

RUNNING HEAD: Emotional memories and fears of compassion

The origins of fears of compassion:

Shame and lack of safeness memories, fears of compassion and psychopathology

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Regarding rights of study participants, authorization was obtained from the Ethical Committee of the Cognitive and Behavioural Research Centre at the University of Coimbra and from the schools and private corporations’ boards where the sample was collected. Before completing the questionnaires participants gave their informed consent and were informed their co-operation was voluntary and that their answers were confidential and only used for the purpose of the study. The order in which the questionnaires were administered was counterbalanced.

No animals have been used.

Abstract

Objectives: Empirical and clinical research suggests that some individuals find self-generating compassion and receiving compassion from others difficult and aversive. However, it is unclear how these fears of compassion are linked to early experiences and to psychopathological symptoms. The present study explores the relationship between shame traumatic memories, centrality of shame memories, early memories of warmth and safeness, fears of compassion, and depression, anxiety and paranoid symptoms.

Method: Participants were 302 individuals from the general community population, who completed self-report measures of fears of compassion, shame memories, early affiliative memories, and psychopathology.

Results: Shame traumatic and central memories were positively associated with fears of compassion for self, for others and from others, whereas early memories of warmth and safeness were negatively related to such fears. Path analyses revealed that fears of compassion *for self* and of receiving compassion *from others* mediated the effects of shame traumatic memory, centrality of shame memory and early memories of warmth and safeness on depressive, anxious and paranoid symptoms.

Conclusion: These findings have implications for therapeutic interventions as these fears, as well as the negative shame-based emotional memories fuelling them, may need to be addressed in therapy to assist patients in self-generating and receiving compassion.

Keywords: Shame; Depression; Anxiety; Paranoid ideation; Fear of compassion

Introduction

In recent years, there has been an increasing interest in research regarding compassion and its beneficial effects on well-being (e.g., Davidson & Harrington, 2002; Gilbert, 2005, 2009, 2010ab; Goetz, Keltner & Simon-Thomas, 2010; Neff, 2003). Although definitions of compassion may vary (e.g., Goetz et al., 2010; Gilbert, 2005), there is a broad consensus that it involves “a sensitivity to the suffering of self and others, with a deep commitment to try to relieve it” (Dalai Lama, 1995), and that it is related to feelings of kindness, gentleness and warmth (Fehr, Sprecher & Underwood, 2009). Also, compassion has been seen as a multidimensional construct that comprises several attributes, such as: a motivation to care, a capacity for sympathy, an ability to tolerate unpleasant emotions, and a capacity for empathic understanding, non-judging and non-condemning (Gilbert, 2005, 2009, 2010a). In terms of the orientation of compassion, we can have compassionate motives for others, experience compassion from others, and have compassion for ourselves (Neff, 2003; Gilbert, 2009, 2010a).

A growing body of research has been suggesting that compassion is positively associated with well-being indicators such as happiness, life satisfaction, social connectedness, optimism, curiosity, wisdom, adaptive coping and positive affect, and negatively linked to depression, anxiety, stress, self-criticism, shame and rumination (e.g., Neff, 2003; Neff, Rude, & Kirkpatrick, 2007; Goetz et al., 2010; Barnard & Curry, 2011). Given such beneficial effects, compassion has recently become the focus of training programs and therapeutic interventions for a range of mental health problems, especially characterised by self-criticism and shame (Gilbert & Procter, 2006). In fact, there is increasing evidence that helping people to develop compassion for themselves and for others has a powerful impact on mental and physical well-being (e.g., Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008; Hutcherson, Seppala, & Gross,

2008; Jain et al. 2007; Jazaieri et al., 2013; Lutz, Greischar, Rawlings, Ricard, & Davidson, 2004; Neff & Germer, 2013; Pace et al., 2008; Shapiro, Brown, & Biegel, 2007). For example, Compassion Focused Therapy, primarily designed for people suffering from high levels of self-criticism and shame, has shown therapeutic effectiveness in patients with mood disorders (Gilbert & Procter, 2006; Kelly, Zuroff, & Shapira, 2009), psychosis (Braehler et al., 2013; Mayhew & Gilbert, 2008; Laithwaite et al., 2009), eating disorders (Gale et al., 2012), personality disorders (Lucre & Corten, 2013), and trauma and PTSD (Lawrence & Lee, 2013; Bowyer, Wallis, & Lee, 2013).

Fears of compassion

However, there is increasing evidence from empirical research and clinical anecdote that some individuals, particularly those high in self-criticism, can find self-generating compassion and receiving compassion from others difficult or aversive and can be fearful of it (Gilbert, McEwan, Matos & Rivis, 2011; Gilbert, McEwan, Gibbons, Chotai, Duarte, & Matos, 2012; Longe et al., 2010; Rockliff et al., 2008; Rockliff et al., 2011). Specifically, it has been suggested that people can develop fears of compassion for the self, for others and of receiving compassion from others (Gilbert et al., 2011). Recently, a new line of research has pointed out that such fears, and in particular fears of compassion for the self and of receiving compassion from others, are linked to a range of psychopathological indicators, such as self-criticism, insecure attachment, alexithymia, fears of happiness, lower levels of empathy and mindfulness, increased symptom of depression, anxiety and stress (Gilbert et al., 2011, 2012), shame and eating disorders (Kelly, Carter, Zuroff, & Borairi, 2012), and to high levels of physiological indicators of stress response (Duarte, McEwan, Barnes, Gilbert, & Maratos, 2014).

Although such studies demonstrate that individuals vary in the extent to which they have fears of compassion, evidence into the origins and vulnerability for the

development of these fears is still scarce. Clinical observations and attachment literature (Liotti, 2004) suggest that individuals with emotional memories of being abused, neglected or shamed by their caregivers tend to experience compassion for oneself and from others as threatening and aversive.

Shame experiences

Since early in life, shame experiences occur in our interactions with significant others and can go from being criticized by a parent, bullied by peers, rejected by a lover, or failing at something important, to being neglected, sexually or physically abused. Shame is linked to the experience of threat or loss of abilities to create desirable images of oneself in the mind of the other (i.e., being seen as an unattractive social agent, looked down upon, criticized or held in contempt) so that others may reject, exclude or harm the self (Gilbert, 1998, 2007). Also, according to several authors this is a vital emotion to one's sense of self and self-identity (Gilbert, 1998, 2007; Lewis, 1992; Tangney & Dearing, 2002). Thus, the variety of shame episodes we experience throughout our lives may engender a negative sense of self as seen by others and may lead to depreciative self-evaluations and feelings.

Shame experiences posit a threat to the social self and self-identity. Research has indeed found that early shame experiences can be recorded in autobiographical memory as central emotional memories, shaping personal identity, structuring the life narrative and forming a salient reference point to give meaning to other events (Pinto-Gouveia & Matos, 2011). In addition, shame memories from childhood and adolescence were found to reveal traumatic memory features, capable of eliciting intrusions, strong emotional avoidance and hyperarousal symptoms, acting as threat-activating memories (Matos & Pinto-Gouveia, 2010). Such shame memories with traumatic and centrality features have been found to increase current shame feelings and vulnerability to

psychopathological symptoms, namely depression, anxiety (Matos & Pinto-Gouveia, 2010, 2014; Pinto-Gouveia & Matos, 2011; Matos, Pinto-Gouveia & Costa, 2013) and paranoid ideation (Matos, Pinto-Gouveia & Duarte, 2012; Matos, Pinto-Gouveia & Gilbert, 2013; Pinto-Gouveia, Matos, Castilho & Xavier, 2012). Therefore, shame experiences in early life may increase one's proneness to experience fear, avoidance, grief, loneliness or even aggression when being the recipient of compassion. In fact, this might be because these shame experiences seem to activate and strengthen the threat affect regulation system by creating a sense of a threatened social self, where one is perceived as vulnerable, defective, unworthy of love, or weak, and others are seen as critical, judgmental, emotionally unavailable or even dangerous, which reinforces shame and other negative emotions (e.g., anxiety, sadness, anger) and negative beliefs about being the recipient of care, compassion and love from others. At the same time, shame experiences may be associated with the underdevelopment of the affiliative soothing affect regulation system, linked to one's sense of social safeness and ability to regulate threat and negative emotions through affiliative affective and motivational states, such as compassion (Gilbert, 2009; Liotti, 2004; Matos, Pinto-Gouveia & Duarte, 2015)

In contrast, early positive affiliative interactions and memories of experiencing safeness, warmth and nurturing during childhood are associated with well-being and health, self-accepting and nurturing abilities, and ultimately they protect against psychopathology, such as depression (Cacioppo Berston, Sheridan, & McClintock, 2000; Masten, 2001; Matos, Pinto-Gouveia & Duarte, 2013, 2015; Schore, 2001; Richter, Gilbert, & McEwan, 2009). These early experiences of warmth and safeness seem to promote the development of the affiliative soothing system, which is linked to one's ability use affiliative positive emotions (e.g., compassion), generated within the

self or others, to down-regulate the threat system and associated negative affective states (Gilbert, 2009).

However, the way in which these early life events, such as experiences of shame or safeness within the family and in the wider social context, are linked to the development of fears of receiving and giving compassion and to increased vulnerability to psychopathological symptoms remains to be studied.

Aims

Therefore the present study set out to explore the relationship between shame traumatic memories, centrality of shame memories and early memories of warmth and safeness, and fears of compassion, and depression, anxiety and paranoid symptoms. It is expected that the traumatic and centrality features of shame memories would be positively associated with fears of compassion for self, for others and from others, whereas early memories of warmth and safeness would be negatively related to such fears. Also, it is predicted that shame traumatic memories, centrality of shame memories and fears of compassion would be positively correlated with depression and anxiety symptoms and paranoid ideation, and that early positive affiliative memories would show a negative association with these psychopathological indicators.

In addition, this research aims at investigating the mediator effect of fears of compassion on the association between early shame and safeness memories, and depression, anxiety and paranoid symptoms. Specifically, two mediator models will be tested in which it is predicted that fears of compassion would mediate the impact of shame traumatic memory characteristics, centrality of shame memory and early memories of warmth and safeness on depressive and anxiety symptoms (Model A), and on paranoid ideation (Model B).

Method

Participants

Participants in this research were 302 individuals (131 men and 171 women) from the general community population. Participants mean age was 36.28 ($SD = 11.45$) with age ranging from 18 to 62. Forty three per cent ($n = 130$) of the subjects were married, 41% ($n = 125$) were single, 7.9% ($n = 24$) cohabited with a partner, 7% ($n = 21$) were divorced and 2 were widows. The participants' years of education mean was 13.06 ($SD = 3.52$) and 46% ($n = 139$) had a medium socio-economic level, 26% ($n = 79$) low and 9.6% ($n = 29$) high, 11% ($n = 34$) were college students, and 7% ($n = 34$) were retired or unemployed.

Procedure

A convenience sample was collected in the center region of Portugal using snowball sampling procedure and within several institutions' staff, namely schools and private corporations. Authorization was obtained from these Institutions' boards and from the Ethical Committee of the XX at the University of XX. Before completing the questionnaires, participants gave their informed consent and were informed that their cooperation was voluntary and that their answers were confidential and only used for the purpose of the study. The order in which the questionnaires were administered was counterbalanced.

Measures

Internal consistencies for all measures are presented in Table 1.

Priming for the shame memory.

Before completing the measures, participants were given a brief introduction on the concept of shame and were asked to recall a significant and stressful shame experience from their childhood or adolescence. Afterwards they were instructed to

answer the two shame memory related questionnaires based on that experience. This adjustment in the instructions has been made in other studies (Matos & Pinto-Gouveia, 2010; Pinto-Gouveia & Matos, 2011) and it does not seem to affect the validity of the measures.

Centrality of Event Scale (CES; Berntsen & Rubin, 2006; Portuguese version by Matos, Pinto-Gouveia, & Gomes, 2010) assesses the extent to which a memory for a stressful event (in this case, a shame experience) forms a reference point for personal identity and to attribution of meaning to other experiences in a person's life. This 20-item self-report questionnaire is rated on a 5-point Likert scale (1-5), and measures three interdependent characteristics of a highly negative emotional event that load on to a single underlying factor: the extent to which the event is a central component of one's personal identity ("*I feel that this event has become part of my identity.*"), is viewed as a landmark in one's life story ("*I feel that this event has become a central part of my life story.*") and acts as a reference point for inferences and attributions in everyday life ("*This event has coloured the way I think and feel about other experiences.*"). High scores on the CES indicate high centrality of that event to one's personal identity or life story. In its original study and Portuguese version, the CES showed sound psychometric properties with a high internal consistency (Cronbach $\alpha = .94$ and $.96$ respectively).

Impact of Event Scale – Revised (IES-R) was developed by Weiss & Marmar (1997; Portuguese version by Matos, Pinto-Gouveia, & Martins, 2011). The IES-R is a self-report instrument designed to measure current subjective distress for any specific life event, and specifically in this study in relation to the shame memory remembered by the participants. This scale has 22 items rated on a 5-point Likert scale (0–4). The IES-R is composed of three subscales that measure the three main characteristics of traumatic memories: avoidance ("*I stayed away from reminders of it*"), intrusion ("*Any reminder*

brought back feelings about it") and hyperarousal ("*I was jumpy and easily startled*") that parallel the DSM-IV criteria for PTSD. Higher scores on the IES-R are indicative of higher traumatic memory features of a particular event. In the original study, Cronbach alphas of the subscales ranged from .87 to .92 for intrusion, .84 to .86 for avoidance and .79 to .90 for hyperarousal (Weiss & Marmar, 1997). The Portuguese version revealed a one-dimensional structure with sound psychometric properties, with a Cronbach' alpha of .96 (Matos et al., 2011).

Early memories of warmth and safeness scale (EMWSS, Richter et al., 2009; Portuguese version by Matos, Pinto-Gouveia & Duarte, 2016) was designed to measure personal emotional memories, specifically the recall of feeling warm, safe, accepted and cared for in childhood. It comprises 21 items ("*I felt cared about*", "*I felt appreciated the way I was*") rated on a Likert scale assessing how frequently each statement applied to the participants' childhood (0 = No to 4 = Yes, most of the time). Higher mean scores on this measure indicate higher recollection of feelings of warmth and safeness within one's family in early life. Both in its original study and in the Portuguese version, the EMWSS presented an excellent internal consistency, with a Cronbach's alpha of .97.

Fears of Compassion Scales (Gilbert et al., 2011; Portuguese version by Matos, Pinto-Gouveia, Duarte, & Simões, 2016) comprises three scales measuring: Fears of expressing compassion *for others* (10 items, 9 in the Portuguese version; "*Being too compassionate makes people soft and easy to take advantage of*"); Fears of receiving compassion *from others* (13 items; "*I try to keep my distance from others even if I know they are kind*"); and Fears of compassion *for self* (15 items; "*I worry that if I start to develop compassion for myself I will become dependent on it*"). Respondents were asked to rate on a Likert scale how much they agree with each item statement (0 = *Don't agree at all*, to 4 = *Completely agree*). In the original and the Portuguese version

studies, the Cronbach's alphas were .72/.88 for fears expressing compassion for others, .80/.91 for fears of receiving compassion from others, and .83/.94 for fears in giving compassion to self, respectively.

Depression, Anxiety and Stress Scales (DASS-42; Lovibond & Lovibond, 1995; Portuguese version by Pais-Ribeiro, Honrado & Leal, 2004) is a self-report measure composed of 42 items and designed to assess three dimensions of psychopathological symptoms: depression, anxiety and stress. The items indicate negative emotional symptoms and are rated on a 4-point Likert scale (0-3). Higher mean scores on these subscales reveal higher levels of these psychopathological symptoms. On the original version, Lovibond and Lovibond (1995) found the subscales to have high internal consistency (Depression Cronbach's $\alpha = .91$; Anxiety Cronbach's $\alpha = .84$; Stress Cronbach's $\alpha = .90$). In the present study, only the Depression and Anxiety subscales will be considered.

General Paranoia Scale (GPS; Fenigstein & Vanable, 1992; Portuguese version by Lopes & Pinto-Gouveia, 2005) is a 20-item self-report scale designed to assess paranoia in college students. It measures the following characteristics: the belief that another person, or a powerful external influence, is commanding the individual's thoughts and behaviours ("*Someone has been trying to influence my mind*"); the belief of a conspiracy against oneself, i.e. others are working together to conspire against the individual ("*My parents and family find more fault in me than they should*"); the belief of being spied on and talked negatively about oneself behind one's back ("*I sometimes feel as if I am being followed*"); a general suspicion regarding others and a lack of trust in people ("*It is safer to trust no one*"); and finally the presence of feelings of resentment ("*I am sure I get a raw deal from life*"). Each item is rated on a 5-point Likert scale (1-5) and high mean scores indicate higher levels of paranoid ideation.

Fenigstein and Venable (1992) found this scale to have good internal consistency across their four North-American samples (Cronbach $\alpha = .84$).

Data Analyses

Data analyses were conducted using Predictive Analytics Software (PASW) and Analysis of Momentary Structure (AMOS; SPSS Inc., 2009). Pearson correlation coefficients were performed to explore the association between the variables. Partial correlations between the study variables were also computed controlling for age, however given that there was no significant effect of age on these associations, this variable was not included in the analyses.

Mediational studies were then conducted, testing for the mediator effect of fears of compassion (mediators) on the relationships between shame traumatic memory (IES-R), centrality of shame memory (CES), early memories of warmth and safeness (EMWSS; independent, exogenous variables), and depression and anxiety symptoms (DASS-42; dependent, endogenous variables; Model_A), and paranoid ideation (GPS; dependent, endogenous variables; Model_B). Two separate models were tested due to the different phenomenological nature of psychopathological symptoms of depression and anxiety, and paranoid ideation. In addition, due to sample size restrictions the statistical power of the model would be reduced if all variables were included in a single model.

Path analyses were carried out to test for these mediator effects. This technique is a special case of structural equation modeling (SEM) and considers hypothetical causal relations between variables that have already been defined. A Maximum Likelihood method was used to evaluate the regression coefficients significance. The SEM procedure estimates the optimal effect of one set of variables on another set of

variables in the same equation, controlling for error (Byrne, 2010; Kline, 2005). Multivariate outliers were screened using Mahalanobis squared distance (D^2) method and uni- and multivariate normality was assessed by skewness and kurtosis coefficients. There was no severe violation of normal distribution ($|Sk| < 3$ and $|Ku| < 8-10$; Kline, 2005). Well-known and recommended goodness of fit indices were used to assess model fit. The significance of direct, indirect and total effects was assessed using χ^2 tests. A Bootstrapping resampling method was further used to test the significance of the mediational paths, using 1000 bootstrap samples and 95% confidence intervals (CIs; Kline, 2005).

Results

Descriptive Statistics

Descriptive statistics for all study variables are presented in Table 1. Mean values and standard deviations were similar to those reported in previous studies using general population samples (e.g., Gilbert et al, 2011; Matos, Pinto-Gouveia & Gilbert, 2013; Matos, Pinto-Gouveia & Duarte, 2012, 2013; Pinto-Gouveia & Matos, 2011).

[Table_1_around_here]

Correlations

Pearson correlation coefficients are given in Table 2. Results showed that shame traumatic and central memories were positively associated with fears of compassion *for self*, *for others* and *from others* whereas early memories of warmth and safeness were negatively related to such fears. Fears of compassion were positively correlated with depressive and anxious symptoms and with paranoid ideation. All correlations were stronger in magnitude for fears of compassion *for self* and *from others* than for fears of compassion *for others*. Shame memories traumatic and centrality features were positively related to depression and anxiety symptoms, and paranoid ideation. Early

memories of warmth and safeness were negatively associated with such psychopathological symptoms.

In line with the proposed hypotheses, the associations between these variables were further explored through mediation models.

[Table_2_around_here]

Path Analyses

Mediator effect of fears of compassion on the relationship between shame traumatic memories, centrality of shame memories and early memories of warmth and safeness on depression and anxiety symptoms (Model_A).

The final adjusted model, consisting of 30 parameters, is depicted in Figure 1. Path analysis results showed that the model presents a very good fit to the data, $\chi^2/df = 1.639$, $p = .146$, CFI = .997, TLI = .987, NFI = .992, RMSEA = .046, $p < .001$.

All the paths were statistically significant and bootstrap resampling method results confirmed the significance of the indirect mediational paths. The model accounted for 37% of depression and 42% of anxiety variances.

Indirect mediational test results indicated that centrality of shame memory (CES) predicted heightened depression ($b_{CES} = .14$, 95% CI = .080 to .210) and anxiety ($b_{CES} = .13$, 95% CI = .080 to .207) fully through increased fear of compassion *for the self* (FCSelf) and fear of receiving compassion *from others* (FCFromOthers). Early memories of warmth and safeness (EMWS) predicted less depressive ($b_{EMWS} = -.12$, 95% CI = -.186 to -.068) and anxious symptoms ($b_{EMWS} = -.11$, 95% CI = -.117 to -.064) fully through increased fears of compassion *for the self* (FCSelf) and *from others* (FCFromOthers).

In addition, results showed that shame traumatic memory (IES-R) directly predicted increased depressive ($b_{IES-R} = .96$; $SEb = .16$; $Z = 6.16$; $\beta = .30$, $p < .001$) and

anxious symptoms ($b_{IES-R} = 1.07$; $SEb = 1.14$; $Z = 7.91$; $\beta = .37$, $p < .001$). There were also small and marginally significant indirect effects of shame traumatic memory on depression ($b_{IES-R} = .014$, 95% CI = .000 to .044) and anxiety ($b_{IES-R} = .014$, 95% CI = .001 to .042) through fears of compassion *from others* (FCFromOthers).

In this model, fear of compassion *for the self* was a better predictor of depression ($b_{FCSelf} = .23$; $SEb = .04$; $Z = 5.56$; $\beta = .35$, $p < .001$) and anxiety ($b_{FCSelf} = .19$; $SEb = .04$; $Z = 5.39$; $\beta = .33$, $p < .001$), than fears of compassion *from others* (Depression: $b_{FCFromOthers} = .10$; $SEb = .05$; $Z = 2.00$; $\beta = .13$, $p = .046$; Anxiety: $b_{FCFromOthers} = .09$; $SEb = .04$; $Z = 2.06$; $\beta = .13$, $p = .039$).

[Figure_1_around_here]

In conclusion, these findings reveal that fears of compassion for the self and of receiving compassion from others fully mediated the effect of centrality of shame memory and early memories of warmth and safeness on depressive and anxious symptoms. Although fears of receiving compassion from others partially mediated the impact of shame traumatic memory on anxious symptoms, there were still direct effects of shame traumatic memory on depression and anxiety.

Mediator effect of fears of compassion on the relationship between shame traumatic memories, centrality of shame memories and early memories of warmth and safeness on paranoid ideation (Model_B).

Figure 2 illustrates the final adjusted model, consisting of 24 parameters. Results indicated that the model presents a very good fit to the data, $\chi^2/df = 1.407$, $p = .239$, CFI = .998, TLI = .990, NFI = .993, RMSEA = .037, $p < .001$. The model accounted for 42% of paranoia ideation variance.

Indirect mediational test results indicated that centrality of shame memory (CES) predicted greater paranoid ideation ($b_{CES} = .14$, 95% CI = .083 to .214) fully through heightened fear of compassion *for the self* (FCSelf) and fear of receiving compassion *from others* (FCFromOthers). Early memories of warmth and safeness (EMWS) predicted diminished paranoid ideation ($b_{EMWS} = -.13$, 95% CI = -.200 to -.075) fully through increased fears of compassion *for the self* (FCSelf) and *from others* (FCFromOthers).

Furthermore, shame traumatic memory (IES-R) predicted increased paranoid ideation directly ($b_{IES-R} = 1.38$; $SEb = .23$; $Z = 6.08$; $\beta = .20$, $p < .001$) and partially through fear of receiving compassion *from others* (FCFromOthers) ($b_{IES-R} = .04$, 95% CI = .003 to .074).

Regarding paranoid ideation, fear of receiving compassion *from others* was a better predictor ($b_{FCFromOthers} = .42$; $SEb = .07$; $Z = 5.61$; $\beta = .35$, $p < .001$), than fears of compassion *for the self* ($b_{FCSelf} = .18$; $SEb = .06$; $Z = 3.00$; $\beta = .18$, $p = .003$).

[Figure_2_around_here]

To sum up, results indicated that fears of compassion *for self* and of receiving compassion *from others* partially mediated the effects of shame traumatic memory on paranoid ideation, and fully mediated the effects of centrality of shame memory and early memories of warmth and safeness on paranoid ideation.

Moreover, while fear of compassion *for self* had a stronger effect on depression and anxiety symptoms, fear of receiving compassion *from others* was the best predictor of paranoid ideation.

Discussion

There is increasing evidence that cultivating compassion for self and others has powerful effects on a range of mental and physical well-being indicators (e.g., Barnard

& Curry, 2011; Lutz et al., 2004; Pace et al., 2008). However, a recent line of research has been showing that people can develop fears of, and resistance to, affiliative and positive emotions, which have been linked to psychopathology. In particular, there is evidence that some individuals, particularly for those high in self-criticism, can find directing compassion for themselves and for others, and receiving compassion from others, difficult, aversive or even threatening (Gilbert et al., 2011; Gilbert et al., 2012; Rockliff et al., 2011). Nevertheless, it is still unclear how early interpersonal experiences can contribute to the development of these fears of compassion. Therefore, this study aimed at exploring the relationship between shame memories (their traumatic and centrality to identity features) and early memories of warmth and safeness and fears of compassion, and how these would impact on current psychopathological symptoms.

Correlational analyses showed that individuals with heightened fears of compassion presented higher levels of depressive and anxious symptoms, and paranoid ideation. It is worth noting that the magnitude of these correlations was stronger for fears of compassion for self and of receiving compassion from others. These results are in line with our hypotheses and previous research showing that fears of compassion are linked to psychopathological symptoms (Gilbert et al., 2011; Gilbert et al., 2012; Kelly et al., 2012).

Furthermore, and in accordance to our hypothesis and prior studies (Matos & Pinto-Gouveia, 2010, 2014; Matos et al., 2012; Matos, Pinto-Gouveia & Gilbert, 2013; Pinto-Gouveia & Matos, 2011; Pinto-Gouveia et al., 2012), our findings revealed that increased traumatic and centrality to identity characteristics of shame memories were associated with higher symptoms of depression, anxiety and paranoid ideation. Also, the lack of early safeness and warmth memories was correlated to higher psychopathological symptoms, in line with previous findings (Matos et al., 2013;

Richter et al., 2009). Key in this study was the finding that individuals whose shame memories revealed increased levels of traumatic and centrality to identity characteristics and who recalled less early memories of feeling safe and nurtured as a child, reported higher levels of fears of compassion for others.

Taking together these findings and previous theoretical and empirical accounts (Gilbert, 2010a; Gilbert et al, 2011; Liotti, 2004) we hypothesized that fears of compassion for self and from others would mediate the impact of shame traumatic memories, centrality of shame memories and early memories of warmth and safeness on depression and anxiety symptoms, and on paranoid ideation. Path analyses results confirmed these hypotheses and indicated that fears of compassion for self and of receiving compassion from others mediated the effects of shame traumatic memory (partially), centrality of shame memory (fully) and early memories of warmth and safeness (fully) on depressive, anxiety symptoms and paranoid ideation.

Thus, it seems that shame memories that function as trauma memories and that become central to personal identity and life story, along with a lack of affiliative memories, may promote perceptions of having compassion for self and from others as frightening and aversive. A possible explanation for these findings may be twofold. On the one hand, experiencing shame events, especially when these are stored as trauma memories and become central to one's identity, may render one to feel inferior, defective, powerless and unattractive, and to perceive others as critical, rejecting, condemning or abusive, thus influencing the formation of negative self-other schemas (Matos & Pinto-Gouveia, 2014; Matos, Pinto-Gouveia, & Gilbert, 2013). This, in turn, may engender a sense of ongoing threat to one's social self which constantly triggers the threat system (Gilbert, 2010a; Matos et al., 2013, 2015). On the other hand, the lack of experiences of safeness and warmth as a child may lead to an undeveloped safeness-

soothing system, which undermines one's ability to generate warmth and feel safe within social relationships and effective emotional regulation (Gilbert, 2009, 2010a; Matos & Pinto-Gouveia, 2014). These early affiliative experiences may lay down conditioned emotional memories where the need for soothing, safeness and care becomes associated with fear, loneliness, sadness and grief (Gilbert, 2009; Liotti, 2004). Therefore, the experience of an affiliative emotion such as compassion may reactivate these conditioned emotional memories and thus elicit these same feelings of shame, threat or even anger, linked to the activation of the threat system, and feelings of sadness, loneliness and grief, associated with a compromised soothing-safeness system. Hence, these negative emotional experiences may underline the development of current fears of compassion. These fears may in turn render an individual more vulnerable to defeat and threat responses when faced with stressful life events, which can manifest as symptoms of depression, anxiety, or paranoia, which at the same time cannot be toned down by compassionate feelings of warmth and safeness.

It is also worth noting that, besides from being mediated by fears of compassion, shame traumatic memories also had a direct effect on depression, anxiety and paranoid ideation. Thus, by triggering intrusions, flashbacks, hyperarousal symptoms and emotional avoidance, shame traumatic memories may embody an enduring threat to one's sense of self and psychological integrity, which impacts directly on negative affect. This is in line with prior research on the association between shame memories and psychopathology (Matos & Pinto-Gouveia, 2010, 2014; Matos et al., 2015) and is supported by recent findings regarding the pervasiveness of shame in post-traumatic stress disorder (Harman & Lee, 2010). In contrast, the direct effects of centrality of shame memory and early memories of warmth and safeness on the outcomes was non-

significant in the final models, since these effects are fully mediated by fears of compassion.

Furthermore, another interesting finding was that while fear of compassion for self had a stronger effect on depression and anxiety symptoms, fear of receiving compassion from others was the better predictor of paranoid ideation. It seems that while seeing one as not worthy of self-compassion may be particularly linked to a sense of the self as inadequate, defective, subordinate and powerless, which increases vulnerability to depression and anxiety; being suspicious and defensive towards the expression of compassion from others may be especially related to beliefs that others are critical, hostile and rejecting, and have malevolent intentions of others towards the self.

This study entails several implications for therapy. First, it highlights the need to assess and target traumatic and central shame memories as they can impact in current symptomatology and become a roadblock for therapy. Second, Compassion Focused Therapy (Gilbert, 2009, 2010a) could be used to foster feelings of social safeness and develop self-compassion. This could promote the development of the blocked safeness-soothing system and help regulate threat and distress associated with shame memories. However, practitioners should be cautious with these patients as the expression of kindness and work to cultivate one's self-compassion attributes might result in the reactivation of these negative emotional memories and activate powerful emotions and conditioned emotional reactions (e.g., fight, avoidance, escape). In these individuals who have few, or no positive affiliative memories, the therapist might be a source of threat, and may in turn elicit feelings of aloneness, grief and disconnection (Gilbert et al., 2011; Rockliff et al., 2011). All this may represent a major block to recovery and so

it might be pertinent to assess and target possible fears of compassion, especially with patients with significant shame memories and a lack of safeness memories.

Although the results of this study are promising, they are not without limitations and thus should be interpreted with caution. First, given the relatively small sample size, these findings should be replicated in larger and more representative samples of the general community population. Also, given the abovementioned clinical implications, future research using clinical samples (e.g., depressed, anxious, paranoid patients) is of great importance. In addition, the cross-sectional nature of the data limits interpretations regarding causality. Thus, future studies using a longitudinal design are called for to overcome such limitation. Finally, although we used a self-report and retrospective methodology, which can raise some concerns regarding the influence of current emotional states on these recollections and their accuracy, it has been suggested that retrospective recall may be a stable and reliable measure of early life events (Brewin, Andrews, & Gotlib, 1993). Additionally, data from other studies assessing shame memories using a structured interview along with self-report measures further support the reliability of the present data (Matos & Pinto-Gouveia, 2014; Matos, Pinto-Gouveia & Costa, 2013).

In sum, this is the first study to shed light on the origins of fears of compassion, and their association with early negative emotional memories and psychopathology.

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Table 1

Descriptive Statistics of the Variables in Study (N = 302)

	<i>M</i>	<i>SD</i>	Cronbach' α
FC_Others	19.52	7.11	.88
FC_FromOthers	16.57	10.32	.91
FC_Self	16.61	12.41	.94
IES-R	3.73	2.52	.96
CES	42.04	18.18	.97
EMWSS	63.54	14.69	.97
DASS – Depression	7.05	8.19	.96
DASS – Anxiety	6.59	7.36	.93
GPS	42.91	12.39	.93

Note. FC_Others: Fears of Compassion for Others; FC_Self: Fears of Compassion for Self; FC_FromOthers: Fears of Compassion From Others; IES-R: Impact of Event Scale-Revised; CES: Centrality of Event Scale; EMWSS: Early Memories of Warmth and Safeness Scale; DASS: Depression, Anxiety and Stress Scales; GPS: General Paranoia Scale

Table 2

Pearson's Correlation Matrix (Two Tailed) of Study Variables (N = 302)

	1	2	3	4	5	6	7	8	9
1. FC_Others	1								
2. FC_Self	.50**	1							
3. FC_FromOthers	.51**	.70**	1						
4. IES-R	.18**	.33**	.36**	1					
5. CES	.16**	.37**	.36**	.61**	1				
6. EMWSS	-.13*	-.32**	-.34**	-.32**	-.24**	1			
7. DASS Depression	.22**	.54**	.48**	.46**	.43**	-.27**	1		
8. DASS Anxiety	.24**	.53**	.49**	.52**	.44**	-.25**	.85**	1	
9. GPS	.36**	.52**	.58**	.47**	.39**	-.32**	.54**	.56**	1

Note. FC_Others: Fears of Compassion for Others; FC_Self: Fears of Compassion for Self; FC_FromOthers:

Fears of Compassion From Others; IES-R: Impact of Event Scale-Revised; CES: Centrality of Event Scale;

EMWSS: Early Memories of Warmth and Safeness Scale; DASS: Depression, Anxiety and Stress Scales; GPS:

General Paranoia Scale

** $p < .001$

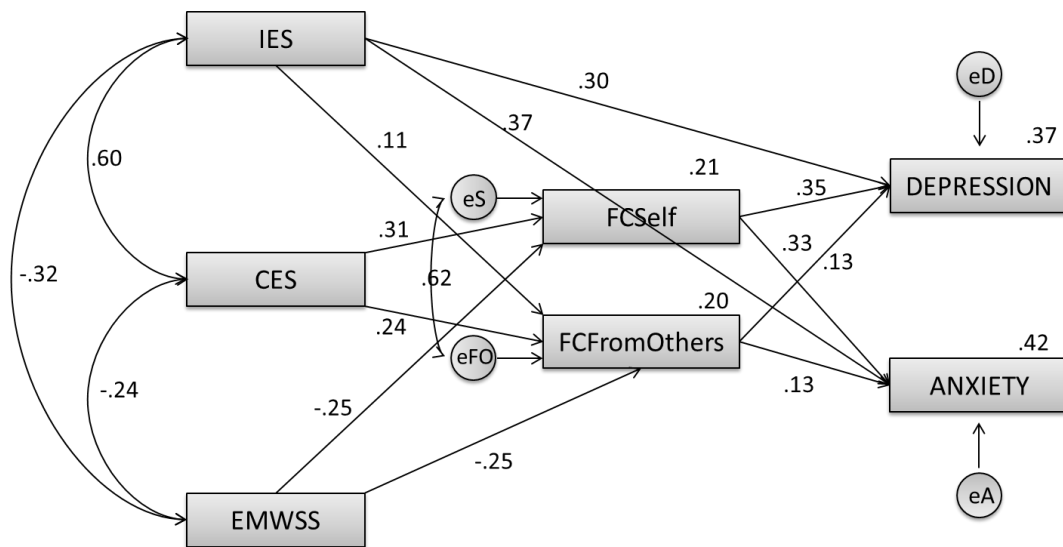


Figure 1. Results of mediation path analysis showing the relationships among fears of compassion (FCSelf, FCFromOthers), shame traumatic memories (IES-R), centrality of shame memories (CES) and early memories of warmth and safeness (EMWSS) and depression and anxiety symptoms.

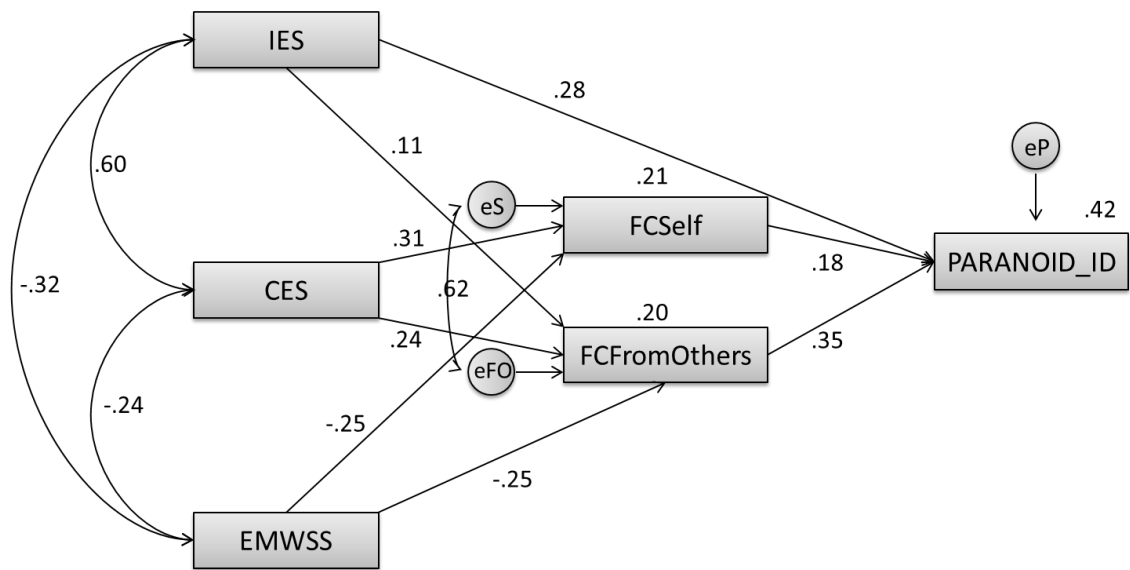


Figure 2. Results of mediation path analysis showing the relationships among fears of compassion (FCSelf, FCFromOthers), shame traumatic memories (IES-R), centrality of shame memories (CES) and early memories of warmth and safeness (EMWSS) and paranoid ideation.