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Scared of Compassion: Fear of Compassion in Anxiety, Mood, and Nonclinical Groups

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Author notes

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Abstract

Objectives: Fear of receiving compassion from others, expressing compassion to others, and being compassionate towards oneself have been identified as potentially important factors in the persistence of depression, stress disorders, and eating disorders. There is good reason to expect that these fears may play a role in anxiety and related difficulties, but there is little available information on the extent to which they are present and associated with symptom severity.

Methods: This study compared the severity of the three fears of compassion (receiving, expressing to others, and showing to oneself) in those with a principal diagnosis of depression ($n = 34$), obsessive-compulsive disorder (OCD; $n = 27$), social anxiety disorder (SAD; $n = 91$), generalized anxiety disorder (GAD, $n = 43$), and a control sample with no mental health difficulties ($n = 212$).

Results: Those with depression, OCD, SAD, and GAD exhibited greater fear of receiving compassion and fear of self-compassion than controls, and the differences between anxious and control groups remained significant even when controlling for depressed mood. Whereas fears of compassion did not predict symptom severity over and above depressed mood in people with GAD, fear of receiving compassion uniquely predicted SAD symptom severity, and fear of expressing compassion for others uniquely predicted OCD symptom severity in those high on fear of self-compassion.

Conclusions: Fear of compassion is higher in those with anxiety and related disorders than non-anxious controls. Although further research is needed, clinicians may benefit from assessing fear of compassion and addressing it in treatment.

Keywords: anxiety/anxiety disorders, OCD/obsessive-compulsive disorder, self-compassion, compassion, fear of compassion

Practitioner Points

- Those with anxiety and related disorders may fear receiving compassion from others or expressing compassion for themselves, even when controlling for depression
- It may be informative to assess for fear of compassion and incorporate discussions about these fears into treatment, as these fears may interfere with treatment progress

Main document (inc. figs and tables)

Scared of Compassion: Fear of Compassion in Anxiety, Mood, and Nonclinical Groups

Compassion is the sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it (Gilbert, 2017; Neff, 2003). It is theorized to have evolved as part of our human attachment system (Gilbert, 2014), which involves caring and soothing functions. As such, compassion is associated with positive mental wellbeing (Brown & Brown, 2015; Neff, 2009), and low self-compassion in particular is associated with a wide range of mental health difficulties (e.g., Barnard & Curry, 2011; MacBeth & Gumley, 2012). Treatments that address compassion, such as Compassion Focused Therapy (Gilbert, 2010, Gilbert, 2014), Mindful Self-Compassion (Germer & Neff, 2013), and Buddhist-derived Loving-Kindness and Compassion Meditations have been found to improve psychological wellbeing (e.g. Leaviss & Uttley, 2015; Neff & Germer, 2013; Shonin, Van Gordon, Compare, Zangeneh, & Griffiths, 2015).

There is good evidence that one's ability to be compassionate towards themselves or others is influenced by their early childhood experiences with attachment figures. For example, Mikulincer, Shaver, Gillath and Nitzberg (2005) found that self-compassion is lower in those with insecure attachment. More recently, Gilbert and colleagues proposed that those same early experiences may result in a *fear* of compassion; that is, for some people, being treated compassionately, expressing compassion towards others, and/or being compassionate towards the self is anxiety-provoking. Gilbert and colleagues speculated that a fear of compassion may develop in those who have learned associations between positive emotions and aversive outcomes, or for whom activation of the attachment system leads to activation of emotional memories (Gilbert, McEwan, Matos, & Rivis, 2011). Fear of compassion is thought to be an inhibitor or barrier for developing a compassionate stance towards yourself or others; in fact,

lower levels of fear of self-compassion are related to higher levels of self-compassion (e.g. Jazaieri et al., 2013). Fear of compassion has been shown to be associated with early experiences, such as shame memories (Matos, Duarte, and Pinto-Gouveia, 2017), childhood abuse (Miron, Seligowski, Boykin, and Orcutt, 2016), and maltreatment (Boykin, Himmerich, Pinciotti, Miller, Miron, & Orcutt, 2018), and is also related to current mental wellbeing, such as depression, stress, self-criticism, and distress (Gilbert et al., 2011; Kirby, Day & Sagar, 2019).

Although compassion is closely linked to mental wellbeing, to date there have been few investigations of fear of compassion and specific mental health difficulties. Fear of compassion has been implicated in the eating disorders (e.g. Kelly, Vimalakanthan, & Carter, 2014), post-traumatic stress disorder (e.g. Miron, Sherrill, and Orcutt, 2015), and, perhaps most extensively, in depression. In a sample of people with depression, Gilbert, McEwan, Catarino, Baiao, and Palmeira (2014) found that severity of depressive symptoms was associated with fear of self-compassion and fear of compassion from others. In a study of adolescents, fear of self-compassion was related to non-suicidal self-injury (Xavier, Gouveia, and Cunha, 2016). Several studies have shown that fear of compassion mediates the relationship between self-criticism and depression (Gilbert et al., 2014; Joeng & Turner, 2015), although one study found that fear of compassion from others was a moderator in this relationship (Hermanto et al., 2016).

Although fear of compassion has been shown to be relevant to some forms of psychopathology, there is currently no published research on the extent to which people with anxiety and related disorders fear compassion. A recent meta-analysis found moderate effect sizes for the relationship between fears of compassion and mental health outcomes; however, the authors noted that an area of lacunae in the literature is how fears of compassion compare across different anxiety disorders (Kirby, Day, Sagar, 2019). Given that fear of compassion is

associated with general levels of anxiety and stress (Gilbert et al., 2011), and is associated with anxious attachment, which is in turn associated with adult anxiety (e.g., Schimmenti and Bifulco, 2015), there is reason to expect it could be especially important to the development and persistence of anxiety and related disorders. In addition, those with anxiety disorders show lower levels of self-compassion than those without anxiety disorders. For example, Werner and colleagues (2012) found that those with social anxiety disorder (SAD) had lower self-compassion than controls, even when controlling for levels of depression and general anxiety, and that self-compassion was also inversely related to fear of evaluation. Similarly, self-compassion was found to be inversely related to the severity of obsessive-compulsive disorder (OCD; Wetterneck, Lee, Smith, & Hart, 2013) and with worry in people with generalized anxiety disorder (GAD; Hoge et al., 2013). However, the relationship between *fear* of compassion (that is, fear of compassion for others, fear of being treated with compassion, and fear of self-compassion) and presence and severity of anxiety disorders has not yet been studied.

Given that compassion-focused treatments are becoming more common, exploring the role of fear of compassion in the anxiety and related disorders is an important research aim. Since we know that a fear of compassion is amenable to treatment efforts (e.g. Goldin & Jazaieri, 2017; Jazaieri et al., 2013), collecting data on mean levels of fear of compassion across anxiety disorder groups may help us determine whether compassion-centered treatments for those with anxiety is indicated. Furthermore, fear of compassion may be implicated in the negative thoughts, assumptions, and schema that are targeted in cognitive-behavioural therapies (e.g. 'people will judge me if I do not respond appropriately to their acts of compassion'). In addition, fear of compassion is related to difficulty identifying and describing emotions, as well as lower mindfulness (Gilbert, McEwan, Gibbons, Chotai, Duarte & Matos, 2012), and higher perceived

risk of disclosure of negative events and emotions (Dupasquier, Kelly, Moscovitch, and Vidovic & 2018), all of which are potentially treatment-impairing behaviours, no matter the modality. Thus, exploring the role of fear of compassion in the anxiety disorders could reveal facets of their presentation, and in turn important new targets of treatment.

This study explores: a) the extent to which people with an anxiety or related disorder fear compassion, as compared to people with a mood disorder and those with no anxiety diagnosis; b) whether fear of compassion in anxiety disorder groups can be accounted for by symptoms of depression, and c) whether fear of compassion is related to symptom severity within each diagnostic group when controlling for depression. To this end, the Fear of Compassion Scale (FOCS) was administered to a community sample of people with a principal diagnosis of a mood disorder (either major depressive disorder or persistent depressive disorder), OCD, SAD, GAD, or a screened control sample with no mental health diagnoses. The FOCS is composed of three subscales; fear of showing compassion to others, fear of being treated compassionately, and fear of self-compassion. Based on previous research, we hypothesized that those with depression would have greater fear of self-compassion than the other groups, and that all clinical groups would have greater fear of all three types of compassion than the healthy controls. However, there were no theoretical grounds on which to predict whether the anxiety groups would differ on specific fears of compassion. Lastly, we expected that fear of compassion would predict anxiety disorder severity, above and beyond the predictive ability of symptoms of depression.

Methods

Procedure

Participants were recruited through the Anxiety Studies Division (ASD) at a Canadian University between 2015 and 2019. The ASD recruits adults aged 18+ from the community with and without an anxiety or related disorder (see Moscovitch et al., 2015). Interested participants responded to flyers or internet ads and were contacted by phone to be screened using the Mini International Neuropsychiatric Interview ("MINI") screening questions. Those who responded negatively to all of the MINI screening questions were considered to be "healthy controls" and were invited to complete demographic questions and study measures.

Those who reported anxiety on the screening questions were invited to come in to the lab for a full diagnostic assessment using the MINI, adapted for DSM-5 use (Sheehan et al., 1998; Sheehan, 2014). The MINI is a structured clinical interview that has shown agreement with other diagnostic measures. The MINI was administered by highly trained graduate clinicians who were supervised by registered psychologists. Diagnostic determinations were finalized after case presentation in a group supervision meeting. Assessors rated the severity of each diagnosis using a Clinical Severity Rating scale (CSR) from 0 to 7, with a 4 indicating clinically significant symptoms. Following the MINI, participants provided demographic information and completed a battery of self-report questionnaires, including those described below. All participants were compensated $40 for their participation.

Participants

For the purposes of this investigation, participants were grouped according to their principal diagnosis. In the case of co-morbidity, the principal diagnosis was considered to be the one with the highest CSR rating (Moscovitch et al., 2015). Diagnostic and demographic

information of the sample are presented in Table 1. The final sample consisted of 407 participants: 34 people who had a principal diagnosis of current Major Depressive Disorder (MDD) or Persistent Depressive Disorder (PDD), 27 people with a principal diagnosis of OCD, 91 people with a principal diagnosis of SAD (including 1 individual with performance-only SAD), 43 people with a principal diagnosis of GAD, and 212 control participants with no mental health problem.

Analysis of variance tests revealed no significant difference between groups on age (F(4,401)=.751, p=.558) or clinical severity (F(3,190)=1.951, p=.123). The most frequent ethnicity reported by this sample was White (67.5%), followed by South Asian (10.4%) and Asian (10.0%), with all other ethnicities each making up less than 4% of this sample. Chi squared tests revealed no differences between groups on ethnicity (χ^2(40)=47.294, p=.199) or gender composition (χ^2(4)=7.485, p= .112), although each group was primarily comprised of women.

[Table 1 here]

Measures

The Fears of Compassion Scales (FOCS; Gilbert et al., 2011) include three self-report scales intended to assess fear of expressing compassion for others (10 items; FOCS-EXP), fear of receiving compassion from others (13 items; FOCS-REC), and fear of self-compassion (15 items; FOCS-SC). This measure includes items such as “People will take advantage of you if you are too forgiving and compassionate” (FOCS-EXP), “Feelings of kindness from others are somehow frightening” (FOCS-REC), and “I feel that I don’t deserve to be kind and forgiving to myself” (FOCS-SC). All items are rated on a 5-point Likert Scale, from 0 (“Don’t agree at all”) to 4 (“Completely agree”). Higher scores indicate greater fear of compassion. In our sample,

reliability of the fear of compassion for self and from others scales were very strong (α = .945 and .924, respectively), as was that of the fear of compassion for others scale (α = .875).

The Depression Anxiety Stress Scale (DASS-21; Lovibond & Lovibond, 1995) is a 21-item self-report measure assessing mental health symptoms over the past week. This measure has shown strong internal consistency, convergent and discriminant validity, and a consistent three-factor structure in clinical and non-clinical samples (Brown, Chorpita, Korotitsch, & Barlow, 1997; Lovibond & Lovibond, 1995). In this paper, the depression (DASS-D) and stress (DASS-S) scales were used to measure depression severity and generalized anxiety severity, respectively. The anxiety scale (DASS-A) has been shown to measure physical hyperarousal (Antony et al., 1998), and is more applicable to panic disorder, so was excluded in this study. The depression scale, consisting of 7 items, asks questions about common depression symptoms, such as the ability to experience positive emotions, motivate oneself, and self-worth. The stress scale consists of 7 items, including items that assess nervous energy, over-reactions, worry, and ability to relax. Respondents select a number from 0 ("Did not apply to me at all") to 3 ("Applied to me very much, or most of the time"). In this sample, reliability of the depression scale was very strong (α = .930), as was that of the stress scale (α = .895).

The Dimensional Obsessive-Compulsive Scale (DOCS; Abramowitz et al., 2010) is a 20-item, self-report measure used to assess OCD symptoms and severity (e.g. time spent on OCD concerns, avoidance of triggers). Items are scored from 0, indicating an absence of that symptom, to 4, indicating an extreme presence of that symptom. This scale shows good internal consistency, convergent validity, and ability to discriminate those with OCD from those with other anxiety disorders and from a non-clinical population of students. In our sample, the

reliability of this scale was very strong (α = .902). This was included as a symptom severity measure of OCD.

The Social Phobia Inventory (SPIN; Conner et al., 2000) is a 17-item measure intended to assess the breadth and depth of social anxiety in respondents. This measure includes items that assess how much respondents fear social situations, as well as fear of physical symptoms of anxiety in social situations. Respondents reply to items on a 5-point Likert scale from “not at all” to “extremely” bothered by these symptoms in the past week. It has shown good internal consistency, test-retest reliability, convergent and divergent validity, and ability to distinguish those with social anxiety from those with panic disorder or obsessive-compulsive disorder (Conner et al., 2000; Antony, Coons, McCabe, Ashbaugh, & Swinson, 2006). In this study, we used the SPIN to assess severity of social anxiety concerns (α= .957).

Results

Analyses were conducted using SPSS version 24. Prior to analyses, data were examined for outliers within groups. Outliers were defined as data points three standard deviations or further from the group mean and discontinuous from the distribution. Outliers were replaced with the second most extreme data point in that group (Kwak & Kim, 2017). In the control group there were two outliers on the FOCS-SC subscale and one outlier on the FOCS-Total. In the depression group there was one outlier on DASS-D scores. Skew and kurtosis for these variables were within acceptable limits (Kline, 1998). Correlations between symptom severity scales and fear of compassion scales were all significant (See Table 2), and the fear of compassion scales were moderately to highly correlated with each other.

[Table 2 here]

Fear of compassion across diagnostic groups

A multivariate analysis of variance (MANOVA) was conducted on the three FOCS scale scores, with diagnostic group as the independent variable. We hypothesized that those in the mood disorder group would have higher fears of self-compassion than the other groups, and that the mood and anxiety disorder groups would have higher scores on all three FOCS subscales than the group with no diagnosis. Means and standard deviations of the fear of compassion scales across groups are presented in Table 3. The effect of group was significant, Wilk's λ (16)= .635, $p < .001$, $\eta_p^2 = .140$. Tests of univariate between-subjects effects revealed significant group differences on all three subscales.

[Table 3 here]

To determine group differences on each subscale, post hoc analyses using Scheffe's tests were conducted. Results for each subscale are described below.

Fear of expressing compassion to others. Although there was a significant univariate main effect of group on the fear of expressing compassion scale, no two groups differed significantly from each other.

Fear of receiving compassion from others. Post hoc tests revealed that the control group had significantly lower scores on the fear of receiving compassion scale than all clinical groups. Furthermore, those in the MDD/PDD and SAD groups had higher fear of receiving compassion than those in the GAD group. The OCD group did not significantly differ from the MDD/PDD, SAD, and GAD groups.

Fear of self-compassion. Post hoc tests revealed that all clinical groups had higher scores on the fear of self-compassion scale than did the control group. The MDD/PDD group had higher scores than the GAD group. There were no other between-groups differences.

Fear of compassion when controlling for depression

To explore whether greater fear of compassion in those with anxiety and related disorders could be accounted for by depressed mood, we first examined the correlation between the three self-compassion scales and the Depression scale of the DASS, collapsing across anxiety diagnoses (note that we did not include the MDD/PDD group in this analysis; see Table 4). Depression scores correlated significantly with fear of receiving compassion from others and fear of self-compassion. Correlations between fear of compassion scales remain significant when controlling for depression.

[Table 4 here]

In order to determine whether severity of symptoms of depression accounted for differences between the control and anxious groups, a MANOVA was conducted with group (Controls, OCD, SAD, and GAD) as the fixed factor, DASS-D scores as a covariate, and the three fear of compassion scores as the dependent variables. The main effect of group was significant, Wilk's λ (9)= .90, $p < .001$, $\eta_p^2 = .03$. We thus examined the between-subjects effects. The univariate effect of group on fear of expressing compassion towards others was no longer significant, $F(3, 369) = 0.85$, ns. The univariate effect of group on fear of receiving compassion was significant, $F(3, 369) = 10.44$, $\eta_p^2 = .08$, $p < .001$, as well as the univariate effect of group on fear of self-compassion, $F(3, 369) = 5.50$, $\eta_p^2 = .04$, $p < .001$. Post-hoc follow up tests using simple contrasts revealed that each of the three clinical groups had greater fear of receiving compassion than the controls ($F(3, 364) = 10.44$, $\eta_p^2 = .08$, $p < .001$) and greater fear of self-compassion than the controls ($F(3, 364) = 5.49$, $\eta_p^2 = .04$, $p < .001$). Simple contrasts revealed that the SAD group had greater fear of receiving compassion than did those with GAD ($F(1, 129) = 13.16$, $\eta_p^2 = .09$, $p < .001$). Thus, differences between the anxiety groups on fear of receiving compassion and fear of self-compassion observed earlier remained significant when controlling for depression.

Fear of compassion and symptom severity

Finally, we examined whether fear of compassion predicted symptom severity in the anxiety and related disorders groups, controlling for symptoms of depression. To this end, we conducted linear regression analyses on severity measures (DOCS for OCD severity, SPIN for SAD severity, and DASS-S for GAD severity) within each clinical anxiety group, entering the DASS-D on the first step and the fear of compassion scales on the second step. All collinearity

statistics were within acceptable range (VIF<4, Tolerance>.20; Hair et al., 2010). See Table 5 for descriptive statistics on symptom severity scales in each group.

[Table 5 here]

We expected that fear of compassion would predict anxiety symptom severity when controlling for depressed mood. See Table 6 for regression results. Within the SAD group, depression scores significantly predicted social anxiety severity ($R^2 = .110$, F (1, 87) = 10.603, $p = .002$). The FOC scales on the second step resulted in a near-significant R^2 change (R^2 change = .080, F (4, 87) = 4.85, $p = .050$). Of the fear of compassion scales, only the FOCS-REC coefficient was significant in predicting SPIN scores, $\beta = .324$, $p = .046$. For those with GAD, depression scores predicted severity ($R^2 = .279$, F (1, 42) = 15.875, $p < .001$), but FOC did not (R^2 change = .006, F (4, 42) = 3.79, $p = .958$).

Within the OCD group, depression scores predicted OCD severity ($R^2 = .314$, F (1, 26) = 11.45, $p = .002$), but entry of the FOC scales on the second step did not (R^2 change = .161, F (4, 26) = 2.25, $p = .111$). However, within this step, fear of expressing compassion for others was a significant predictor of OCD severity, $\beta = .370$, $p = .048$. Inspection of the zero-order and semi-partial correlations indicated that fear of self-compassion was operating as a suppressor variable, with a zero order r of .149, but a partial correlation of -.312. We conducted exploratory follow-up analyses using a median split on fear of self-compassion and conducted separate regression analyses on each group on OCD severity, with DASS-D entered on the first step followed by the fear of expressing and fear of receiving compassion scales. We found that for those low in fear of self-compassion (n =14), fear of expressing compassion to others was not predictive of OCD severity beyond depression scores (R^2 change = .003, ns). However, for those high in fear of self-compassion (n = 13), addition of the FOC scales resulted in a significant change in R^2 of .45 (p <

.01). Fear of expressing self-compassion was a significant unique predictor of OCD symptoms (sr^2 = .35, p < .004), such that greater fear was associated with greater symptom severity. However, these results should be interpreted with caution given the low *n*s.

[Table 6 here]

In sum, severity of OCD, SAD, and GAD was predicted by severity of symptoms of depression. When controlling for depression, fear of expressing compassion for others was a significant predictor of OCD severity for those high on fear of self-compassion. Fear of receiving compassion uniquely predicted SAD severity over and above depression scores. Fear of compassion did not predict GAD severity when depression was controlled for.

Discussion

The aim of this study was to investigate the extent to which people with anxiety and related disorders fear compassion, as compared to those with a mood disorder and no diagnosed mental health difficulty. We hypothesized that all clinical groups would score higher than the controls on all three compassion fears, but that those with depression would have the highest fear of self-compassion. This prediction was partially supported; all clinical groups scored higher than controls on fear of self-compassion and fear of receiving compassion, even when controlling for depression. The depressed group was only higher than the GAD group on fear of self-compassion. We did not find group differences on fear of expressing compassion for others. This finding fits with the extant literature, which shows that the fear of expressing for others subscale is less related to mental health outcomes than the other two subscales (Kirby, Day, & Sagar, 2019). It may be that giving and receiving compassion are related to different biological processes.

That people with GAD showed less fear of receiving compassion and less fear of self-compassion than those with depression, and less fear of receiving compassion than those with SAD, may reflect differences in the self-view. Whereas depression and social anxiety tend to be characterized by negative core ideas about the self (e.g., I am worthless, I am incompetent, I am unlovable; Harris & Curtin, 2002; Pinto-Gouveia, Castilho, Galhardo, & Cunha, 2006), GAD is characterized by negative core ideas about the world (e.g., the world is a dangerous place; Riskind & Williams, 2005). For those with depression or social anxiety, negative core ideas about the self may cause people be less able to believe or accept that they deserve compassion. Future research could explore the extent to which fear of compassion relates to core beliefs in people with anxiety disorders.

Another aim of the study was to determine whether fear of compassion predicted symptom severity in those with SAD, OCD, and GAD, controlling for severity of symptoms of depression. In the GAD group, fear of compassion did not predict symptom severity when controlling for depression. Fear of compassion may be less relevant to the severity of GAD than other disorders. However, our study is limited in that we used the DASS-S to assess GAD severity. Although it is highly correlated with measures of GAD, it was not developed specifically to assess GAD. Future work could explore this relationship with more specific measures (e.g. the Penn State Worry Questionnaire; Meyer, Miller, Metzger, & Borkovec, 1990).

In the OCD group, greater fear of expressing compassion to others was a significant predictor of greater symptom severity for those with high fear of self-compassion. These findings should be taken with caution, given that the change in R^2 for that step was not significant, the sample size for this group was limited, and the analyses used to explore the suppression effect were post-hoc. However, critical parenting is a well-studied phenomenon in OCD (e.g. Chambless & Steketee, 1999). Those who experienced punitive or critical parenting may have been less likely to see compassion modeled, and may develop negative beliefs about showing compassion to self and others. In fact, exploratory analyses show that, within the OCD group, the two FOC-EXP items that were most correlated with OCD severity scores were ‘people will take advantage of me if they see me as too compassionate’ (r=.46) and ‘being compassionate towards people who have done bad things is letting them off the hook’ (r=.47). The latter item may be related to the moral rigidity that is sometimes noted in OCD presentations (e.g. Whitton, Henry, & Grisham, 2014). Furthermore, people with more severe OCD may worry that showing compassion to family members will result in a reduction in family member accommodation of OCD symptoms (e.g. providing reassurance, following OCD-driven rules, or allowing

completion of compulsion to take priority; Calvocoressi et al., 1995). Future research could examine whether high family accommodation and/or criticism is associated with greater fear of expressing compassion for others in those with OCD.

We found that fear of receiving compassion was associated with greater SAD symptom severity, when controlling for depression. This is consistent with the finding that people with social anxiety uniquely not only fear negative evaluation, but also fear positive evaluation (e.g., Weeks & Howell, 2012). People with SAD may worry that if others get too close, they will discover flaws or weaknesses. For example, exploratory analyses show that, within the SAD group, the item 'if people are friendly and kind, I worry they will find out something bad about me that will change their mind' was significantly correlated with social anxiety severity scores ($r = .39$). This may be one explanation for the findings that those who fear receiving compassion (Dupasquier et al., 2018) and those with social anxiety (Meleshko & Alden, 1993) tend to engage in less self-disclosure, which can impede the development of meaningful relationships. Finally, people with social anxiety may mistrust the motive behind expressions of compassion by others, attributing it to pity or politeness as opposed to genuine compassion. For people with SAD, fear of receiving compassion may be an obstacle to gracious responding to expressions of compassion, which in turn may alienate support networks, and may also be a barrier to treatment seeking. Future research could examine the extent to which fear of compassion relates to treatment seeking behaviour.

These findings are preliminary as our sample sizes were relatively small and were overrepresented by women. Further work should explore these variables in a more representative sample, as gender differences have been found for fear of compassion (Gilbert et al., 2011). In addition, these findings can only apply to a small number of clinical representations; for

example, this study cannot speak to the role of fear of compassion in externalizing disorders. Further work could also explore whether there are more complex relationships between psychopathology symptoms and fear of compassion. For example, it is possible that depression moderates the relationship between anxiety and fear of compassion. Unfortunately, due to the sample sizes for our clinical groups, particularly the OCD group, we were unable to properly test this in the current study. Finally, our control sample was screened but was not administered the full MINI. As such, it is possible that the sample included people with a clinically significant disorder, which could reduce the difference in means between our healthy controls and those with a diagnosis.

Despite these shortcomings, our findings provide data on the FOCS scales in samples of people with OCD, GAD, and SAD. The scores in our anxiety groups were on par with those of the group with depression, and were greater than those of the healthy controls when controlling for depression. The association between fear of compassion and both OCD and SAD symptom severity was not accounted for solely by depression. This suggests that there is merit in conducting further research on this construct for those with anxiety and related disorders. In terms of clinical implications, this study suggests that there is merit in assessing fear of compassion in people seeking treatment for anxiety and related disorders. If relevant, this fear should be targeted, as it may be an impediment to treatment engagement and progress. There is some evidence that fear of compassion can be reduced through the use of compassion-centered treatments; however, future research could explore whether fear of compassion could be targeted through other modalities, and if so, the types of techniques that may be useful.

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Tables and Figures

Table 1. Demographic and diagnostic information, by diagnostic group

Diagnostic Group (n)	Mean CSR (SD)	Mean age (SD)	% female
Control (212)	--	29.14 (11.73)	66.5
MDD/PDD (34)	5.44 (1.11)	31.47 (14.48)	80.0
OCD (27)	5.22 (0.70)	26.81 (8.79)	74.1
SAD (91)	5.07 (0.74)	27.27 (10.20)	64.8
GAD (43)	5.26 (0.66)	28.54 (11.62)	76.7

Note. CSR= clinical severity rating. MDD/PDD= major depressive disorder/persistent depressive disorder. OCD=obsessive-compulsive disorder. SAD=social anxiety disorder. GAD=generalized anxiety disorder.

Table 2. Zero-order correlations between Fear of Compassion scales and Anxiety and Depression severity scales in the whole sample.

	FOCS-EXP	FOCS-REC	FOCS-SC	DASS-D	DOCS	SPIN	DASS-S
FOCS-EXP	-	.48**	.37**	.17**	.27**	.24**	.20**
FOCS-REC		-	.81**	.63**	.47**	.66**	.59**
FOCS-SC			-	.66**	.43**	.59**	.58**
DASS-D				-	.53**	.65**	.74**
DOCS					-	.47**	.58**

SPIN			-	.66**

Note. FOCS-EXP= Fear of expressing compassion for others. FOCS-REC= Fear of receiving compassion from others. FOCS-SC= Fear of self-compassion. DASS-D = Depression, Anxiety, Stress Scales, Depression subscale. DOCS= Dimensional Obsessive-Compulsive Scale. SPIN= Social Phobia Inventory. DASS-S= Depression Anxiety Stress Scales, Stress subscale. ** indicates $p < .001$. *N*s range from 403-407.

Table 3. Fears of compassion, by group

FOCS Scale	Group (n)	Mean Score (SD)	Univariate *F* value (df)
Fear of expressing compassion for others	Control (212)	16.72 (8.63)	3.065 (4,402)
	MDD/PDD (35)	20.66 (7.34)	$\eta_p^2 = .029$
	OCD (27)	18.52 (8.00)	$p < .02$
	SAD (90)	19.48 (8.97)	
	GAD (43)	16.35 (8.66)	
Fear of receiving compassion from others	Control (212)	11.39 (9.27)	45.43 (4,402)
	MDD/PDD (35)	26.97 (11.20)	$\eta_p^2 = .311$
	OCD (27)	23.15 (12.06)	$p < .001$
	SAD (90)	25.41 (10.19)	
	GAD (43)	17.91 (9.10)	
Fear of self-compassion	Control (211)	10.72 (10.98)	42.46 (4,402)
	PDD/MDD (35)	30.63 (12.49)	$\eta_p^2 = .300$
	OCD (27)	25.19 (13.64)	$p < .001$
	SAD (91)	25.43 (12.31)	
	GAD (43)	20.12 (12.17)	

Note. MDD/PDD = major depressive disorder/persistent depressive disorder, OCD = obsessive-compulsive disorder. SAD = social anxiety disorder. GAD = generalized anxiety disorder.

Table 4. Correlations between Fear of Compassion scales and Depression scale in anxiety groups.

	FOCS-EXP	FOCS-REC	FOCS-SC	DASS-D

FOCS-EXP	-	.38**	.19*	.03
FOCS-REC	.41**	-	.75**	.42**
FOCS-SC	.21*	.67**	-	.48**

Note. Zero-order correlations are above the diagonal and partial correlations (controlling for depression) are below the diagonal. FOCS-EXP= Fear of expressing compassion for others. FOCS-REC= Fear of receiving compassion from others. FOCS-SC= Fear of self-compassion. DASS-D = Depression scale of the Depression, Anxiety, Stress Scale. * indicates $p < .05$, ** indicates $p < .001$. *N*s range from 156-157.

Table 5. Severity scores, by diagnostic group

Diagnostic Group (n)	Mean DASS-D (SD)	Mean DOCS Total (SD)	Mean SPIN Total (SD)	Mean DASS-S (SD)
Control (212)	2.72 (3.33)	8.07 (10.42)	13.80 (11.51)	3.33 (2.24)
MDD/PDD (34)	14.91 (3.66)	16.35 (11.86)	39.59 (14.28)	11.88 (3.98)
OCD (27)	8.81 (6.09)	31.19 (12.50)	32.19 (17.55)	10.63 (5.01)
SAD (91)	9.45 (5.52)	16.32 (11.97)	44.21 (10.87)	9.97 (4.78)
GAD (43)	8.19 (4.92)	19.35 (11.87)	33.05 (11.51)	11.88 (3.87)

Note. DASS-D= Depression Anxiety Stress Scales, Depression subscale. DOCS= Dimensional Obsessive-Compulsive Scale. SPIN= Social Phobia Inventory. DASS-S= Depression Anxiety Stress Scales, Stress subscale. MDD/PDD = major depressive disorder/persistent depressive disorder. OCD=obsessive-compulsive disorder. SAD=social anxiety disorder. GAD=generalized anxiety disorder.

Table 6. Regression results: Predicting symptom severity from fear of compassion scales

Group	Step	Predictor	R	R^2 change	p	β	r	sr^2
OCD	1	DASS-D	.561	.314	.002	.561*	.561	.315
	2	FOC-EXP	.689	.161	.111	.370*	.382	.105
		FOC-REC				.202	.208	.014

		FOC-SC				-.409	.149	.057
SAD	1	DASS-D	.331	.110	.002	.331*	.331	.110
	2	FOC-EXP	.435	.080	.050	-.193	-.085	.032
		FOC-REC				.324*	.343	.040
		FOC-SC				-.008	.295	<.001
GAD	1	DASS-D	.566	.320	<.001	.566*	.566	.320
	2	FOC-EXP	.576	.011	.891	.056	.037	.002
		FOC-REC				.092	.344	.003
		FOC-SC				-.046	.333	<.001

Note. OCD=obsessive-compulsive disorder. SAD=social anxiety disorder. GAD=generalized anxiety disorder. DASS-D= Depression Anxiety Stress Scales, Depression subscale. FOCS-EXP= Fear of expressing compassion for others. FOCS-REC= Fear of receiving compassion from others. FOCS-SC= Fear of self-compassion. * indicates $p < .05$, **.