, CMNI Total=conformity to masculine norms inventory total score

Independent samples t-tests were conducted to determine gender differences for fears of compassion. Female participants (M=2.01, SD=.748) did not differ from male participants (M=2.13, SD=.736) in fear of compassion for others (t=-1.16, p=.247). Female participants (M=1.35, SD=.761) also did not differ from male participants (M=1.27, SD=.698) in fear of compassion from others (t=.691, p=.491). Lastly, female participants (M=1.06, SD=.900) showed no differences from male participants (M=1.18, SD=.710) in fear of self-compassion (t=-1.00, p=.319). No differences were therefore found between genders in any of the three fear of compassion scales.

The hypothesized relationships between conformity to masculine norms and fears of compassion for others, from others, and for self were not found. Positive correlations were predicted, but each relationship was deemed to be insignificant. Three two-tailed Pearson's correlations were employed to test the relationships in question. Fear of compassion for others, fear of compassion from others, and fear of self-compassion (see Table 11) each failed to demonstrate significant correlations with conformity to masculine norms among male participants.

CHAPTER 5

DISCUSSION

Summary of Findings

This study examined links between fears of compassion and interpersonal and intrapsychic behavior, stable personality traits, and mental health outcomes among a sample of college students. More specifically, it was predicted that fear of compassion for others would be negatively associated with both affiliative and emancipating behavior toward, for, or about one's primary caregiver. Fear of compassion from others was predicted to be negatively associated with both affiliative and autonomous separation behavior in response to a primary caregiver. Lastly, fear of self-compassion was hypothesized to be negatively correlated with both behavioral active self-love and behavioral self-emancipation.

Regarding personality traits, fears of compassion for others, from others, and for self were hypothesized to be negatively associated with extraversion, agreeableness, and conscientiousness, while positively associated with neuroticism. Fears of compassion for others, from others, and for self were further predicted to be positively correlated with mental health outcomes of depression, generalized anxiety, social anxiety, academic distress, eating concerns, family problems, hostility, and substance use. Lastly, fears of compassion for others, from others, and for self were hypothesized to be positively correlated with the degree to which men conform to masculine gender norms, among the male students in the sample.

Fear of Compassion and Interpersonal & Intrapsychic Behavior

Consistent with expectations, fear of self-compassion showed significant negative correlations with affiliative intrapsychic behavior on the SASB introject surface. This suggests that a fear of self-compassion is associated with lower levels of warmth toward one's self. Fear of self-compassion also exhibited significant negative correlations with affiliative interpersonal behavior on transitive and intransitive surfaces, while no hypotheses were formulated with respect to these surfaces. Thus, a fear of self-compassion is associated with lower levels of warmth in approaching and reacting to others. In contrast, fear of compassion from others failed to reflect the hypothesized negative correlation with affiliative behavior on the intransitive surface. Fear of compassion from others did, however, show significant negative correlations with SASB affiliation on the transitive and introject surfaces, about which no hypotheses were made. Lastly, fear of compassion for others failed to show the hypothesized negative correlation with SASB affiliation on the transitive surface, with a focus on other. No relationship was found between fear of compassion for others and intransitive affiliation. Fear of self-compassion was found to negatively correlate with warmth in approaches to others and treatment of oneself, exhibiting medium effect sizes. Fear of self-compassion further demonstrated a negative correlation of a small effect size with warmth in interpersonal reactions with others. Fear of compassion from others was found to negatively correlate at a small effect size with warmth in approach to others and at a medium effect size with warmth in treating oneself.

In contrast to the findings for the affiliation dimensions of the SASB, SASB autonomy (on all surfaces) failed to significantly correlate with any of the fear of compassion variables. The hypothesized relationships predicting that fear of compassion would involve efforts to control oneself or others were not supported. These findings failed to support the notion that individuals fearing compassion act differently within interpersonal transactions in the degree to which they show efforts to control or emancipate themselves or others.

The current findings link higher levels of fear of compassion to lower levels of affiliative behavior and seem unrelated to controlling behavior. Fearing compassion from others and fearing self-compassion therefore do indeed appear to be associated with one's behavior in interpersonal transactions. Those fearing self-compassion behaviorally engage in lower levels of self-love and higher levels of self-attack. They further are less likely to both initiate active loving behavior towards others and respond to others with less reactive love, while more likely to initiate attacking and recoiling from others.

Individuals may come to fear self-compassion from lower engagement in active self-love or higher engagement in self-attack relative to those lower in fear of self-compassion. This explanation is consistent with prior literature (Gilbert et al., 2012; Gilbert, 2009) that suggested that limited experience with interpersonal compassion could impair the development of the ability to process compassion appropriately. Such deficits could facilitate difficulties and uncertainties in receiving compassion from oneself or others, eventually conditioning the activation of fear in response. Conversely, their comparatively lower levels of active self-love and higher levels of self-attack within interpersonal interactions may lead them to develop fears associated with self-compassion. Compassion from others may not be trusted, while self-compassion may be perceived as threatening, overpowering, addictive, or unreliable (Gilbert et al., 2011).

These findings fit with the theoretical underpinnings for the development and phenomena of fear of self-compassion (e.g. Gilbert, 2009; Gilbert et al., 2011), in which the affiliative emotions associated with self-compassion are feared. It makes sense, then, that these individuals would be less likely to engage in affiliative behavior in the first place, and that affiliative behavior from another would elicit lower levels of affiliative behavior in response towards oneself or another, perhaps by activating a fear of affiliative emotions. Conversely, the experience of social safeness has been found to increase compassion in all three directions and lower fears of compassion in all three directions (Kelly & Dupasquier, 2016). These authors found a link between recalled parental warmth and feelings of social safeness, supporting the theorized importance of affiliative emotion in the capacity to give and receive compassion. The present study builds on the relatively novel construct of fear of compassion by demonstrating correlations among lower levels of affiliation in interpersonal and intrapsychic behavior.

Fear of self-compassion had consistently stronger correlations than fears of compassion for and from others. Fear of compassion from others was significantly associated with lower levels of affiliative behavior towards others and towards oneself on the introject surface. Fear of compassion from others did not, however, correlate with affiliation in reactions with others. Those persons who tend to fear compassion from others appear to engage in lower levels of affiliative behavior towards others and towards themselves, but may not differ from others in the extent to which they receive affiliative behavior from primary caregivers. These individuals initiate lower levels of affiliation towards primary caregivers, even if they do not necessarily report experiencing differing degrees of affiliation with their caregivers. Whereas increasing attachment security fosters compassion for others (Mikulincer, Shaver, Gillath, & Nitzberg, 2005b), fearing compassion from others was found here to be associated with lower interpersonal warmth towards others. Those fearing compassion from others also treat themselves with lower levels of affiliation within these interactions. This pattern may be reflected in a guarded or defensive interpersonal presentation.

Perhaps the limitations from this study's use of survey measures and limited ecological validity failed to capture the ways that fear of compassion from others leads one to respond to others with respect to degree of affiliation. Alternatively, fear of compassion from others may involve feeling helpless or powerless to prevent compassion from others that is ego-dystonic. Interacting in a minimally affiliative manner towards others may represent an attempt to elicit a likewise minimally affiliative response, thereby reducing the likelihood of experiencing the feared compassion from others. People may consciously or unconsciously adopt a stance hoping that, "If I don't show too much love towards you, hopefully you won't show too much love back." Given that low feelings of social safeness has been associated with a tendency to assume that others will be judgmental and rejecting (Gilbert et al., 2009), greater attachment insecurity, and lower perceived social support from others (Kelly, Zuroff, Leybman, & Gilbert, 2012), those fearing compassion from others may treat others with less warmth and expect less in return.

It is important to consider how fear of compassion may be developed from early experiences of being punished, neglected, or harmed while the emotions of soothing, contentment, and social safeness were activated. Perhaps then receiving low levels of affiliation in early life would not facilitate fear of compassion from others. The opportunity for compassion from others to become linked to aversive outcomes may not be present at early stages of development. People may instead need to experience compassion in order to develop the fear, whereas those without experiences receiving compassion could be less likely to develop a conditioned response involving fear.

Alternatively, it may be that limited early experiences with compassion may precipitate a sense of fear of unfamiliar affiliative emotions. The findings of this study suggest that individuals fearing compassion from others are less outwardly oriented and may thereby experience positive emotions as more muted than others. One possible explanation for this link may be that stronger affiliative emotions are feared. The relationship between insecure attachment and emotional distress has been found to be mediated by the combination of low self-compassion and high fear of self-compassion (Joeng et al., 2017). This combination may illustrate how outcomes may be feared, through memories or expectations that emotional support will be unavailable or insufficient. Fears of compassion may then consist of distrust in the capacity of affiliative emotion to effectively soothe oneself.

Fear of Compassion and Personality

Fears of compassion demonstrated relationships with a range of independent personality traits. The current findings support that notion that individuals fearing compassion operate differently in several overarching domains than those who do not. As expected, fears of compassion for others, from others, and for one's self showed significant negative correlations with trait agreeableness and positive correlations with neuroticism. Fear of compassion from others and fear of self-compassion both exhibited the hypothesized negative correlations with extraversion and conscientiousness.

However, fear of compassion for others failed to show the predicted relationships with extraversion and conscientiousness. Individuals displaying fear of self-compassion and/or fear of compassion for others may have personality traits toward higher levels of neuroticism, low agreeableness, low conscientiousness, and low extraversion.

The findings of this study are largely consistent with the relevant literature that reports that individuals fearing compassion show difficulties experiencing and expressing positive emotions while experiencing heightened levels of negative emotions, especially those pertaining to a sense of threat (Gilbert et al., 2012; Gilbert et al., 2014). Those fearing compassion appear more susceptible to emotions of anger, anxiety, and fear at baseline while additionally more likely to exhibit clinical levels of generalized anxiety or social anxiety. This susceptibility may be developed from early experiences with threat and submissiveness (Gilbert, 2005). Lowered levels of extraversion among those fearing compassion from others or from oneself are consistent with the notion of positive affiliative emotions eliciting distress and being avoided or resisted (e.g. Gilbert et al., 2012). Moreover, underdeveloped abilities to process and receive compassion could help explain the appearance of a less extraverted personality style. Those fearing compassion also exhibit lower levels of agreeableness. Those fearing compassion are likely to have experiences which may produce difficulties being able to trust the affection of others. Lower levels on the subfacets of altruism and trust may be especially implicated. Fear of self-compassion is associated with lower levels of affiliative behavior towards oneself and in response to others, which would appear consistent with a less agreeable orientation towards others.

Additionally, these findings support the role of conscientiousness in mindful abilities (Neff et al., 2007). Abilities to engage in mindfulness are considered a necessary component for abilities in self-compassion. Among those fearing compassion, mindfulness skill deficits may impair one's receptivity to compassion from others or from oneself by limiting the recognition of opportunity or need for such affect regulation. Without active awareness of one's current emotions, one may not consciously recognize compassion or self-compassion to be a potentially beneficial experience. The alexithymia associated with fears of compassion (Gilbert et al., 2012) may be understood in this context as well. Limited ability to identify, understand, and verbalize one's emotions could make affiliative emotions feel threatening. Conversely, having developed abilities to self-regulate and experience social safeness may likewise allow for development of conscientious personality traits and skills in mindfulness.

Fear of Compassion and Mental Health Outcomes

Consistent with prior literature, fears of compassion were found to be positively correlated with unwanted mental health outcomes, as measured by the CCAPS-62 (Locke et al., 2011), with a range of small to large effect sizes. Fear of compassion for others and fear of self-compassion have been found here to show significant positive correlations with discrete measures of depression, generalized anxiety, social anxiety, academic distress, family distress, eating concerns, hostility, and substance use. Fear of compassion for others was found in the current study to be positively correlated to depression, generalized anxiety, social anxiety, eating concerns, hostility, and substance use, but no relationship was found with family distress or academic distress. Fears of compassion had previously shown evidence of relationships to other measures of depression, anxiety, and disordered eating (Gilbert et al., 2014, 2011; Kelly et al., 2014), while this is the first study to find a link between fears of compassion and substance use, hostility, family distress, and academic distress among college students. The present study therefore adds to the range of negative outcomes associated with experiencing fear of compassion. While much of the literature has focused on clinical samples, this study suggests generalizability to a nonclinical undergraduate population using a measure constructed for use with college students.

Fear of compassion has a demonstrated association with self-reported problematic substance use, linked to risk of meeting diagnoses of alcohol use disorders (McAleavey et al., 2012). Substance use may serve an alternative form of affect regulation for those with deficits in the ability to take in affiliative emotion and experience its benefits. For fear of self-compassion especially, this explanation may have merit, as a resistance to self-compassion likely drives people towards other types of coping behavior. This has been demonstrated with fear of self-compassion and self-injurious behavior (Miron et al., 2015). Further research may be warranted to more comprehensively investigate the substance use patterns among individuals with fears of compassion. For instance, it may be possible to distinguish between clinical and nonclinical populations, while some substances may be more utilized than others.

Previous literature has offered empirical support for a connection between childhood family problems and fears of compassion (Miron, Seligowski, Boykin, & Orcutt, 2016; Miron et al., 2015). This study adds to the literature in offering evidence of ongoing, present day family distress among those demonstrating fears of compassion from others and for self. Individuals with a fear of self-compassion show lower levels of affiliation within interpersonal transactions with their primary caregivers in addition to distress from family problems. Similarly, evidence has suggested attachment figures to be important in facilitating the development of self-soothing abilities, and that the relationship between having received lower levels of parental warmth and fears of compassion can be explained by low levels of affiliative emotion, especially social safeness (Kelly & Dupasquier, 2016). The observed correlation between fears of compassion from oneself and from others with distress from current familial relationships fits this body of evidence. Broader difficulties maintaining relationships may be implicated as well if fears of compassion serve to block or limit opportunities for affiliative interpersonal connection.

Furthermore, hostility among those fearing compassion appears consistent with lower levels of agreeableness. Hostility could interfere with interpersonal connection while protecting against the feared affiliative emotions associated with compassion. Self-attacking behavior among those fearing self-compassion, as demonstrated by the SASB introject surface, may also characterize a self-directed form of such hostility. Consistent with social mentality theory, self-compassion may represent an internal threat, stimulating the threat-based affective processing system. Gilbert (2009) has suggested that those fearing self-compassion likely exhibit hostile self-to-self relationships, and the findings of this study would be consistent with this theory.

Fear of Compassion and Gender

No differences were found between genders for any of the three fears of compassion. Men who endorsed higher degrees of conformity to masculine norms were not more likely to show signs of fear of compassion than men endorsing lower conformity to masculine norms. Thus, this hypothesis was not supported. These results suggest that gender and masculine gender norm adherence are not significantly associated with fearing compassion.

Fear of Compassion Patterns and Implications

This study expands the literature on fears of compassion. Compassion from others, for others, and for oneself has significant psychological benefits, yet those who develop fears of compassion not only have limited access to these benefits but also experience additional difficulties. These difficulties have been found to extend beyond those associated with low levels of self-esteem and low levels of self-compassion alone (Gilbert et al., 2011; Kelly, et al., 2014; Kelly et al., 2012).

Those fearing self-compassion interact with others in a manner characterized by lower levels of affiliation than those without a fear of self-compassion. This finding is consistent with theoretical notions that affiliative emotions are feared or avoided (Gilbert, 2009). People fearing self-compassion indeed behave in a manner characterized by less affiliative emotion, or even by the absence of affiliative emotion. More specifically, this study suggests that they appear to do so in their present-day relationships with attachment figures. Those exhibiting high attachment anxiety or high attachment avoidance can be afraid of self-compassion due to fears of being emotionally hurt (Mikulincer & Shaver, 2007). These fears appear to persist into emerging adulthood and correlate with interpersonal and intrapsychic behavior.

Those harboring fears of compassion show stable personality styles differing from those without fears of compassion, characterized by lower extraversion, higher neuroticism, lower agreeableness, and lower conscientiousness. Aside from psychological outcomes, such individuals approach the world in a different manner. These differences in core personality traits may support the assumption that fears of compassion are developed gradually and from a young age alongside overall personality development. Affiliative feelings, care-seeking, and receptivity to compassion may have been accompanied by early attachment experiences of criticism, abuse, or neglect. Perhaps instead those exhibiting this personality profile are more vulnerable to develop fears of compassion. These personality traits are associated with vulnerability to various specific mental health problems.

Those with fears of compassion are more likely to engage in self-reported problematic substance use, exhibit hostility towards others, and experience ongoing distress from family problems. Additionally, fear of self-compassion is linked to academic distress among college students. Coupled with heightened distress associated with family problems, individuals fearing self-compassion may be at higher risk of failure to meet their academic goals. The present study therefore adds to the range of problems for which individuals fearing compassion are at risk.

The findings of this study support other literature suggesting that individuals fearing compassion are among those most able to benefit from cultivating and practicing self-compassion (Dupasquier, Kelly, Moscovitch, & Vidovic, 2018; Kelly et al., 2014; Mayhew & Gilbert, 2008). The array of negative outcomes tied to fears of compassion offers several domains to be ameliorated through the practice of self-compassion. Dupasquier et al. (2018) conceptualized self-compassion as less threatening than social support among those fearing compassion from others and found self-compassion to lower the correlation between fear of compassion from others and the perceived risk of making emotional disclosures to others. The present study found fear of self-compassion to be linked to lower levels of affiliation behavior, including expressed affiliation as measured by the SASB. Perhaps the practice of self-compassion could heighten the degree to which those fearing self-compassion express affiliation through their behavior. This could in turn allow for the formation of closer relationships and reduction of the psychiatric symptoms associated with fears of compassion.

The combination of low self-compassion with high fear of self-compassion also merits consideration, as it has been found to partially mediate the respective relationships between anxious attachment and depression and between avoidant attachment and depression (Joeng et al., 2017). The same authors found the combination of low self-compassion with high fear of self-compassion to fully mediate the relationship between anxious attachment and anxiety, while partially mediating that between avoidant attachment and anxiety. Those with high levels of attachment anxiety have limited abilities to self-soothe (Pepping, Davis, O'Donovan, & Pal, 2015), and it may be that experiencing compassion from others or for others would require self-soothing for those fearing self-compassion. Perhaps those fearing compassion from others exhibit lower interpersonal affiliation towards others so as to avoid situations in which they may have to rely on their limited self-soothing abilities. Similarly, self-attack may protect against experiencing feared affiliative emotions from oneself. Learning to tolerate and practice self-compassion may therefore facilitate reduction of the association between attachment anxiety and anxious symptoms. Individuals fearing compassion could ultimately form closer relationships through this practice. Additionally, mental health providers may benefit from considering ways in which those fearing compassion from others are less likely to display affiliation within the context of treatment, so as not to misunderstand these clients' experiences.

Clinical Implications

The findings of this study are also beneficial in supporting the assumptions behind compassion-focused theory and social mentality theory. CFT has benefitted individuals resistant to compassion (Barnard & Curry, 2011; Paul Gilbert & Procter, 2006), and the present findings help demonstrate the behavioral components of fear of compassion that interventions like CFT could improve. That is, CFT may in turn improve clients' interpersonal and intrapsychic displays of and receptivity to affiliation, a hypothesis which could be tested using the SASB.

Studying relationships with one primary caregiver, fear of self-compassion is inversely related to multiple dimensions of affiliative behavior and linked to low levels of social safeness and low levels of extraversion. These findings together suggest that individuals fearing compassion may be less likely to seek out others for support. It appears that feared affiliative emotion facilitates isolation from others rather than social connection. Therapists would likely benefit from recognizing the ways in which a fear of compassion might be presented, so as to select more targeted forms of treatment, like that proposed by compassion focused therapy (Gilbert, 2009). Compassionate mind training may help individuals with underdeveloped abilities to process compassion cultivate such abilities, in turn reducing sensitivity to internal and external social threats and facilitating opportunities to access the psychological benefits associated with receiving and giving compassion.

Regardless of their theoretical approach, clinicians would likely benefit from awareness of the patterns of interpersonal and intrapsychic behavior reflected among those fearing self-compassion or compassion for others. While the present study measured interpersonal transactions among participants and a primary caregiver, various psychodynamic and interpersonal orientations assume these dynamics to likewise present themselves in the therapeutic relationship. Both therapeutic process and outcome would likely be impacted by a client's fear of compassion, given the demonstrated importance of the therapeutic relationship for outcome (e.g. Lambert & Barley, 2001). Fearing compassion may even predispose one to not seek needed treatment in the first place if one suspects that treatment would involve receiving interpersonal warmth.

Compassion Focused Theory appears well-suited to the ability of a clinician to identify and respond to fear of compassion in a client. Should the findings of this study indeed generalize to a therapeutic relationship, it can be expected that clients fearing self-compassion would exhibit less warmth towards a therapist and towards oneself, while experiencing lower levels of warmth than would be expected by the therapist's interaction. Therapists may consider how such dynamics may be attributable to fear of compassion to better understand the interpersonal process and improve client outcome. Specifically, viewing self-compassion or one's own compassion towards the client as a potential social threat could help explain their behavior within the interaction.

Limitations

This study involves several limitations. First, the concepts investigated pertaining to fear of compassion remain in the early stages of their development. Further empirical research is needed to guide the literature and the focus of the associations discovered. On a similar note, the findings of this study relied on self-report survey methodology, and their generalizability is likely limited due to a lack of behavioral observation. These findings may not reflect participants' behavioral experiences in their everyday interpersonal interactions. Additional points of data may be needed to better contextualize these results, whereas current interpretations are based on participants' descriptions of their own perspective of their personal experiences on surveys in a laboratory setting. The use of an undergraduate sample may also limit the degree to which these findings can be applied to other demographic groups.

Furthermore, the scoring protocol for the SASB was altered from that which has been previously empirically validated. This unconventional approach did, however, yield acceptable internal consistency. Another quality to consider relates to alexithymia. Given the association between fears of compassion and alexithymia, it is possible that self-report methodology may suffer from limited variance for measures capturing emotional awareness (i.e. the SASB and fear of compassion scales). Those with difficulties identifying and verbalizing their emotions may have difficulties in reporting their emotional experiences. Such possibilities may warrant further investigation in future research.

Future Directions

The hypothesis that threat and safety seeking may be forms of interpersonal or intrapsychic control was not supported by the SASB data in this study. Fears of compassion have been linked to alexithymia (Gilbert et al., 2012), and difficulties recognizing and processing emotions may suggest a conditioned or subconscious response to cope with fear rather than conscious recognition or choice to engage in interpersonal or intrapsychic control. Thus, perhaps these forms of control do indeed occur but do not depend on one's awareness. Consistent with the processing systems suggested by social mentality theory (Gilbert, 1989), the threat regulation system could be immediately and automatically activated in response to compassion. A conditioned response may not be consciously understood and reported by participants in survey research. Given the ability of the SASB's behavioral rating system to assess the actual tone of interpersonal behavior, use of the rating system would provide a measure of key variables from this study that did not rely on self-report of autonomy and affiliation. Alexithymia may limit the degree to which someone fearing compassion could understand and disclose his or her emotional experiences within interpersonal transactions.

Furthermore, this study examined fear of compassion in present day interactions with primary caregivers. Fear of compassion was tied to levels of affiliation within interactions with primary caregivers, while it may also similarly correlate with behavior in other interpersonal relationships. A future study may examine the behavioral components of fear of compassion in the context of relationships with close friends or romantic partners. Furthermore, interactions earlier in life may be expected to show similar patterns to those found in this study. A future study may examine past relationships to better understand the developmental trajectory of fears of compassion. It may also utilize a population of younger adolescents rather than college students. Such a study could help explore the developmental timeline when the cognitive capacity for self-to-self intrapsychic relations can first be recognized, potentially informing the tenets of social mentality theory and compassion focused therapy. It may indeed be that a fear of self-compassion develops through internal working models based on the way that important others have treated us, perhaps involving heightened attack or diminished love. Another promising realm for future study is the *combination* of high fear of self-compassion with low self-compassion. Some studies have investigated the detrimental effects of this combination thus far (e.g. Dupasquier et al., 2018; Kelly, et al., 2012). Integrating measures of self-compassion and of fear of self-compassion may offer deeper insight into the relationships found in the present study. For instance, those with lower capacities for self-compassion (i.e. both low self-compassion and high fear of self-compassion) may have even lower levels of affiliation in interpersonal and intrapsychic relationships, may fall at more extreme ends of personality scales, and may experience even scores indicating distress on outcome measures.

Conclusion

Fears of compassion exhibited correlations with several important variables in the present study. Fear of self-compassion is tied to low levels of affiliation with oneself and others in interpersonal and intrapsychic interaction, while fear of compassion from others is tied to low affiliation with oneself and towards others. Individuals fearing compassion tend to be less extraverted, agreeable, and conscientious, while more prone to negative emotion. They are additionally more likely to experience depression, generalized anxiety, social anxiety, and eating concerns, while those specifically fearing compassion from oneself or others are additionally more likely to experience academic and family distress, higher levels of substance use, and a sense of hostility. Further study on fears of compassion will even better illustrate how fears of compassion operate and manifest in daily life.

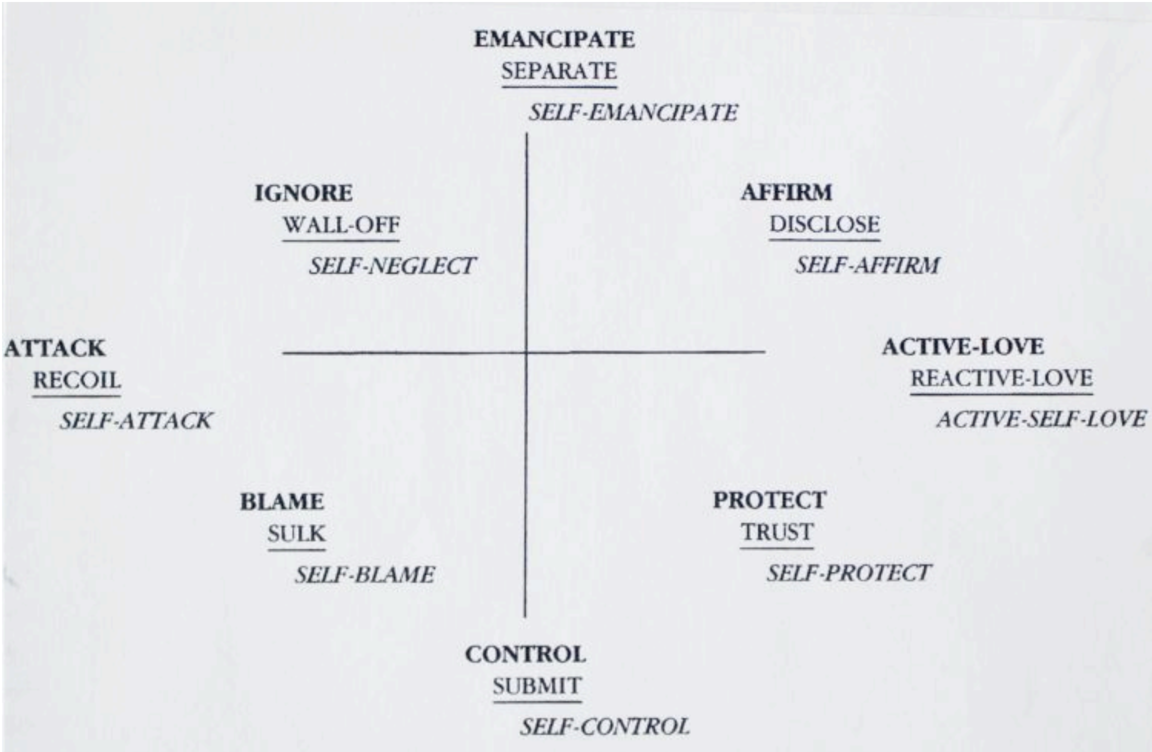

Figure 1. SASB simplified cluster model. Reprinted from Lorna Smith Benjamin, by L.S. Benjamin, 2012, Retrieved August 15, 2016 from https://lornasmithbenjamin.files.wordpress.com/2012/10/one-word-cluster-model-from-benjamin-1996.jpg. Copyright 1993 by Guilford Press. Reprinted with permission.

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Appendix A

The Structural Analysis of Social Behavior

(SASB; Benjamin, 1974)

INTREX Medium Form A /Introject. Copyright 1995, University of Utah

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Please use an answer sheet marked "introject" and indicate how well each question describes **YOURSELF.** Rate yourself twice: at your best, and at your worst. First, try to remember a specific time a few days/weeks/months ago when you were at your best, and while thinking of that time, rate the best version. Then think of a specific time a few days/weeks/months ago when you were at your worst, and rate the worst version. Please do not go back in time further than one year.

YOURSELF AT YOUR BEST

Use the scale that appears at the top of the answer sheet.

----

1. Without concern or thought, I let myself do and be whatever I feel like.

2. Without considering what might happen, I hatefully reject and destroy myself.

3. I tenderly, lovingly cherish myself.

4. I put energy into providing for, looking after, developing myself.

----

5. I punish myself by blaming myself and putting myself down.

6. Aware of my personal shortcomings as well as my good points, I comfortably let myself be "as is".

7. I am recklessly neglectful of myself, sometimes completely "spacing out".

8. To make sure I do things right, I tightly control and watch over myself.

----

9. I let myself do whatever I feel like and don't worry about tomorrow.

10. Without thought about what might happen, I recklessly attack and angrily reject myself.

11. I very tenderly and lovingly appreciate and value myself.

12. I take good care of myself and work hard on making the most of myself.

----

13. I accuse and blame myself for being wrong or inferior.

14. With awareness of weaknesses as well as strengths, I like and accept myself "as is."

15. I carelessly let go of myself, and often get lost in an unrealistic dream world.

16. To become perfect, I force myself to do things correctly.

[Items are presented a second time to rate introject at WORST]

Intrex Medium Form B: He/Present. Copyright 1995, University of Utah.

Please use an answer sheet marked "interpersonal" and indicate how well each question describes: **YOUR SIGNIFICANT OTHER PERSON AT HIS BEST** Use the scale that appears at the top of the answer sheet.

----

1. He lets me speak freely, and warmly tries to understand me even if we disagree.

2. He walls himself off from me and doesn't react much.

3. He puts me down, blames me, punishes me.

4. Without giving it a second thought, he uncaringly ignores, neglects, abandons me.

----

5. He learns from me, relies upon me, accepts what I offer.

6. He happily, gently, very lovingly approaches me, and warmly invites me to be as close as I would like.

7. With much sulking and fuming, he scurries to do what I want.

8. He clearly and comfortably expresses his own thoughts and feelings to me.

----

9. To keep things in good order, he takes charge of everything and makes me follow his rules.

10. He thinks, does, becomes whatever I want.

11. He knows his own mind and "does his own thing" separately from me.

12. Without worrying about the effect on me, he wildly, hatefully, destructively attacks me.

----

13. With much kindness, he teaches, protects, and takes care of me.

14. Without much worry, he leaves me free to do and be whatever I want.

15. He relaxes, freely plays, and enjoys being with me as often as possible.

16. With much fear and hate, he tries to hide from or get away from me.

----

17. He likes me and tries to see my point of view even if we disagree.

18. He closes off from me and mostly stays alone in his own world.

19. He tells me my ways are wrong and I deserve to be punished.

20. Without giving it a thought, he carelessly forgets me, leaves me out of important things.

----

21. He trustingly depends on me, willingly takes in what I offer.

22. With much love and caring, he tenderly approaches if I seem to want it.

23. He bitterly, resentfully gives in, and hurries to do what I want.

24. He peacefully and plainly states his own thoughts and feelings to me.

----

25. To make sure things turn out right, he tells me exactly what to do and how to do it.

26. He defers to me and conforms to my wishes.

27. He has a clear sense of what he thinks, and chooses his own ways separately from me.

28. Without caring what happens to me, he murderously attacks in the worst way possible.

----

29. In a very loving way, he helps, guides, shows me how to do things.

30. Without much concern, he gives me the freedom to do things on my own.

31. He is joyful and comfortable, altogether delighted to be with me.

32. Filled with disgust and fear, he tried to disappear, to break loose from me.

For questions #33 through 64, change from rating him to rating

YOURSELF IN THIS RELATIONSHIP.

----

33. I let him speak freely, and warmly try to understand him even if we disagree.

34. I wall myself off from him and don't react much.

35. I put him down, blame him, punish him.

36. Without giving it a second thought, I uncaringly ignore, neglect, abandon him.

----

37. I learn from him, rely upon him, accept what he offers.

38. I happily, gently, very lovingly approach him, and warmly invite him to be as close as he would like.

39. With much sulking and fuming, I scurry to do what he wants.

40. I clearly and comfortably express my own thoughts and feelings to him.

----

41. To keep things in good order, I take charge of everything and make him follow my rules.

42. I think, do, become whatever he wants.

43. I know my own mind and "do my own thing" separately from him.

44. Without worrying about the effect on him, I wildly, hatefully, destructively attack him.

---

45. With much kindness, I teach, protect, and take care of him.

46. Without much worry, I leave him free to do and be whatever he wants.

47. I relax, freely play, and enjoy being with him as often as possible.

48. With much fear and hate, I try to hide from or get away from him.

---

49. I like him and try to see his point of view even if we disagree.

50. I close off from him and mostly stay alone in my own world.

51. I tell him his ways are wrong and he deserves to be punished.

52. Without giving it a thought, I carelessly forget him, leave him out of important things.

---

53. I trustingly depend on him, willingly take in what he offers.

54. With much love and caring, I tenderly approach if he seems to want it.

55. I bitterly, resentfully give in, and hurry to do what he wants.

56. I peacefully and plainly state my own thoughts and feelings to him.

----

57. To make sure things turn out right, I tell him exactly what to do and how to do it.

58. I defer to him and conform to his wishes.

59. I have a clear sense of what I think, and choose my own separate ways.

60. Without caring what happens to him, I murderously attack him in the worst way possible. ---

61. In a very loving way, I help, guide, show him how to do things.

62. Without much concern, I give him the freedom to do things on his own.

63. I am joyful and comfortable, altogether delighted to be with him.

64. Filled with disgust and fear, I try to disappear, to break loose from him.

[Items are presented a second time (him/ me with him) to assess this relationship at WORST]

Appendix B

Fear of Compassion Scales

(Gilbert, McEwan, Matos, & Rivis, 2011)

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.

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

Don't Agree At All 0 1 2 3 4 Completely Agree

Fear of expressing compassion for others

1. Being too compassionate makes people soft and easy to take advantage of

2. People will take advantage of you if you are too forgiving and compassionate

3. I fear that being too compassionate makes people and easy target

4. I fear that if I am too compassionate, some people will become too dependent upon me

5. People will take advantage of me if they see me as too compassionate

6. I fear that if I am too compassionate, vulnerable people can be drawn to me and drain my emotional resources

7. Being compassionate towards people who have done bad things is letting them off the hook

8. There are some people in life who don't deserve compassion

9. For some people I think discipline and proper punishments are more helpful than being compassionate to them

10. People need to help themselves rather than waiting for others to help them

Fear of responding to the expression of compassion from others

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

Fear of expressing kindness and compassion towards yourself

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

Appendix C

NEO-FFI-3

(Costa & McCrae, 1992)

This questionnaire contains 60 questions. Read each statement carefully. For each statement, fill in the circle with the response that best represents your opinion.

Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)

1. I am not a worrier.
2. I like to have a lot of people around me.
3. I enjoy concentrating on a fantasy or daydream and exploring all its possibilities, letting it grow and develop.
4. I try to be courteous to everyone I meet.
5. I keep my belongings neat and clean.
6. At times I have felt bitter and resentful.
7. I laugh easily.
8. I think it's interesting to learn and develop new hobbies.
9. At times I bully or flatter people into doing what I want them to.
10. I'm pretty good about pacing myself so as to get things done on time.
11. When I'm under a great deal of stress, sometimes I feel like I'm going to pieces.
12. I prefer jobs that let me work alone without being bothered by people.

13. I am intrigued by the patterns I find in art and nature.
14. Some people think I'm selfish and egotistical.
15. I often come into situations without being fully prepared.
16. I rarely feel lonely or blue.
17. I really enjoy talking to people.
18. I believe letting students hear controversial speakers can only confuse and mislead them.
19. If someone starts a fight, I'm ready to fight back.
20. I try to perform all the tasks assigned to me conscientiously.
21. I often feel tense and jittery.
22. I like to be where the action is.
23. Poetry has little or no effect on me.
24. I'm better than most people, and I know it.
25. I have a clear set of goals and work toward them in an orderly fashion.
26. Sometimes I feel completely worthless.
27. I shy away from crowds of people.
28. I would have difficulty just letting my mind wander without control or guidance.
29. When I've been insulted, I just try to forgive and forget.
30. I waste a lot of time before settling down to work.
31. I rarely feel fearful or anxious.
32. I often feel as if I'm bursting with energy.
33. I seldom notice the moods or feelings that different environments produce.
34. I tend to assume the best about people.

35. I work hard to accomplish my goals.
36. I often get angry at the way people treat me.
37. I am a cheerful, high-spirited person.
38. I experience a wide range of emotions or feelings.
39. Some people think of me as cold and calculating.
40. When I make a commitment, I can always be counted on to follow through.
41. Too often, when things go wrong, I get discouraged and feel like giving up.
42. I don't get too much pleasure from chatting with people.
43. Sometimes when I am reading poetry or looking at a work of art, I feel a chill or wave of excitement.
44. I have no sympathy for beggars.
45. Sometimes I'm not as dependable or reliable as I should be.
46. I am seldom sad or depressed.
47. My life is fast-paced.
48. I have little interest in speculating on the nature of the universe or the human condition.
49. I generally try to be thoughtful and considerate.
50. I am a productive person who always gets the job done.
51. I often feel helpless and want someone else to solve my problems.
52. I am a very active person.
53. I have a lot of intellectual curiosity.
54. If I don't like people, I let them know it.
55. I never seem to be able to get organized.

56. At times I have been so ashamed I just wanted to hide.

57. I would rather go my own way than be a leader of others.

58. I often enjoy playing with theories or abstract ideas.

59. If necessary, I am willing to manipulate people to get what I want.

60. I strive for excellence in everything I do.

Appendix D

Counseling Center Assessment of Psychological Symptoms

(CCAPS-62; Locke et al., 2012)

INSTRUCTIONS: The following statements describe thoughts, feelings, and experiences that people may have. Please indicate how well each statement describes you, during the past two weeks, from “not at all like me” (0) to “extremely like me” (4), by marking the correct number. Read each statement carefully, select only one answer per statement, and please do not skip any questions.

0 - Not at all Like Me 1 2 3 4 - Extremely Like Me

1. I get sad or angry when I think of my family
2. I am shy around others
3. There are many things I am afraid of
4. My heart races for no good reason
5. I feel out of control when I eat
6. I enjoy my classes
7. I feel that my family loves me
8. I feel disconnected from myself
9. I don't enjoy being around people as much as I used to
10. I feel isolated and alone
11. My family gets on my nerves

12. I lose touch with reality
13. I think about food more than I would like to
14. I am anxious that I might have a panic attack while in public
15. I feel confident that I can succeed academically
16. I become anxious when I have to speak in front of audiences
17. I have sleep difficulties
18. My thoughts are racing
19. I am satisfied with my body shape
20. I feel worthless
21. My family is basically a happy one
22. I am dissatisfied with my weight
23. I feel helpless
24. I use drugs more than I should
25. I eat too much
26. I drink alcohol frequently
27. I have spells of terror or panic
28. I am enthusiastic about life
29. When I drink alcohol I can't remember what happened
30. I feel tense
31. When I start eating I can't stop
32. I have difficulty controlling my temper
33. I am easily frightened or startled
34. I diet frequently

35. I make friends easily
36. I sometimes feel like breaking or smashing things
37. I have unwanted thoughts I can't control
38. There is a history of abuse in my family
39. I experience nightmares or flashbacks
40. I feel sad all the time
41. I am concerned that other people do not like me
42. I wish my family got along better
43. I get angry easily
44. I feel uncomfortable around people I don't know
45. I feel irritable
46. I have thoughts of ending my life
47. I feel self-conscious around others
48. I purge to control my weight
49. I drink more than I should
50. I enjoy getting drunk
51. I am not able to concentrate as well as usual
52. I am afraid I may lose control and act violently
53. It’s hard to stay motivated for my classes
54. I feel comfortable around other people
55. I like myself
56. I have done something I have regretted because of drinking
57. I frequently get into arguments

58. I find that I cry frequently

59. I am unable to keep up with my schoolwork

60. I have thoughts of hurting others

61. The less I eat, the better I feel about myself

62. I feel that I have no one who understands me

Appendix E

Conformity to Masculine Norms Inventory

(CMNI-22; Mahalik, Locke, Ludlow, & Freitas, 2003)

The following items contain a series of statements about how men might think, feel or behave. The statements are designed to measure attitudes, beliefs, and behaviors associated with both traditional and non-traditional masculine gender roles.

Thinking about your own actions, feelings and beliefs, please indicate how much **you personally agree or disagree with each statement** by circling SD for "Strongly Disagree", D for "Disagree", A for "Agree", or SA for "Strongly agree" to the right of the statement. There are no correct or wrong answers to the items. You should give the responses that most accurately describe your personal actions, feelings and beliefs. It is best if you respond with your first impression when answering.

---

1. My work is the most important part of my life SD D A SA
2. I make sure people do as I say SD D A SA
3. In general, I do not like risky situations SD D A SA
4. It would be awful if someone thought I was gay SD D A SA

5. I love it when men are in charge of women SD D A

SA

6. I like to talk about my feelings SD D A

SA

7. I would feel good if I had many sexual partners SD D A

SA

8. It is important to me that people think I am heterosexual SD D A

SA

9. I believe that violence is never justified SD D A

SA

10. I tend to share my feelings SD D A

SA

11. I should be in charge SD D A

SA

12. I would hate to be important SD D A

SA

13. Sometimes violent action is necessary SD D A

SA

14. I don’t like giving all my attention to work SD D A

SA

15. More often than not, losing does not bother me SD D A

SA

16. If I could, I would frequently change sexual partners SD D A

SA

17. I never do things to be an important person SD D A

SA

18. I never ask for help SD D A

SA

19. I enjoy taking risks SD D A

SA

20. Men and women should respect each other as equals SD D A

SA

21. Winning isn't everything, it's the only thing SD D A

SA

22. It bothers me when I have to ask for help SD D A

SA