

**RESEARCH ARTICLE**

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# Psychometric properties of the German version of the fears of compassion scales

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**Abstract**

The cultivation of compassion is associated with beneficial effects on physical and psychological health, satisfaction with life and social relationships. However, some individuals, especially those high in psychopathological symptoms or those with particular disorders such as borderline personality disorder (BPD) may demonstrate pronounced fears of engagement in compassionate experiences or behaviours. Furthermore, fears of compassion have been found to impede progress in psychotherapy. The 38-item fears of compassion scales (FCS) is a self-report questionnaire for measuring trait levels of fears of compassion (a) one receives from others (FCFO), (b) one feels towards others (FCTO) and (c) one feels for oneself (self-compassion; FSC). The FCS is an internationally used instrument of proven validity and reliability in both clinical and nonclinical samples. In the present study, a German translation of the FCS including its three subscales was provided, and the psychometric properties were examined in 430 participants from four different samples: (a) a sample from the general population; (b) a mixed sample of psychiatric residential and outpatients; (c) a clinical sample of residential and outpatients with a primary diagnosis of BPD and (d) a sample of healthy control participants. Internal consistencies were excellent for the German version of the FCS and acceptable to excellent for its subscales. Correlations with established measures of mental health demonstrate its validity. Additionally, the German FCS discriminates significantly between individuals from the general population and patients, thus supporting its specificity. The German FCS is suitable to detect potential obstacles in cultivating compassion in psychotherapeutic treatments and beyond.

**KEYWORDS**

clinical and nonclinical samples, fears of compassion, German version, psychometric properties, self-report questionnaire

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## 1 | INTRODUCTION

Compassion is a psychological concept that has received increasing scientific interest during the last 20 years. Some define compassion as an emotion (Goetz, Keltner, & Simon-Thomas, 2010), and others define it as a multidimensional construct (Jazaieri et al., ; Strauss et al., 2016). One of the most influential and frequently used definitions is that of Gilbert (2014), who defines compassion as a motif, involving the 'sensitivity to suffering in self and others with a commitment to try alleviate or prevent it'. An increasing number of studies have demonstrated that compassion influences emotional processing, that is, attending to, processing, remembering and reacting to emotional stimuli (Kirby, Doty, Petrocchi, & Gilbert, 2017; Seppälä et al., 2017). These key processes are directly linked to the activity of the autonomic sympathetic nervous system, which enables emotion-related action tendencies such as the approach to relevant others and caregiving. The activity of the parasympathetic nervous system enables the corresponding calming and soothing tendencies. Previous studies have shown that giving and receiving compassion is physiologically linked to adaptive heart rate variability (e.g., Cosley, McCoy, Saslow, & Epel, 2010; Kim et al., 2020; Kirby et al., 2017; Matos et al., 2017; Petrocchi, Ottaviani, & Couyoumdjian, 2017; Rockliff, Gilbert, McEwan, Lightman, & Glover, 2008), blood pressure and cortisol reactivity (Cosley et al., 2010). Additionally, previous research has shown that compassion training affects the activation of the amygdala and of other brain areas involved in emotional processing and empathy (Derntl et al., 2010; Desbordes et al., 2012; Klimecki, Leiberg, Lamm, & Singer, 2013). Investigations on functional brain plasticity after compassion and empathy training suggest compassion may reflect a new coping strategy to reverse empathic distress and to strengthen resilience (Klimecki et al., 2013; Klimecki, Leiberg, Ricard, & Singer, 2014). Furthermore, compassion activates are affiliated with feelings of soothing, calming and well-being, which are linked to specific neuro-physiological systems, especially endorphin and oxytocin, which are distinct from 'drive and excitement' systems (Depue & Morrone-Strupinsky, 2005). On a psychological level, several studies have found a significant reduction in anxiety, depression, feelings of inferiority and shame, self-criticism, fears of compassion and distress in response to compassion training. These studies also found significant increases in well-being, positive affect and affiliation, feelings of relaxation and safety, self-compassion, compassion for others and from others (e.g., Gilbert & Procter, 2006; Klimecki et al., 2013; Leaviss & Uttley, 2015; Matos et al., 2017; Petrocchi et al., 2017), life satisfaction and well-being (e.g., Barnard & Curry, 2011; K. D. Neff & Germer, 2013; K. D. Neff, Kirkpatrick, & Rude, 2007; Zessin, Dickhäuser, & Garbade, 2015), closer social relationships (e.g., Yarnell & Neff, 2013) and feelings of social connectedness (e.g., Cozolino, 2006; Crocker & Canevello, 2012; Petrocchi et al., 2017).

Thus, compassion has recently become the focus of interventions for a range of mental health problems. To date, six empirically based interventions that aim to cultivate compassion have been developed (Kirby, 2017): compassion focused therapy (CFT; Gilbert, 2014), mindful self-compassion (MSC; K. D. Neff & Germer, 2013), compassion

### Key Practitioner Message

- Fears of compassion have been found to impede progress in psychotherapy.
- The German version of the fears of compassion scale (FCS) is a reliable and valid measure to detect fears of compassion.
- The German version of the FCS and its subscales clearly discriminate between clinical and nonclinical participants.
- Patients with a diagnosis of borderline personality disorder show the strongest fears of compassion among the investigated clinical and nonclinical samples.
- The German version of the FCS is suitable to assess demands for specific psychotherapeutic interventions which can reduce fears of compassion.

cultivation training (CCT; Jinpa, 2010); cognitively based compassion training (CBCT; Pace et al., 2009), cultivating emotional balance (CEB; Kemeny et al., 2012) and loving-kindness (LKM) or compassion meditation (CM; Wallmark, Safarzadeh, Daukantaitė, & Maddux, 2013). A recent meta-analysis investigated the effectiveness of these interventions relative to control groups across 21 randomized control trials (RCTs) and identified significant between-group differences on self-report measures of compassion ( $d = 0.55$ , CI [0.33–0.78]), which included self-compassion ( $d = 0.70$ , CI [0.59–0.87]), mindfulness ( $d = 0.54$ , CI [0.38–0.71]), depression ( $d = 0.64$ , CI [0.45–0.82]), anxiety ( $d = 0.49$ , CI [0.30–0.68]), psychological distress ( $d = 0.47$ , CI [0.19–0.56]) and well-being ( $d = 0.51$ , CI [0.30–0.63]; Kirby, 2017). Despite these beneficial effects on mental health and well-being, implementing compassion has revealed major limitations in some individual's abilities and motivations to develop compassion (Gilbert, 2010). Previous research has shown that some groups of individuals who might benefit most from cultivating compassion, also have major deficits in their abilities and motivation to cultivate compassion (Ebert, Edel, Gilbert, & Brüne, 2018; Gilbert et al., 2012; Gilbert, McEwan, Matos, & Ravis, 2011; Kelly, Carter, Zuroff, & Borairi, 2013; MacBeth & Gumley, 2012; Xavier, Gouveia, & Cunha, 2016). These groups include individuals experiencing a variety of traits, which include self-harm, self-criticism and shame, insecure attachment, alexithymia, low levels of empathy and mindfulness, increased symptoms of depression and anxiety, rumination and eating disorders. Early insecure attachment experiences, neglect, abuse, traumatization and excessive feelings of shame were identified as particularly relevant predictors for the development of fear of compassion for the self, for others and from others (e.g., Matos et al., 2017). These early affiliative experiences may lay down conditioned emotional memories in which the need for soothing, safeness and care becomes associated with fear, loneliness, sadness and grief (Gilbert, 2010; Liotti, 2004). In particular, traumatic experiences or memories of shame, which are of critical importance

for identity, may render one to feel inferior, defective, powerless and unattractive and to perceive others as critical, rejecting, condemning or abusive. These feelings will influence the formation of negative self-other schemas and engender a sense of ongoing threat to one's social self (Gilbert, 2010; Matos, Duarte, & Pinto-Gouveia, 2015; Matos & Pinto-Gouveia, 2014; Matos, Pinto-Gouveia, & Gilbert, 2013). Additionally, a lack of experience of security, safety and being nurtured 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 will also disrupt effective emotional regulation (Gilbert, 2009, Gilbert, 2010; Matos & Pinto-Gouveia, 2014; Porter et al., 2020). Research supporting these assumptions indicates that a fear of compassion is predictive of lower oxytocin levels in patients with borderline personality disorder (BPD; Ebert et al., 2018). Consequently, the engagement in compassionate experiences or behaviours are linked to fears of being seen as weak or self-indulgent, of being judged or rejected due to compassionate efforts, of becoming too upset or overwhelmed by the needs of others when engaged in compassionate behaviours, and thus, the thinking that compassion will be viewed by others as manipulative or self-interested (Gilbert & Mascaro, 2017; Vitaliano, Zhang, & Scanlan, 2003). Furthermore, for individuals with high levels of self-criticism and interpersonal insecurity, being in compassion-based interventions may not produce soothing or safe effects, but rather increases stress, which can be measured using physiological indicators (Longe et al., 2010; Rockliff et al., 2008; Rockliff et al., 2011). In addition, strong fears of compassion have been shown to impede engagement, progress and outcome in psychotherapy (Gilbert et al., 2011; Kelly et al., 2013; Merritt & Purdon, 2020).

To specifically examine resistance to compassion, Gilbert et al. (2011) developed the fears of compassion scales (FCS). This self-report questionnaire assesses trait levels of fears of compassion on three scales: (a) fears of compassion one receives from others (FCFO); (b) fears of compassion one feels towards others (FCTO) and (c) fears of compassion one feels for oneself (self-compassion; FSC). Examinations of psychometric properties of the FCS in the original validation study reveal large correlations between the fears of compassion from others and fears of self-compassion subscales, as well as medium correlations between these two subscales and the fears of compassion towards others subscale (Gilbert et al., 2011). Internal consistencies of the original FCS subscales, which is assessed using Cronbach's  $\alpha$ , are .85–.87 for the fears of compassion from others subscale,  $\alpha = .78$ –.84 for the fears of compassion towards others subscale and  $\alpha = .85$ –.92 for the fears of self-compassion subscale (Gilbert et al., 2011). The FCS is an internationally used instrument that has demonstrated promising validity and reliability across multiple studies (Cunha & Paiva, 2012; Gilbert, Clarke, Hempel, Miles, & Irons, 2004; Kupeli, Chilcot, Schmidt, Campbell, & Troop, 2013; Pinto-Gouveia, Castilho, Matos, & Xavier, 2013). A recent meta-analysis with data from 4,723 participants from clinical and nonclinical populations showed positive correlations between mental health difficulties (self-criticism, shame, depression, anxiety, distress and well-being) and fears of self-compassion ( $r = .49$ ), fears of compassion towards others ( $r = .30$ ) and

fears of compassion from others ( $r = .48$ ). The strongest associations were found between the mental health variables of shame, self-criticism and depression and the FCS subscales of fears of self-compassion (FSC) and fears of compassion from others (FCFO). Overall, associations are significantly stronger for clinical populations than for nonclinical populations (Kirby, Day, & Sagar, 2019). Earlier findings have already demonstrated the FCS's potential to discriminate between clinical and nonclinical populations. The findings of a comparative study of 155 female undergraduate students and 97 females starting eating disorder treatment revealed significantly higher scores on the fears of self-compassion subscale in the latter sample (Kelly, Vimalakanthan, & Carter, 2014). A recent 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 ( $N = 212$ ) and identified greater fear of receiving compassion and fear of self-compassion in patients compared to healthy controls. The differences between anxious and control groups remained significant even when controlling for depressed mood (Merritt & Purdon, 2020). Furthermore, the FCS has been shown to have sensitivity to changes in the therapeutic contexts of interventions that target the reduction of fears of compassion (Braehler et al., 2013; Dupasquier, Kelly, Moscovitch, & Vidovic, 2018; Gilbert & Procter, 2006; Judge, Cleghorn, McEwan, & Gilbert, 2012; Kelly et al., 2013; Krieger, Berger, & Grosse Holtforth, 2016; Shahar et al., 2012; Sommers-Spijkerman et al., 2018), making it ideal for evaluating treatment outcomes.

Due to the importance of examining fears of compassion in the context of psychotherapeutic interventions and beyond, the FCS has been translated into Portuguese (Oliveira, Ferreira, Mendes, & Marta-Simões, 2017), Italian (Dentale et al., 2017) and Japanese (Asano et al., 2017); the Italian and Japanese versions have already been validated (Asano et al., 2017; Dentale et al., 2017). A translation and psychometric evaluation of the FCS into German is missing. The purpose of this study was to provide a German translation of the FCS and to establish its psychometric properties, including internal consistency, as well as convergent and discriminant validity in a German sample.

## 2 | METHOD

### 2.1 | Translation of the FCS

To ensure the maintenance of the principles of good practice for the translation and cultural adaption of the patient-reported outcome measure, the German version of the FCS (Gilbert et al., 2011) was translated following the recommendations of the 'ISPOR Task Force for Translation and Cultural Adaptation' (Wild et al., 2005) using a 10-step procedure for translation, which is described in Table 1. Following the original version of the FCS the three subscales consist of 10, 13 and 15 items, respectively. Respondents are required to

**TABLE 1** Steps in the translation process

- (1) The authors of the original version of the FCS were consulted for authorization. Three independent native German speakers who were fluent in English were determined.
- (2) The original FCS was translated into German by the determined native German speakers.
- (3) The three resulting translations were compared and merged into a single forward translation.
- (4) The resulting German version of the FCS was translated back into English by an independent professional translator.
- (5) The back-translation was reviewed by means of a comparison of the back-translated versions of the instrument and the original to highlight and investigate discrepancies between the original and the reconciled translation.
- (6) To resolve discrepancies between back-translated versions of the instrument and the original, the items of the German version of the FCS were harmonized.
- (7) The results were initially debriefed by testing the instrument on a small group of relevant people from clinical and nonclinical samples in order to test alternative wordings and check for the understandability, interpretation and cultural relevance of the translation.
- (8) The test persons' interpretations of the translation with the original version were compared to highlight and amend discrepancies. Items were finalized.
- (9) Items were reviewed a final time to highlight and correct any typographic, grammatical or other errors.
- (10) A final report was written at the end of the process, documenting the development of each translation.

Note: The fears of compassion scales (FCS; Gilbert et al., 2011) was translated following the recommendations of the 'ISPOR Task Force for Translation and Cultural Adaptation' (Wild et al., 2005) using a 10-step procedure for translation.

indicate the degree to which they are in accordance with each statement on a 5-point Likert scale (0 = 'Don't agree at all' to 4 = 'Completely agree'). Higher scores indicate a stronger fear of compassion from others (range: 0–52), fear of compassion towards other people (range: 0–40) and fear of self-compassion (range 0–60).

## 2.2 | Participants and procedure

Participants were included if they were 18 years or older, fluent in German and provided informed consent.

In the present study, a total of 430 individuals were included into the study between 2016 and 2019. Participants belonged to one of the following convenience samples: (a) a sample from the general population in Germany, (b) a sample of psychiatric inpatients and outpatients with different psychiatric diagnoses from several clinical settings in Germany, (c) a clinical sample of residential patients and outpatients with a primary diagnosis of BPD and (d) a sample of healthy control participants, whereby any psychiatric disorder was ruled out.

The sample from the general population was recruited through advertisements on several online platforms for people potentially interested in psychological research ([www.psychologie-onlineforschung.de](http://www.psychologie-onlineforschung.de); <https://www.psychologieforum.de/>; [www.psychologieforum.at](http://www.psychologieforum.at); [www.psychnet.ch](http://www.psychnet.ch)) and on facebook™. Advertisement provided a description of the goal of the study, informed consent and the link to the questionnaire. A total of 244 participants opened the survey link. As 75 individuals solely provided informed consent or stopped filling out the questionnaire, an actual full dataset of 169 participants from the general population were analysed.

Participants from the mixed clinical sample were recruited by their psychologists and psychiatrists in charge from several residential and outpatient psychiatric services of different public clinics in

Germany. All participants of the clinical sample received paper and pencil versions of the survey due to a possible lack of access to the Internet. A total of 146 mixed clinical patients started filling out the questionnaire. Of those, seven individuals stopped filling out the questionnaire and were therefore omitted from the analyses. This resulted in a full data set of 139 patients.

The clinical sample of residential and outpatients with a primary diagnosis of BPD were recruited by the psychologists and psychiatrists in charge. Of those 80 individuals, 14 stopped filling out the questionnaire and were therefore omitted from the analyses. A total of 66 BPD patients was analysed.

Finally, a sample of 56 mentally healthy control persons had been screened using the Structured Clinical Interview for DSM-IV Axis I Disorders Clinician Version (SCID-CV; First, Spitzer, Gibbon, & Williams, 1997; Wittchen, Wunderlich, Gruschwitz, & Zaudig, 1997) and the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997; Fydrich, Renneberg, Schmitz, & Wittchen, 1997) by means of which any psychiatric disorder was ruled out. These participants received a link to the online questionnaire and filled out the questionnaire completely.

## 2.3 | Diagnostic instruments

In the mixed clinical and BPD sample, the complete SCID-CV (First, Spitzer, et al., 1997; Wittchen et al., 1997) and SCID-II (First, Gibbon, et al., 1997; Fydrich et al., 1997) were conducted to determine the diagnostic status. The population-based sample received a screening of the SCID-CV and SCID-II, and they were asked whether they are in psychotherapeutic treatment and in which treatment setting (residential vs. outpatient) as part of the online study questionnaire. The control group received the same screening as a telephone

interview. The presence of a current mental illness and current psychotherapeutic treatment were exclusion criteria for this sample.

## 2.4 | Self-ratings

### 2.4.1 | Self-compassion scale

The self-compassion scale (SCS; Hupfeld & Ruffieux, 2011; K. Neff, 2003) measures trait levels of self-compassion on 26 items. The scale contains statements on thoughts, emotions and behaviours associated with several components of self-compassion which can be assigned to six subscales: self-kindness (five items), self-judgement (five items), common humanity (four items), isolation (four items), mindfulness (four items), overidentification (four items). Items are rated on a 5-point Likert scale ranging from 1 ('almost never') to 5 ('almost always'). In previous studies, the SCS has demonstrated concurrent validity, convergent and discriminant validity. Reliability was excellent as indicated by Cronbach's  $\alpha = .91$  and a test-retest reliability of  $r_{tt} = .92$  (K. Neff, 2003).

### 2.4.2 | Rosenberg's self-esteem scale

The Rosenberg self-esteem scale (RSES; Rosenberg, 1965; von Collani & Herzberg, 2003) is a self-report measure of global self-esteem. The scale consists of 10 items, which are rated on a 4-point Likert scale from 1 ('strongly disagree') to 4 ('strongly agree'). Validation of the original RSES demonstrated excellent internal consistency with Cronbach's  $\alpha = .92$  and test-retest reliabilities of  $r_{tt} = .85$  and  $.88$ . A German validation study reported good internal consistency of  $\alpha = .85$  (von Collani & Herzberg, 2003).

### 2.4.3 | Self-criticism

The self-criticism subscale of the short version of the depressive experiences questionnaire (DEQ; Krieger et al., 2014; Zuroff, Quinlan, & Blatt, 1990) is a seven-item self-report measure of self-criticism. Items are scored on a 7-point Likert scale, ranging from 1 ('strongly disagree') to 7 ('strongly agree'). The self-criticism subscale has shown acceptable to good internal consistencies with Cronbach's  $\alpha = .72$ – $.86$  in nonclinical samples and  $\alpha = .71$ – $.84$  clinical samples (Krieger et al., 2014).

### 2.4.4 | Hospital anxiety and depression scale

The hospital anxiety and depression scale (HADS; Petermann, 2015; Zigmond & Snaith, 1983) assesses the frequency of depressive symptoms (HADS-D) and anxiety symptoms (HADS-A) over the past week on 14 items, which are rated on 4-point scales. This instrument is an internationally used instrument for screening mental disorders

due to its sensitivity for mild manifestations of psychopathological symptoms and changes over time and its high acceptance in non-clinical samples. Cronbach's  $\alpha$  varies for HADS-D from  $.67$  to  $.90$  (mean  $.82$ ) and for HADS-A from  $.68$  to  $.93$  (mean  $.83$ ; [e.g., Bjelland, Dahl, Haug, & Neckelmann, 2002]). Results of a German validation study indicate good reliability in clinical and nonclinical samples (Hinz & Brähler, 2011).

### 2.4.5 | Satisfaction with life scale

The satisfaction with life scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985; Glaesmer, Grande, Braehler, & Roth, 2011) is the internationally most used instrument to assess satisfaction with life. It consists of five items which are rated on a 7-point Likert scale ranging from 1 ('strongly disagree') to 7 ('strongly agree'). Findings from several studies indicate good to excellent internal consistency with Cronbach's  $\alpha$  between  $.79$  and  $.89$  (Adler & Fagley, 2005; Diener et al., 1985; Steger, Frazier, Oishi, & Kaler, 2006) and good convergent and discriminant validity. Results from a validation study of the German version of the SWLS ( $N = 2,519$ ) demonstrated excellent internal consistency with Cronbach's  $\alpha = .92$ .

### 2.4.6 | Adult attachment scale

The adult attachment scale (AAS; Collins & Read, 1990; Schmidt, Strauss, Höger, & Brähler, 2004) is a 15-item self-report instrument representing attachment-related attitudes. The dimensional scales of the AAS assess openness for intimacy in relationships, trust in other people and fear of becoming abandoned (Schmidt et al., 2004). Items are rated on 5-point Likert scales. Internal consistency of the original AAS was acceptable with  $\alpha = .75$  for the subscale trust,  $\alpha = .72$  for the subscale fear and  $\alpha = .69$  for the subscale closeness to others. Investigation of the German version of the AAS indicate an acceptable internal consistencies of  $\alpha = .72$ – $.79$  for all subscales.

### 2.4.7 | Short scale for the assessment of social desirability

The short scale for the assessment of social desirability (German version: Kurzsкала zur sozialen Erwünschtheit, KSE; Winkler, Kroh, & Spiess, 2006) investigates the tendency to provide social desirable answers in surveys. This self-report instrument consists of six items which are rated on a 5-point Likert scale. In the original validation study, this instrument has shown an internal consistency of  $\alpha = .60$  which might be rated acceptable when considering the small number of items of the scale.

The BPD sample and the healthy control sample received only the FCS and the German versions of the SCS (Hupfeld & Ruffieux, 2011; K. Neff, 2003) and RSES (Rosenberg, 1965; von Collani & Herzberg, 2003).

## 2.5 | Data analytic plan

Internal consistencies of FCS total and subscale scores were assessed with Cronbach's  $\alpha$ . Intercorrelations between subscales were calculated using Pearson's correlation coefficient (one-tailed testing against 0). Similarly, convergent validity was assessed by computing Pearson correlations (one-tailed) between FCS subscale scores and scores on self-report measures of theoretically related constructs (i.e., SCS, RSES, TDEQ-12-SF, HADS, SWLS, AAS, SSASD). A Kruskal-Wallis test using  $\chi^2$  approximation was conducted to examine between group differences on age as the data were not normally distributed. Fisher's exact test was used to analyse between group differences on gender, education level, diagnosis and treatment setting. Bonferroni corrected post hoc tests were computed for between group comparisons to avoid inflation of the type-I error. Due to significantly different variances in between group comparisons on the

self-rating questionnaires, Satterthwaite corrections were made. Although the total FCS score was calculated in the data analysis of this study, it is recommended to always report the scores from the three subscales to differentiate the three dimensions of fears of compassion. Descriptives, standard psychometric analyses and internal consistency were conducted in SPSS 23.0 (IBM SPSS statistics).

## 3 | RESULTS

The majority of the  $n = 430$  participants were female (78.3%); their mean age was 24.8 years ( $SD = 5.9$ , range = 18–72 years). Between group comparisons indicated significant differences concerning gender, age, education level and diagnosis. An overview of the four groups' characteristics including education and anamnestic data is provided in Table 2.

**TABLE 2** Sample characteristics of the four samples

	Population based sample ( $n = 169$ )	Mixed clinical sample ( $n = 139$ )	BPD patient sample ( $n = 66$ )	Healthy control sample ( $n = 56$ )	Difference
Age, years					$\chi^2(3) = 125.09$ ; $p \leq .001$
<i>M</i> ( <i>SD</i> )	27.77 (7.98)	36.71 (14.45)	21.44 (3.39)	21.29 (2.15)	
Range	18–57	18–72	18–26	18–25	
Gender, <i>n</i> (%)					$p = .027$
Male	34 (20.1)	37 (26.6)	5 (7.6)	13 (23.2)	
Female	134 (79.3)	102 (73.4)	60 (90.9)	43 (76.8)	
Diverse	1 (0.6)	0	1 (1.5)	0	
Educational level, <i>n</i> (%)					$p \leq .001$
None	2 (1.2)	1 (0.7)	0	0	
Low (primary school, lower vocational education)	8 (4.7)	26 (18.7)	6 (9.1)	0	
Intermediate (secondary school, vocational education)	6 (3.6)	48 (34.5)	30 (45.5)	9 (16.1)	
High (higher vocational education, university)	104 (61.6)	56 (41.3)	30 (45.5)	47 (83.9)	
Other educational level	49 (29.0)	5 (3.6)	0	0	
Disorders (DSM-IV-TR), <i>n</i> (%)					
Affective disorder	23 (13.6)	92 (66.2)	39 (59.1)	0	$p = .140$
Anxiety disorder	13 (7.7)	35 (25.2)	12 (18.2)	0	$p \leq .001$
Obsessive–compulsive disorder	1 (0.6)	7 (5.0)	0	0	
Borderline personality disorder	15 (8.9)	30 (21.6)	66 (100)	0	
Posttraumatic stress disorder	9 (5.3)	15 (10.8)	20 (30.3)	0	$p \leq .001$
Addictive disorder	3 (1.3)	4 (2.9)	9 (13.6)	0	$p \leq .001$
Eating disorder	2 (1.2)	17 (12.2)	26 (39.4)	0	$p = .085$
Other disorder	2 (1.6)	12 (8.6)	13 (19.7)	0	$p \leq .001$
Disorder unknown	6 (3.6)	0	0	0	
Current treatment, <i>n</i> (%)					$p \leq .001$
Residential patients	1 (0.6)	100 (71.9)	42 (63.6)	0	
Outpatient	26 (15.4)	37 (33.8)	24 (36.3)	0	
No treatment	142 (84.0)	2 (1.4)	0	0	

### 3.1 | Internal consistencies and intercorrelations between FCS total and subscale scores

Cronbach's  $\alpha$ , means, SDs and intercorrelations of FCS total and subscale scores are displayed in Table 3. According to widely accepted standards (Cicchetti, 1994) internal consistencies for FCS total score and the three subscales were good to excellent in all four samples (Cronbach's  $\alpha$  ranged from .76 to .96). As expected, all three subscales fears of compassion from others, fears of compassion towards others and fears of self-compassion were positively correlated with medium to large ( $r \geq 0.3$ ) intercorrelations in all four samples suggesting that the three dimensions are interrelated but not entirely overlapping. Internal consistencies of all remaining self-ratings are shown in Table 4.

### 3.2 | Between group differences on the FCS subscales

To examine the specificity of the FCS, that is, the potential to discriminate between clinical and nonclinical populations, the four samples were compared based on FCS total score and the subscales. Comparisons drawn across the four groups revealed significant differences between the samples in terms of FCS total score ( $\chi^2(3) = 130.22, p \leq .001$ ) and the three subscales: fears of compassion from others ( $\chi^2(3) = 142.73, p \leq .001$ ), fears of compassion towards others ( $\chi^2(3) = 50.14, p \leq .001$ ) and fears of self-compassion ( $\chi^2(3) = 118.21, p \leq .001$ ). Post hoc tests results showed significant differences between the four samples for most of the FCS subscales (all  $p$  values are Bonferroni-corrected), revealing the following pattern. The BPD sample showed significantly higher scores for the FCS total scale and for subscales fears of compassion from others and fears of self-compassion relative to the other three samples (with  $p$  values of  $\leq .05$ ). Furthermore, significantly higher scores on the fears of compassion towards others subscale were found for the BPD sample relative to the population-based and healthy control sample (with  $p$  values of  $\leq .05$ ). The mixed clinical sample showed significantly higher scores on the fears of compassion from others, fears of compassion towards others and fears of self-compassion subscales relative to the population-based and healthy control samples (with  $p$  values of  $\leq .05$ ). No significant differences on any of the three FCS subscales appeared between the population-based and healthy control samples. Differences between the FCS subscale scores remained significant when controlling for age, gender, and education level (with  $p$  values of  $\leq .05$ ). For further between group comparisons for the FCS, see Table 5. Table 6 displays means and standard deviations and between group differences for the other investigated self-rated questionnaires.

### 3.3 | Convergent and discriminant validity of the FCS

The convergent validity of the FCS was investigated for the population-based and mixed clinical samples. As shown in Table 4,

**TABLE 3** Pearson intercorrelations and internal consistency of the FCS subscales in the population-based, mixed clinical, BPD and healthy control sample

FCS total	Population-based sample			Mixed clinical sample			BPD sample			Healthy control sample			
	FCS total	FCFO	FCTO	FCS total	FCFO	FCTO	FCS total	FCFO	FCTO	FCS total	FCFO	FCTO	FCS
FCFO	-	-	-	-	-	-	-	-	-	-	-	-	-
FCTO	.56*	-	-	.52*	-	-	.46*	-	-	.72*	-	-	-
FCS	.80*	.56*	-	.74*	.32*	-	.75*	.49*	-	.80*	.67*	-	-
Cronbach's $\alpha$	.96	.93	.95	.95	.92	.94	.92	.86	.89	.96	.80	.92	.95

Abbreviations: BPD, borderline personality disorder; FCS, fears of compassion scale; FCFO, fears of compassion from others; FCTO, fears of compassion towards others. \* $p < .001$ .

**TABLE 4** Internal consistencies and Pearson correlations between the FCS subscale scores and other psychological constructs in the population-based and mixed clinical sample

FCS	Population-based sample				Mixed clinical sample			
	FCFO	FCTO	FSC	$\alpha$	FCFO	FCTO	FSC	$\alpha$
Depressive experiences questionnaire short version, subscale self-criticism (TDEQ)	.07	-.08	.11	.81	.54**	.20*	.49**	.77
Self-compassion scale (SCS)								
Positive facets	-.47**	-.22**	-.52**	.92	-.26**	.07	-.37**	.93
Negative facets	.71**	.42**	.70**	.91	.61**	.30**	.57**	.89
Rosenberg self-esteem scale (RSES)	-.68**	-.45**	-.69**	.83	-.05	.04	-.02	.73
Hospital anxiety and depression scale (HADS)								
Depressive symptoms	.27**	.25**	.30**	.69	.54**	.16	.47**	.86
Anxiety symptoms	.16*	.04	.18*	.67	.47**	.13	.47**	.82
Satisfaction with life scale (SWLS)	-.65**	-.46**	-.63**	.90	-.54**	-.13	-.50**	.85
Adult attachment scale (AAS)	.87**	.55**	.76**	.92	.78**	.43**	.62**	.78
Short scale for the assessment of social desirability (SSASD)	-.04	-.03	-.04	.64	-.03	.05	-.05	.64

Abbreviations: FCS, fears of compassion scale; FCFO, fears of compassion from others; FCTO, fears of compassion towards others.  
\* $p < .05$ . \*\* $p < .01$ .

**TABLE 5** Means, standard deviations and between group comparisons on the FCS in the four samples

Measure	Population based sample ( $n = 169$ )	Mixed clinical sample ( $n = 139$ )	BPD patient sample ( $n = 66$ )	Healthy control sample ( $n = 56$ )	Difference
FCS total, $M$ ( $SD$ )	42.55 (27.76)	73.06 (28.87)	85.08 (24.56)	43.63 (25.46)	$\chi^2(3) = 130.22, p \leq .001$
FCFO	13.56 (11.05)	24.37 (11.81)	32.94 (9.97)	12.13 (9.22)	$\chi^2(3) = 142.73, p \leq .001$
FCTO	13.81 (6.68)	19.49 (7.83)	19.27 (7.78)	16.32 (6.87)	$\chi^2(3) = 50.14, p \leq .001$
FSC	15.18 (13.63)	29.20 (14.49)	34.94 (12.54)	15.18 (12.17)	$\chi^2(3) = 118.21, p \leq .001$

Abbreviations: FCS, fears of compassion scales; FCFO, fears of compassion from others; FCTO, fears of compassion towards others.

**TABLE 6** Means, standard deviations and between group comparisons of the investigated measures in the four samples

Measure	Population based sample ( $n = 169$ )	Mixed clinical sample ( $n = 139$ )	BPD patient sample ( $n = 66$ )	Healthy control sample ( $n = 56$ )	Difference
RSES, $M$ ( $SD$ )	29.82 (6.11)	27.40 (3.50)	26.59 (2.90)	33.27 (3.56)	$\chi^2(3) = 105.91, p \leq .001$
SCS, $M$ ( $SD$ )	80.10 (16.55)	60.86 (17.22)	82.59 (7.68)	74.45 (9.45)	$\chi^2(3) = 260.25, p \leq .001$
Positive facets	37.62 (10.23)	29.63 (10.40)	31.51 (11.32)	41.79 (10.45)	$\chi^2(3) = 123.02, p \leq .001$
Negative facets	42.49 (7.98)	31.24 (10.06)	51.08 (6.88)	32.67 (9.95)	$\chi^2(3) = 158.99, p \leq .001$
TDEQ, $M$ ( $SD$ )	27.10 (16.23)	37.17 (7.05)			$t(306) = -6.80, p \leq .001$
HADS, $M$ ( $SD$ )					
Depressive symptoms	11.17 (4.87)	10.43 (5.16)			$t(306) = 1.29, p = .20$
Anxiety symptoms	11.83 (4.98)	11.43 (6.01)			$t(306) = 0.64, p = .53$
SWLS, $M$ ( $SD$ )	23.04 (7.46)	13.81 (6.33)			$t(304) = 11.51, p \leq .001$
AAS, $M$ ( $SD$ )	34.97 (12.88)	45.85 (9.63)			$t(305) = -8.23, p \leq .001$
SSASD, $M$ ( $SD$ )	25.63 (5.85)	25.19 (3.81)			$t(306) = 0.75, p = .44$

Abbreviations: AAS, adult attachment scale; BPD, borderline personality disorder; HADS, hospital anxiety and depression scale; SCS, self-compassion scale; SSASD, short scale for the assessment of social desirability; SWLS, satisfaction with life scale; RSES, Rosenberg self-esteem scale; TDEQ, short version of the depressive experiences questionnaire.



results yielded medium to large correlations for the fears of compassion from others and fears of self-compassion subscales for the majority of theoretically related constructs in both samples. As expected, both subscales were found to be positively correlated with (a) negative facets of the SCS, (b) symptoms of depression and (c) attachment style problems as assessed by the AAS ( $r \geq 0.30$ , with  $p$  values of  $\leq .05$ ) in both samples. Furthermore, both subscales showed medium to large negative correlations with (d) positive facets of the SCS, (e) the SWLS, and (f) the RSES in both samples ( $r \leq -0.30$ , with  $p$  values of  $\leq .01$ ). In the mixed clinical sample, both subscales showed medium to large positive correlations with symptoms of anxiety as assessed by the HADS ( $r = 0.47$ , with  $p$  values of  $\leq .01$ ). In the population-based sample these correlations were of small sizes ( $r \leq 0.18$ , with  $p$  values of  $\leq .05$ ). The fears of compassion towards others subscale shows significant correlations with most of the theoretically related constructs for the population-based sample ( $|r| = .22-.55$ , with  $p$  values of  $\leq .01$ ). For the mixed clinical sample, small to medium correlations of this subscale were only found with for negative facets of the SCS, attachment style problems as assessed by the AAS and the self-criticism subscale as assessed by the TDEQ. No correlation emerged between the fears of compassion towards others subscale and symptoms of anxiety as assessed by the HADS (with  $|r|$  values of  $\leq .13$  and  $p$  values of  $> .10$ ) in either sample. Interestingly, correlations of the three FSC subscales and the self-criticism subscale of the TDEQ generally appear only for the mixed clinical sample ( $|r| = 0.20-0.54$ , with  $p$  values of  $\leq .05$ ). In contrast, correlations between the three subscales and the RSES are only significant for the population-based sample ( $|r| = 0.45-0.69$ , with  $p$  values of  $\leq .01$ ). The discriminant validity of the FCS was investigated by correlating the three subscales (i.e., fears of compassion from others, fears of compassion towards others and fears of self-compassion) with social desirability as assessed by the short scale for the assessment of social desirability for the population-based and mixed clinical samples. As expected from theory, none of the subscales were significantly related to social desirability (with  $|r|$  values of  $\leq .05$  and  $p$  values of  $> .10$ ) in either sample.

## 4 | DISCUSSION

The aim of the present study was to provide a psychometrically validated German translation of the FCS. Overall, 430 participants from four groups were investigated. The groups included a sample from the general population, a patient sample with mixed clinical diagnoses, a patient sample with a primary diagnosis of BPD and a healthy control sample. Overall, the German version of the FCS and its subscales exhibit acceptable to excellent internal consistency and show a pattern of correlations supporting the validity of the German FCS. Furthermore, the FCS and its subscales were found to clearly discriminate between individuals from the general population and patients, thus supporting the specificity of the German version of the instrument. Finally, the three subscales of the German FCS were intercorrelated between all four samples, and large correlations were identified between the fears of compassion from others and fears of

self-compassion subscales and medium to large correlations were identified between these two subscales and the fears of compassion towards others scale.

These results are in line with those of previous studies on the psychometric properties of the original FCS (Gilbert et al., 2004). Furthermore, in accordance with previous studies on the original FCS and its translations, our results indicate good to excellent levels of internal consistency for the FCS total scale and the three subscales across all of our samples (cf. Asano et al., 2017; Dentale et al., 2017; Gilbert et al., 2011). Additionally, convergent validity was found to be satisfactory for all three subscales in the two investigated samples (the population-based and mixed clinical samples), which is evident by the medium to large correlations with established measures of self-compassion, satisfaction with life, symptoms of depression and secure attachment styles. This result is in accordance with previous research on the convergent validity of the FCS (Cunha & Paiva, 2012; Gilbert et al., 2004; Kupeli et al., 2013; Pinto-Gouveia et al., 2013) and is in line with the results of a recent meta-analysis that identified significant correlations between the three FCS subscales and measures of self-criticism, shame, depression, anxiety, distress and well-being (Kirby et al., 2019). The fears of compassion for others and fears of self-compassion subscales had medium to large correlations with symptoms of anxiety in the mixed clinical sample, whereas these two subscales had small correlations with anxiety symptoms in the population-based sample. This result is in line with previous findings of greater fear of receiving compassion and fear of self-compassion, in patients with a principal diagnosis of depression, OCD, SAD and GAD compared with a control sample with no mental health difficulties (Merritt & Purdon, 2020). The fears of compassion towards others subscale, on the other hand, was found to have no correlation with the anxiety subscale of the HADS in the population-based and mixed clinical sample. From a content point of view, the lack of correlation can possibly be attributed to qualitative differences between fear of compassion for others and fear as defined in the diagnosed mental disorders. Previous studies suggest that fear of compassion for others may be related to personality variables and empathy (e.g., Graziano, Habashi, Sheese, & Tobin, 2007), desired moral identity (e.g., Reed & Aquino, 2003), insecure attachment style (e.g., Feeney & Collins, 2001; Mikulincer, Shaver, Gillath, & Nitzberg, 2005), the personal significance of the recipient (e.g., Bakan, 2005), fear of being submissive, weak or being exploited by others (McLaughlin & Hughes, 2003). From a methodological point of view, previous studies have found only small to medium correlations, even in significant larger samples than ours (e.g., Dentale et al., 2017; Kirby et al., 2019; Merritt & Purdon, 2020). In studies with small sample sizes, such as the Japanese translation and validation study (Asano et al., 2017), no significant correlations were found, indicating that if a correlation exists, it can only be found in large samples. Because the specific reasons for this finding are unknown, further research is needed to understand the similarities and differences between fear of compassion for others and symptoms of anxiety in anxiety related disorders. Two unexpected results emerged from our analysis of convergent validity: Correlations between the three FSC subscales and the self-

criticism subscale of the TDEQ generally only appeared for the mixed clinical sample. In contrast, correlations between the three subscales and the RSES were only found to be significant in the population-based sample. The reasons for these unexpected findings are unknown. Further research is needed to understand the underlying mechanisms and potential differences between clinical and nonclinical samples with respect to the fear of compassion. The results from former studies regarding the specificity of the original FCS demonstrate significant differences between nonclinical and clinical samples (e.g., Kelly et al., 2014; Kirby et al., 2019). Accordingly, our results reveal significant differences between our two clinical samples (the mixed clinical and BPD samples) and two nonclinical samples (the population-based and healthy control samples) for all three subscales. Again, this is in line with the results of greater fear of compassion from others and fear of self-compassion in patients with depression, OCD, SAD and GAD compared with a control sample with no mental health difficulties (Merritt & Purdon, 2020). Our results also extend previous findings in that the BPD sample showed significantly stronger fears of self-compassion and of compassion from others than the three other samples. This result may be due to the more frequent presence of early insecure attachment experiences, neglect, abuse, traumatization and excessive feelings of shame during the childhoods of BPD patients, which is thought to be associated with the development of fears of compassion. A recently published meta-analysis revealed that patients with BPD (a) were over 13 times more likely to report childhood adversity than nonclinical patients, (b) were more likely to report childhood adversity than other clinical populations, (c) reported elevated emotional abuse and neglect relative to controls (Porter et al., 2020). Several limitations should be considered when interpreting these results. First, there are differences between the samples in terms of gender, age and educational attainment. Previous meta-analytical findings on gender differences in self-compassion found that males reported slightly stronger fears of self-compassion than females (Yarnell et al., 2015). Nevertheless, in our study, demographic variables were found to have low, mostly nonsignificant correlations with FCS total and subscales. Second, the majority of individuals from our two patient samples were in residential treatment (82%), with 40% having two and 19% having three or more clinical diagnoses. Our results might, therefore, represent a specific population of individuals with relatively high levels of psychopathology and fears of compassion, and this should be considered when interpreting the very large between group differences found among FCS subscale scores. Third, due to the nonrepresentative distribution of specific mental disorders represented in our patient samples, group comparisons were only drawn between the predefined recruited samples, rather than comparing fears of compassion between mental disorders across samples. Despite these limitations, the results clearly indicate that the German version of the FCS exhibits satisfactory psychometric properties.

Fears of compassion are closely related to mental health difficulties (Kirby et al., 2019) and symptoms of psychopathology (Gilbert et al., 2011; Gilbert et al., 2012; Kelly et al., 2013; MacBeth & Gumley, 2012; Xavier et al., 2016). These fears of compassion are also closely linked to poorer psychotherapeutic treatment outcomes

(e.g., Kannan & Levitt, 2013; Marshall, Zuroff, McBride, & Bagby, 2008; Rector, Bagby, Segal, Joffe, & Levitt, 2000). Future research should test the FCS's potential to assess manifestations of psychopathology and demands for specific psychotherapeutic interventions, for example, CFT (Gilbert & Procter, 2006), across different clinical groups. Because our results indicate the BPD sample reported the strongest fears of self-compassion and fears of compassion from others, it should be further determined whether this feature is particularly pronounced in individuals with a diagnosis of BPD, who might then require more intensive treatment.

In conclusion, the current study suggests that the German version of the FCS is a reliable and valid instrument for measuring fears of compassion. Furthermore, the German FCS exhibits sufficient specificity to assess mild to severe manifestations of fears of compassion and the ability to differentiate between individuals from the general population and between clinical contexts. Thus, the German FCS is a promising instrument for detecting potential obstacles to psychotherapeutic treatment progress. Finally, due to its close relations to physical and psychological health as well as life satisfaction and social relationships, the German FCS can be used as a useful measure of treatment outcomes.

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#### CONFLICT OF INTEREST

No conflict of interest.

#### DATA AVAILABILITY STATEMENT

The data that support the findings of this study are currently available on request from the corresponding author. An active link containing repository name, URL and reference number will be included in the final accepted manuscript.

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## SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of this article.

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