Fear of Compassion is Associated with Treatment Ambivalence and Negative Expectations for Treatment in People with Anxiety

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Author notes

The authors have no known conflicts of interest with regard to this paper. Correspondence concerning this article should be addressed to Olivia A. Merritt at the above address or oamerritt@uwaterloo.ca or 1-519-888-4567 ext. 38809.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Practitioner Points

- Fears of receiving compassion and self-compassion were related to treatment ambivalence and negative treatment expectations
- There may be benefit in targeting fear of compassion early in treatment

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Anxiety disorders have a lifetime prevalence of 17% (Somers, Goldner, Waraich, & Hsu, 2006) and have high social and economic costs (DuPont et al., 1996). Although anxiety disorders can be effectively treated (e.g., Bandelow et al., 2015) less than a quarter of people with an anxiety disorder seek treatment (Alonso et al., 2007) and often after many years of suffering (Cullen et al., 2008; Hollander et al., 1996). Of those who enter treatment, one fifth drop out early, and of those who complete treatment, one third fail to respond (Taylor, Abramowitz, & McKay, 2012). We know that fears and expectations about therapy can influence people's desire to enter treatment (Carlton & Deane, 2000; Deane, Chamberlain, 1994; Deane & Todd, 1996; Thomas, Caputi, & Wilson, 2014; Vogel, Wester, Wei, & Boysen, 2005) and treatment success (Price & Anderson, 2012; Price, Anderson, Henrich, & Rothbaum, 2008; Safren, Heimberg, Juster, 1997). However, we know very little about what factors are associated with treatment attitudes.

Regardless of modality, therapy requires that clients make themselves vulnerable, face their difficulties, and form a supportive relationship with a stranger. Common factors in therapy success include warmth and empathy (Wampold, 2012). It may be that people's ability to receive compassion and to accept a compassionate understanding of their symptoms are important factors in treatment success. Indeed, therapy has been found to yield an increase in self-compassion even when compassion is not directly targeted (Schanche et al., 2011). However, people whose attachment experiences are associated with aversive outcomes are more likely to fear compassion (e.g., Boykin, Himmerich, Pinciotti, Miller, Miron, & Orcutt, 2018; Miron,

Seligowski, Boykin, and Orcutt, 2016). Fear of compassion (FOC) has been associated with stress (Gilbert et al., 2011), shame, self-criticism, and depression (Kirby, Day & Sagar, 2019). The shame associated with FOC is thought to prevent people from accessing social supports. It may also interfere with tasks upon which therapy relies for success. For example, lower self-compassion is itself associated with avoidant coping strategies (Neff, Hseih, and Dejitterat, 2005). Fear of compassion is associated with difficulty identifying and describing emotions (Gilbert, McEwan, Gibbons, Chotai, Duarte & Matos, 2012) and fear of receiving compassion from others is associated with the tendency to conceal feelings of distress (Dupasquier, Kelly, Moscovitch, & Vidovic, 2018).

People with anxiety disorders are more likely to have insecure attachment styles (Kerns & Brumariu, 2014; Schimmenti & Bifulco, 2015) and report greater fear of self-compassion and of receiving compassion than those with no mental health diagnosis, even when controlling for depression (Merritt & Purdon, 2020). Qualitatively, those with depression and anxiety report that, although compassion may be helpful, their mental health challenges impair their ability to be self-compassionate (Pauley & McPherson, 2010). Those with anxiety and those who fear compassion may be among those who would benefit most from therapy. However, their fear of compassion may foster ambivalence about seeking treatment and negative expectations for its success. To date, the relationship between FOC and treatment fears and expectations in people with anxiety disorders has not been directly explored. In the current study we administered the FOC scales and measures of ambivalence about receiving cognitive behaviour therapy (CBT), which is the most widely recommended treatment for anxiety disorders, and expectations of CBT success to people high in anxiety and to those diagnosed with an anxiety disorder. We expected

that greater fear of receiving compassion from others and fear of self-compassion would be related to greater ambivalence about treatment and more negative expectations for treatment.

Methods

Procedure

Two samples of participants were recruited. The first was an analogue sample recruited from a large pool of students who scored at or above the 75th percentile on the DASS– Stress (DASS-S) Subscale, and who received course credit for their participation. The scale was re-administered at the time of the study so we could exclude those no longer above cut off. The clinical sample was recruited from the participant pool of the Anxiety Studies Division (ASD) at a mid-sized Canadian University, which comprises adults with anxiety disorders from the community (Moscovitch et al., 2015). Diagnostic assessment was established using the MINI, DSM-5 adaptation, supplemented by questions from the Anxiety Disorders Interview Schedule (Brown, Barlow, & DiNardo, 1994; Sheehan et al., 1998; Sheehan, 2014). The study was conducted online. After providing informed consent, participants read a brief overview of cognitive behaviour therapy (CBT) and answered questions about what they had read. This was to ensure that all participants had a basic common understanding of CBT. Participants then completed demographic measures and questions about their treatment history, and completed the of fears of compassion, treatment ambivalence, and treatment expectations measures. This study received approval by the university ethics board.

Participants

Analogue sample: Participants whose in-study DASS-S score did not exceed the clinical cutoff score of 12.42 (Ronk, Korman, Hooke & Page, 2013) or who reported no impairment due

to anxiety, were removed from analyses; 32 participants were excluded due to low DASS-S scores and a further 5 were removed due to having no impairment. The final sample (n = 302) had an average age of 19.9 years. The sample was 85.4% female (n=258), 11.3% male (n=34), 3.0% non-binary (n=9) (one non-response), and included people who identified as White (40.7%, n=123), East Asian (19.9%, n=60), and South Asian (17.5%, n=53). Other ethnicities were represented by less than 6% of our sample. With respect to anxiety symptoms, 37.1% (n=112) had received a diagnosis for their anxiety, 44.7% (n=135) had attended therapy for their anxiety at some point in their life, and 13.2% (n=40) were currently in therapy for their anxiety. 29.5% (n= 89) of participants reported that their anxiety is impairing 'to a small degree', 46.4% (n= 140) 'to a moderate degree' and 24.2% (n= 73) 'to a great degree'. The mean DASS-S score in this sample was 28.0 (SD 7.3).

Clinical sample: The clinical sample (n=40) had an average age of 31.7 years. The sample was 82.5% female (n= 33), 12.5% male (n=5), and 5% (n=2) non-binary and included people who identified as White (75%, n=30) and East Asian (7.5%, n=3), with all other ethnicities representing less than 6% of the sample. Principal diagnoses included OCD (10%, n=4), social anxiety disorder (52.5%, n=21), generalized anxiety disorder (25%, n=10), panic disorder (5%, n=2), illness anxiety disorder (5%, n=2), and other specified anxiety disorder (2.5%, n=1), with a subset of the sample meeting for co-principal diagnoses of agoraphobia (n=3), persistent depressive disorder (n=3), specific phobia (n=1), major depressive disorder (n=1), and alcohol use disorder (n=1). With respect to treatment, 75% (n=30) had attended therapy for their anxiety, and 27.5% (n=11) were currently in therapy for their anxiety. The mean DASS-S score in this sample was 20.3 (SD 9.6).

Measures

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). The DASS anxiety scale measures physical, panic-like symptoms (Antony et al., 1998), whereas the DASS stress scale measures worry, anxious energy, and ability to relax; thus, the latter was used in this study to select analogue participants with anxiety. The scale's 7 items are answered on a 0 ("Did not apply to me at all") to 3 ("Applied to me very much, or most of the time") scale. Scale totals are doubled so scores are comparable to the DASS-42. The internal consistency (Cronbach's alpha, "*a*") of the DASS-S was acceptable in both samples ($a_{analogue}$= .71, $a_{clinical}$= .82); the lower reliability in the analogue sample may be due to truncation of range of scores, as only those scoring in the higher range were included in these analyses.

The Fears of Compassion Scales (FOCS; Gilbert et al., 2011) comprise three self-report measures of fear of expressing compassion for others (10 items; FOCS-EXP; 'people need to help themselves rather than waiting for others to help them'), fear of receiving compassion from others (13 items; FOCS-REC; 'wanting others to be kind to oneself is a weakness'), and fear of self-compassion (15 items; FOCS-SC; 'I feel that I don't deserve to be kind and forgiving to myself'). Items are rated on a 5-point Likert Scale, from 0 ("Don't agree at all") to 4 ("Completely agree"). Higher scores indicate greater fears of compassion. All three scales have good psychometric properties (Gilbert et al., 2011).

The Treatment Ambivalence Questionnaire (TAQ; Rowa et al., 2014) is a 26-item scale assessing common concerns about treatment, which shows good internal consistency and

discriminant validity in those with anxiety. It consists of three subscales: personal consequences (e.g., 'I'm starting treatment more for other people than for myself'), adverse reactions (e.g., 'treatment might cause me too much anxiety or distress'), and inconvenience (e.g., 'treatment is going to be too time-consuming'). Items are rated on a 7-point scale from 'strongly disagree' to 'strongly agree'. Higher scores indicate greater ambivalence about treatment.

The Stanford Expectations for Treatment Scale (SETS; Younger, Gandhi, Hubbard, & Mackey, 2012) is a 6-item scale assessing positive and negative expectations for treatment, which shows good reliability and predictive validity in medical settings. For the purpose of this study, item 3 was modified slightly to refer to anxiety ('my anxiety will be completely resolved after treatment'). Respondents choose from a 7-point scale ranging from 'strongly agree' to 'strongly disagree'. Three items are averaged to form the positive expectations scale, and the other three for the negative expectations scale (e.g. 'I am nervous about the negative effects of this treatment').

Results

Analyses were conducted using SPSS version 24. Skew and kurtosis for all variables were within acceptable limits (Kline, 1998). To assess our hypothesis about the relationship between fears of compassion and treatment ambivalence and expectations, we performed bivariate correlations between the scales (see *Table 1*). Findings were consistent across groups. Fears of receiving compassion and of self-compassion were significantly correlated with TAQ-Inconvenience (INC) scores in the analogue sample, and non-significant, similar magnitude correlations in the smaller clinical sample. Fear of expressing compassion for others was significantly related to all three TAQ scales in the analogue sample, and to TAQ-Personal Consequences (PC) and TAQ-Adverse Reactions (AR) in the clinical sample. All three FOC

scales showed significant correlations to the SETS negative scale in the analogue sample, but fear of receiving compassion was the only significant correlation with this scale in the clinical sample. Of note, in both samples there were strong correlations between fear of receiving compassion and fear of self-compassion and treatment ambivalence, specifically the personal consequences and adverse reactions subscales. The relationships had a large effect size in the clinical sample and a medium effect size in the analogue sample (Cohen, 1992). Content analysis of the scale items indicates that these strong correlations are not due to content overlap. To establish whether anxiety influenced these relationships, partial correlations controlling for DASS-S score were calculated. The pattern of correlations was identical (i.e., those that were significant before remained significant, and absolute values showed only minor variations), with the exception of the correlation between TAQ-INC and FOEC in the analogue sample, which became non-significant.

Table 1. Bivariate correlations: fears of compassion and treatment attitudes

	1. FOEC	2. FORC	3. FOSC	4. AMB–PC	5. AMB–AR	6. AMB–INC	7. Positive expectations	8. Negative expectations
1	.883 *.872*	.463*** *.454***	.333*** *.360**	.347*** *.457***	.182** *.429**	.116* *.325*	.119* *.061*	.207*** *.245*
2		.892 *.937*	.707*** *.766****	.504*** *.666****	.355*** *.760****	.304*** *.232*	-.053 *-.070*	.289*** *.417**
3			.924 *.930*	.474*** *.629****	.360*** *.563***	.281*** *.166*	-.070 *-.204*	.240*** *.163*
4				.894 *.876*	.610*** *.761****	.534*** *.427***	-.042 *-.024*	.448*** *.442**
5					.856 *.861*	.478*** *.546****	-.259*** *-.131*	.531*** *.519***

6	.720 *.671*	-.132* *-.149*	.384*** *.345**
7		.756 *.790*	-.024 *.183*
8			.782 *.753*

Note. Correlations for the analogue sample (*n*s=291-300) are in the top row, with correlations for the clinical sample (*n*s=34-40) below them and italicized. Cronbach's alphas are represented along the grey diagonal. FOEC= fear of expressing compassion, FORC= fear of receiving compassion, FOSC= fear of self-compassion; AMB= Treatment Ambivalence, with fears of personal consequences (PC), adverse reactions (AR), and inconvenience (INC) listed, respectively; Positive expectations and negative expectations are subscales of the Stanford Expectations for Treatment Scale (SETS). *** $p < .001$, ** $p < .01$, * $p < .05$.

Discussion

This study investigated whether fear of compassion (FOC) was related to treatment ambivalence and expectations in those with anxiety. The data supported our hypothesis that fear of receiving compassion and fear of self-compassion would be most strongly related to treatment ambivalence and negative expectations for treatment. The association between these factors was the same even when controlling for anxiety. The relationship between fear of receiving compassion and fears of adverse reactions was particularly strong, indicating that those who fear receiving compassion may expect treatment to be distressing. This is consistent with the notion that receiving compassion can lead to overwhelming feelings of sadness and/or grief over compassion that was not received from others (e.g., caregivers) in the past (Gilbert et al., 2011).

Fear of showing compassion to others was also significantly related to treatment ambivalence, albeit to a lesser degree, and most strongly to the TAQ-PC subscale, which includes items such as "people who have been pushing me to get treatment will feel that they've

"won" if I start therapy", and "If my symptoms improve, people will start expecting too much from me". This scale may access competitive motives that are more consistent with "drive" motivations, rather than "soothing" systems that can be activated through compassion (Gilbert, 2009). It may be that negative attachment experiences (e.g., criticism) can lead to both fears about showing compassion to others as well as fears about the reactions of others towards their treatment efforts. Future research could explore the relationship between family variables, fear of compassion, and treatment attitudes. Finally, fear of receiving compassion was associated with negative, but not positive, treatment expectations. Given that treatment expectations are related to treatment outcomes (Price & Anderson, 2012; Price, Anderson, Henrich, & Rothbaum, 2008; Safren, Heimberg, Juster, 1997), future research should explore whether FOC moderates treatment outcomes in those with anxiety, as has been found in eating disorder populations (Kelly, Carter, Zuroff, & Borairi, 2012).

Interestingly, mean anxiety scores were higher in our analogue sample than our clinical sample. This could be a result of sampling differences: our analogue sample was pre-selected to be high on this specific measure. The mean DASS-S score in the clinical sample was in the moderate range, and inclusion was on the basis of having met criteria for one of more anxiety and related disorders. However, the findings remained the same when anxiety was controlled for. This, in addition to the replication of main results across samples, suggests that the findings are reliable. It is important to note that these findings are correlational, so we cannot infer that fear of compassion causes treatment ambivalence, and the clinical sample was relatively small. Further research exploring whether these relationships differ across diagnostic groups is warranted. It would also be interesting to establish whether FOC predicts subsequent treatment avoidance, adherence, and drop-out. The findings suggest that it may be advisable to identify and

address fears of compassion pre-treatment or early in treatment to enhance commitment and outcomes.

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