Fears of Receiving Compassion from Others Predict Safety Behaviour Use in Social Anxiety

Disorder Over and Above Fears of Negative Self-Portrayal

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Abstract

Why do people with social anxiety disorder (SAD) engage in the use of safety behaviours? While past research has established that fears of negative self-portrayal are strongly associated with safety behaviour use in SAD, no research to date has investigated the potential role of fears of receiving compassion. Both types of fears could motivate those with SAD to engage in safety behaviours in order to keep others at a distance. In the present study, 150 participants with a clinical diagnosis of SAD completed measures of fears of negative self-portrayal, fears of receiving compassion, and safety behaviour use. Multiple regression analyses revealed that when controlling for self-portrayal fears, fears of receiving compassion significantly predicted increased use of safety behaviours overall, as well as the use of avoidance and impression management subtypes. Furthermore, there was a significant interaction effect in which greater fears of receiving compassion predicted greater use of impression management at lower levels of self-portrayal fears. We discuss the implications of our findings for addressing safety behaviours in the treatment of SAD.

Keywords: social anxiety, self-portrayal, compassion, safety behaviours, impression management, avoidance

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Individuals with social anxiety disorder (SAD) perceive even benign social opportunities

and contexts as threatening (Wong, Gordon, & Heimberg, 2014), often relying on the use of

safety behaviours in an attempt to prevent feared outcomes of negative evaluation and social

rejection (Salkovskis, 1991). Safety behaviours have been conceptualized as self-protection and

concealment strategies that are employed to mitigate fears of exposing self-perceived negative

attributes to others (Moscovitch, 2009). Indeed, individuals with SAD tend to have elevated self-

portrayal fears and demonstrate greater use of safety behaviours despite the relative

ineffectiveness of these behaviours at relieving anxiety and distress (Moscovitch et al.,

2013). When socially anxious participants engage in a conversation while holding in mind a

negative self-image, they use more safety behaviours, are more likely to believe that they

performed inadequately, and tend to overestimate how poorly they came across to their

conversation partner (Hirsch, Meynen, & Clark, 2004). Thus, fears of negative self-portrayal

have been established as playing a key role in the use of safety behaviours amongst individuals

with SAD.

Alongside their fears about exposing self-perceived flaws and opening themselves up to

criticism, individuals with SAD simultaneously fear expressions of compassion and

warmth (Cunha, Pereira, Galhardo, Couto, & Massano-Cardoso, 2015). In particular, fears

of *receiving* compassion from others have been found to be unique to SAD: when controlling for

depression, fears of receiving compassion were associated with greater symptom severity in

participants with SAD, but not in those with obsessive-compulsive or generalized anxiety

disorder (Merritt & Purdon, 2020). Fears of receiving compassion have been linked to early

shame experiences, and individuals who experience greater fears of compassion recall fewer

positive, affiliative memories from childhood (Matos, Duarte, & Pinto-Gouveia, 2017; Silva,

Ferreira, Mendes, & Marta-Simões, 2019). These experiences are thought to form the foundation

for maladaptive social schema that make it difficult for socially anxious individuals to feel safe

in their social environments (Kelly & Dupasquier, 2016), leading them to interpret compassion

as threatening. In SAD, fears of receiving compassion may specifically centre around related

feelings of unworthiness, the belief that needing compassion from others is a sign of weakness,

or that compassion is equivalent to pity (Gilbert, McEwan, Matos, & Rivis, 2011). Thus, for

people with SAD, fears of receiving compassion may fuel the use of safety behaviours designed

to avoid showing signs of anxiety or other forms of personal distress to others not only to prevent

negative evaluation but perhaps also to prevent other people from offering support (Dupasquier,

Kelly, Moscovitch, & Vidovic, 2018). There is therefore reason to suspect that fears of receiving

compassion are linked with self-protective and self-concealing strategies, namely safety

behaviours, to avoid or reject displays of warmth and care from others; however, the relationship

between fears of receiving compassion and use of safety behaviours has not previously been

investigated.

It is also unclear if individuals with SAD resort to different *types* of safety behaviours to

avoid expressions of care and concern from others. Clark and Wells (1995) proposed two distinct

subtypes of SAD-related safety behaviours: impression management and avoidance. Impression

management strategies are employed to tightly control one's impression on others by enhancing

self-presentation, such as feigning friendliness or using rehearsed phrases in conversation. Their

use creates a favourable façade and distracts from one's actual self. However, impression

management strategies often come at the cost of authentic, genuine self-disclosure and deep,

meaningful social connection by creating a veneer of "innocuous sociability" (Plasencia, Alden, & Taylor, 2011) and deflecting others away from a socially anxious individual's "true," "inadequate" self. In this way, impression management strategies may also allow socially anxious people to conceal underlying feelings of distress and ensure that others do not believe they are in need of any help or compassion.

On the other hand, the goal of avoidance strategies is to reduce one's involvement in a social situation; for example, by overtly avoiding eye contact or limiting self-disclosure. Like impression management strategies, the underlying motivation of avoidance strategies is often to draw attention away from the self. However, the use of avoidance safety behaviours might have a particularly negative impact on the individuals with SAD who use them. For example, one study found that socially anxious participants who used avoidance strategies perceived themselves as looking more anxious and enjoying the conversation less, and reported less desire to pursue further conversation with the same interaction partner in the future (Gray, Beierl, & Clark, 2019). Avoidance safety behaviours also elicit critical reactions from others: partners rated socially anxious research participants as appearing more anxious and less likeable, and objective assessors rated participants lower on positivity when avoidance safety behaviours were being used (Gray et al., 2019; see also Rowa et al., 2015). Like the motivations that may drive the use of impression management strategies for socially anxious individuals who fear receiving compassion, such individuals may also rely on avoidance safety behaviours to ensure that other people do not notice signs of distress or discomfort or imagined flaws that may prompt unwelcome expressions of compassion.

In the present study, we examined the relations between self-portrayal fears, fears of receiving compassion, and use of safety behaviours in individuals with a clinical diagnosis of

SAD. We hypothesized that self-portrayal fears and fears of receiving compassion would each uniquely explain significant variance in use of safety behaviours. We also hypothesized that fears of receiving compassion would interact with self-portrayal fears to further elevate safety behaviour use, such that socially anxious people with higher levels of both self-portrayal fears and fears of compassion would report the greater reliance on self-protective strategies. Finally, we explored the effects of self-portrayal fears, fears of receiving compassion, and their interaction on the use of avoidance and impression management safety behaviours separately in order to determine whether the preferential use of the two safety behaviour subtypes may be differentially related to these two types of underlying fears. Extending our knowledge of the various factors that contribute to safety behaviour use may help to advance treatments targeted at reducing socially anxious individuals' maladaptive over-reliance on social safety behaviours (McManus, Sacadura, & Clark, 2008; Taylor & Alden, 2011).

Methods

Participants

A total of 150 participants over the age of 18 were recruited for the present study with online and flyer advertisements posted in a mid-size Canadian city with a population of approximately 240,000 following procedures detailed in Moscovitch, Shaughnessy et al. (2015). Adults who self-identified as having current difficulties with social anxiety were screened for inclusion and exclusion criteria using an online questionnaire and phone screen adapted from the Mini International Neuropsychiatric Interview (MINI; Sheehan, 2014), a well-validated semi-structured diagnostic interview (Pinninti, Madison, Musser, & Rissmiller, 2003; Sheehan et al., 1998). Participants who endorsed symptoms on the phone screen consistent with a DSM-5 diagnosis of SAD were invited to complete an in-person assessment consisting of the full MINI

and detailed symptom checklists adapted from the Anxiety Disorders Interview Schedule for DSM-5 (ADIS; Brown & Barlow, 2014). The interview was administered by highly trained clinical psychology graduate students. The clinical data supporting the diagnoses recorded by graduate students during the interviews were reviewed in detail by a clinical team consisting of the two psychologists and other graduate student clinicians, who collaboratively established consensus diagnoses for each case based on discussion at weekly meetings. Prior research has established 100% inter-rater reliability for a diagnosis of SAD when two clinicians in our group independently assessed a small sample of the same participants using these methods (see Moscovitch, Waechter et al., 2015). Following the interview, participants completed a series of self-report questionnaires. For inclusion in the current study, participants were required to have a clinically significant SAD diagnosis (i.e., associated with a Clinician Severity Rating of symptoms of 4 or above on a standardized Likert scale ranging from 0 – *none* to 8 – *very severe*). Exclusion criteria included endorsement of active and clinically significant suicidality, mania, psychosis, or substance abuse or dependence. Eligible participants were compensated $40 CAD for their participation.

The mean age of the sample was 27.9 (SD = 11.81). A total of 107 (71.3%) participants identified as female, with the remaining identifying as male (24.7%), transgender (2.7%) or non-binary (1.4%). The majority of participants identified their ethnic or cultural background as White/European (63.3%), with the remaining identifying as South Asian (12%), East Asian (9.3%), Latin American (3.3%), Southeast Asian (2%), Black (1.3%), Indigenous or First Nations (1.3%), West Indian (0.7%), Arab (0.7%), Filipino (0.7%), or Other (5.3%). One hundred and twenty-seven (84.7%) participants reported having completed at least some post-secondary education. SAD represented the principal diagnosis for 86 (57.3%) participants, the

co-principal diagnosis for seven (4.7%) participants, and a secondary diagnosis for 57 (38.0%)

participants. The principal diagnoses of those with a secondary diagnosis of SAD included

generalized anxiety disorder (35.1%), persistent depressive disorder (29.8%), obsessive

compulsive disorder (15.8%), major depressive disorder (7%), panic disorder (5.3%), and

agoraphobia, specific phobia, post-traumatic stress disorder, and bulimia nervosa, each

representing 1.8%. One hundred and thirty-two (88.0%) participants presented with one or more

comorbid diagnoses, whereas SAD represented the sole diagnosis for 18 (12%) participants.

Measures

   Self Portrayal Fears. The Negative Self-Portrayal Scale (Moscovitch & Huyder, 2010) is

a 27-item Likert-type scale that assesses the extent to which individuals fear that specific self-

attributes they view as being deficient will be exposed to scrutiny and evaluation by critical

others in social situations. Participants are instructed to rate the degree to which they are

concerned that certain qualities will become obvious to others in anxiety-provoking situations on

a scale from 1 (*not at all concerned*) to 5 (*extremely concerned*). The NSPS has previously

demonstrated strong internal consistency (Cronbach's α = .96), test-retest reliability, convergent

validity, and discriminant validity in both undergraduate and clinical samples (Moscovitch &

Huyder, 2011), as well as treatment sensitivity (Moscovitch, Rowa et al., 2015). Cronbach's α in

the present sample was .92.

   Fears of Receiving Compassion. Fears of receiving compassion from others were

measured using the Fears of Compassion from Others (FOCS-R) subscale of the Fears of

Compassion Scales (Gilbert et al., 2011). Participants respond to the degree to which they agree

with 13 items (e.g., "Feelings of kindness from others are somehow frightening"), with response

options ranging from 0 (*do not agree at all*) to 4 (*completely agree*). The FOCS-R has previously

demonstrated good internal consistency (α = .85) in a sample of 222 undergraduate students

(Gilbert et al., 2011), and strong internal consistency (α = .92) in a clinical sample of 407

individuals with a range of mood and anxiety concerns (Merritt & Purdon, 2020). Cronbach's

α in the present sample was .87, indicating good internal consistency.

> **Safety Behaviour Use**. The Subtle Avoidance Frequency Examination (SAFE; Cuming et

al., 2009) is a 32-item measure that assesses frequency of safety behaviour use. The SAFE is

comprised of three nonorthogonal factors: inhibiting/ restricting

safety behaviours (11 items), active safety behaviours (15 items), and physical symptom

management (6 items). In the present study, inhibiting/restricting SAFE items (e.g., "remain

silent," "position yourself so as not to be noticed") were conceptualized as a measure

of avoidance safety behaviours. Conversely, active SAFE items (e.g., "rehearse sentences in your

mind," "ask others about your performance") were conceptualized as a measure of impression

management safety behaviours. Participants were instructed to rate the frequency with which

they engage in certain behaviours in social situations on a scale from 1 (*never*) to 5

(*always*). Given our research questions and hypotheses surrounding the specific functions of

avoidance and impression management safety behaviours, items from the physical symptom

management subscale (e.g., "wear clothes or makeup to hide blushing," "wear cool clothes to

prevent sweating") were not included in analyses of separate subscales but were incorporated

into analyses of overall use of safety behaviours, which relied on SAFE total scores (see data

analytic strategy, below). The SAFE has previously been shown to exhibit strong internal

consistency and construct validity, with an overall Cronbach's α of .91 and α values of .87

and .85 for the impression management and avoidance subscales, respectively (Cuming et al.,

2009). Cronbach's α for the complete scale was .89 in the present sample, indicating good

internal consistency. Each subscale also demonstrated acceptable internal consistency ($\alpha = .85$

for avoidance safety behaviours, $\alpha = .81$ for impression management safety behaviours).

Data analytic strategy

Data were analyzed in IBM SPSS Statistics 23 (2015) using multiple linear regression to

test our main hypothesis that fears of receiving compassion uniquely contribute to the use of

safety behaviours while controlling for their well-established association with self-portrayal

fears. Predictor variables were centred based on their respective grand means and entered

hierarchically, with self-portrayal fears entered on the first step, fears of receiving compassion on

the second step, and their interaction on the third step. SAFE total and subscale scores were

entered as the dependent variable in separate analyses. The conditional effects of fears of

receiving compassion on the use of safety behaviours at varying levels of self-portrayal fears

were probed using the PROCESS macro (Hayes, 2013). The Johnson-Neyman technique was

used to identify the regions of significance for any significant interactions. All collinearity

statistics were within acceptable range (VIF < 4, tolerance > .20; Hair et al., 1995).

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Results

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Descriptive statistics and zero-order correlations

See Tables 1 and 2 for descriptive statistics and zero-order correlations. According to

Welch's t-test, scores on the NSPS did not differ significantly between participants with SAD as

a principal vs. secondary diagnosis, $t(106.62) = 0.870, p = .386$. Additionally, scores on the

FOCS-R did not differ, $t(112.10) = 0.823, p = .412$, nor did scores on the SAFE, $t(114.11)$

$= .507, p = .613$.

Overall use of safety behaviours

See Table 3 for regression results. Self-portrayal fears significantly predicted overall use of safety behaviours ($R^2 = .466$, F (1, 148) $= 130.978$, $p < .001$), as did fears of receiving compassion on the second step ($\Delta R^2 = .040$, F (1, 147) $= 12.000$, $p = .001$). When fears of receiving compassion was included in the analysis, self-portrayal fears uniquely accounted for 28.6% of the variability in overall safety behaviour use ($sr^2 = .286$). The self-portrayal fears x fears of receiving compassion interaction on the third step did not result in a significant amount of unique variance explained ($\Delta R^2 = .000$, F (3, 146) $= .117$, $p = .733$), indicating that self-portrayal fears did not moderate the relationship between fears of receiving compassion and overall use of safety behaviours.

Use of impression management safety behaviours

Next, we tested whether fears of receiving compassion predicted use of impression management safety behaviours when controlling for self-portrayal fears. Self-portrayal fears significantly predicted use of impression management ($R^2 = .400$, F (1, 148) $= 100.475$, $p < .001$) in step 1, as did fears of receiving compassion on step 2 ($\Delta R^2 = .039$, F (1, 147) $= 10.419$, $p = .002$). When fears of receiving compassion was included in step 2, self-portrayal fears uniquely accounted for 24.1% of the variability in impression management behaviours ($sr^2 = .241$). There was also a significant self-portrayal fears x fears of receiving compassion interaction on the third step ($\Delta R^2 = .016$, F (1, 146) $= 4.306$, $p = .040$). Probing of simple slopes revealed that at lower self-portrayal fears (-1 SD), fears of receiving compassion predicted greater use of impression management safety behaviours ($B = .326$, $SE = .086$, $t(145) = 3.806$, $p < .001$), whereas at higher self-portrayal fears (+1 SD), fears of receiving compassion did not significantly predict use of impression management safety behaviours ($B = .117$, $SE = .076$, $t(145) = 1.543$, $p = .125$); see Figure 1. The Johnson-Neyman analysis

showed that the relationship between fears of receiving compassion and use of impression management safety behaviours was significant when self-portrayal fears were in the lower 78.00% below a cut-off score of 95.78 on the NSPS, but not for the upper 22.00% who scored above the cut-off.

Use of avoidance safety behaviours

Finally, we tested the effects of fears of receiving compassion on avoidance safety behaviours when controlling for self-portrayal fears. Self-portrayal fears significantly predicted overall use of safety behaviours ($R^2 = .327$, $F(1, 148) = 73.420$, $p < .001$), as did fears of receiving compassion on the second step ($\Delta R^2 = .030$, $F(1, 147) = 6.923$, $p = .009$). When fears of receiving compassion was included in step 2, self-portrayal fears uniquely accounted for 20.1% of the variability in the use of avoidance behaviours ($sr^2 = .201$). The interaction between self-portrayal fears and fears of receiving compassion on step 3 was not significant ($\Delta R^2 = .000$, $F(3, 146) = .102$, $p = .750$), indicating that self-portrayal fears did not moderate the relationship between fears of receiving compassion and use of avoidance safety behaviours.

Discussion

It is well-established that people with SAD use a variety of self-protective and self-concealing strategies to keep others at arm's length (Piccirillo et al., 2016). Cognitive models of social anxiety commonly emphasize that the function of safety behaviours is to prevent the occurrence of feared consequences (Salkovskis, 1991; Clark & Wells, 1995; Hofmann, 2007; Rapee & Heimberg, 2007). In the case of SAD, feared consequences are typically conceptualized as fears of negative evaluation arising from negative self-portrayal (e.g., Moscovitch, 2009), which have been shown to motivate the desire to self-conceal (Moscovitch et al., 2013). The present study investigated whether another type of fear that tends to be elevated in SAD – fear of

receiving compassion from others – might independently explain the use of safety behaviours over and above fears of negative self-portrayal.

Results demonstrated that among individuals with a clinical diagnosis of SAD, fears of receiving compassion from others explained unique variance in use of safety behaviours over and above the contribution of self-portrayal fears. This was true for safety behaviours in general and for both avoidance and impression management subtypes of safety behaviours specifically. These findings emphasize the potential importance of the underlying fear of receiving compassion as a previously overlooked factor that may elevate socially anxious individuals' desire to self-protect and enact avoidance or impression management designed to keep other people at a safe distance. When others express compassion towards them, people with SAD may feel undeserving and unworthy due to their overly critical self-views, believe that expressions of compassion indicate they are truly deficient, or mistrust that support will be consistently available when needed (Gilbert et al., 2011). Socially anxious individuals may also misinterpret genuine concern and compassion from others as pity—and thus confirmation of having exposed their self-perceived flaws (see Moscovitch, 2009), driving them to rely on safety behaviours to prevent or even reject others' intentions to provide compassion.

In particular, at lower levels of self-portrayal fears, fears of receiving compassion positively predicted use of the impression management subtype of safety behaviours. Impression management strategies allow socially anxious individuals to mask their discomfort by appearing friendly and polite while remaining distant and disconnected—for example, by nodding and appearing to listen attentively to the other person as opposed to deeply engaging in an interaction (Schlenker & Leary, 1982). For socially anxious individuals, keeping up this agreeable, albeit superficial, image is preferable to the risk of revealing self-flaws from attempts at more

meaningful social interaction. By adjusting self-presentation in this way, socially anxious

individuals may also be able to come across as convincingly self-sufficient and less in need of

others' social support, preventing others from offering them compassion and also enabling them

to avoid the experience of receiving compassion and potentially receive the support they

genuinely need.

At higher levels of self-portrayal fears, there was a surprising lack of significant

conditional effect of fears of receiving compassion on the use of impression management,

suggesting that individuals with SAD are primarily driven by fear of exposing self-flaws and are

thus more focused on using impression management for self-concealment at all costs than for the

prevention of compassion from others. Indeed, self-portrayal fears already accounted for a large

amount of variance in impression management (sr^2 = .241) in comparison to the unique

contribution of fears of receiving compassion (ΔR^2 = .039) and its moderating effects (ΔR^2

= .016) in subsequent steps of the regression model. Thus, among individuals with

SAD, a fear of negative self-portrayal may represent a more fundamental concern than fears

of receiving compassion, with the former taking priority in the use of impression management

strategies.

When controlling for self-portrayal fears, fears of receiving compassion also positively

predicted use of the avoidance subtype, but did not conditionally predict avoidance safety

behaviours at varying levels of self-portrayal fears. By attracting as little attention as possible

through avoidance strategies, socially anxious individuals may aim to limit chances of exposing

their self-flaws to others, and at the same time may conveniently reduce opportunities for

others to express compassion towards them. However, since avoidance safety

behaviours can actually lead socially anxious individuals to appear overly anxious (Gray et al.,

2019; Rowa et al., 2015)—and thus in need of support—their use may counterproductively elicit unwelcome compassion from others.

Although the present study was cross-sectional and correlational in nature and ultimately cannot confirm directionality in the relationships between variables, our findings are consistent with a plausible causal model explaining how fears of self-portrayal and fears of self-compassion may interact to fuel the use of impression management safety behaviours in SAD. Whereas these two types of fears may be expected to interact synergistically to elevate the use of safety behaviours in the general population, such that increases in both types of fears would generate significant increases in the use of impression management safety behaviours over and above the effects of either fear alone, for people with SAD, elevations in only one of these two fears may be sufficient for increasing their use of such strategies. Specifically, our findings suggest that when individuals with SAD are very fearful of negative self-portrayal, such fears alone are likely to fuel the use impression management safety behaviours irrespective of fears of receiving compassion. In contrast, for those with SAD experiencing lower fears of negative self-portrayal (for example, in more familiar social contexts or while interacting with close others), the extent to which they rely on impression management safety behaviours appears to depend on the degree to which they appraise receiving compassion as an imminent threat. Future research is needed to test this model experimentally in people with and without SAD and to examine whether attempts to prevent anxiety-inducing displays of compassion from others by using strategies to keep them at arm's length are likely to be ineffective at reducing threat perceptions, thus maintaining or even amplifying distress, as seen in prior studies that have examined the consequences of safety behaviour use (e.g., Moscovitch et al., 2013). It would also be worth investigating why the interaction effect was present for impression management, but not avoidance safety behaviours.

Several limitations should be noted, which also help to further clarify important

directions for future research. It is possible that safety behaviour use and fear of compassion are

associated in bidirectional or more complex ways than the current design permit us to test; for

example, greater safety behaviour use may decrease the number of interactions that individuals

with SAD have with compassionate others, resulting in decreased familiarity with receiving

compassion and creating a general fear of these unfamiliar experiences. In the absence of

evidence that their fears are unfounded, use of safety behaviours may therefore reinforce fears of

compassion from others. Future longitudinal studies could examine this idea by collecting

multiple data points of both measures across time. Another limitation was that the majority

of participants in our sample had at least two clinically significant diagnoses and other symptoms

may also have influenced self-portrayal fears, fears of receiving compassion, and safety

behaviour use; for instance, fears of receiving compassion have also been linked to depressive

symptoms (Merritt & Purdon, 2020; Trindade et al., 2018). Though the safety behaviours we

measured using the SAFE are most commonly used by those with SAD, future research could

attempt to disentangle the effects of fears of compassion on safety behaviours by comparing

individuals with SAD alone versus those with comorbid diagnoses. Additionally, all measures

were based on self-report, leading to potential biases in the quantification of different fears and

how often safety behaviours are actually used. Future studies could include daily diaries,

experience sampling methods (ESM), or lab-based interaction tasks that would allow for more

objective coding of the safety behaviours participants might be employing in the face of

compassionate displays from others. As well, the overrepresentation of females in our

sample may limit the generalizability of our findings, as we were unable to investigate any

potential moderating effect of gender given the lack of gender diversity in our sample. As fears

of compassion tend to be associated with masculine role norms (Heath et al., 2017), future research should replicate the present findings using more diverse samples to examine how the effects of fears of compassion may differ across gender identities. Finally, we did not distinguish between treatment-seeking and non-treatment seeking individuals in our sample, as we did not collect data on their treatment seeking status. Though participants were not seeking treatment in conjunction with their participation in the present study, they may have been seeking treatment elsewhere. It is possible that fears of compassion from others may be somewhat reduced in treatment-seeking individuals, as their help-seeking could be considered evidence of some openness to receiving compassion from others. Nonetheless, our results suggest that assessing fears of compassion in socially anxious individuals could point to fruitful clinical targets.

How can the present findings inform treatment processes? In cognitive interventions, clinicians should consider the possibility that clients' hot thoughts may not only centre around fears of negative evaluation, but that even supportive responses from others may be perceived as threatening. The fact that the person has sought out therapy could be used as a jumping off point to examine existing alternative beliefs that warmth and kindness can be helpful. During exposure exercises or behavioural experiments where clients are encouraged to reduce avoidance and impression management safety behaviours, monitoring for feared consequences such as expressions of compassion from others and assessing whether receiving such compassion from others is as bad as they expected it would be may help clients acquire useful experiential evidence. Behavioural experiments in which clients directly attempt to elicit supportive responses from others may also be beneficial in challenging their beliefs about negative consequences and the intent behind positive responses received. Finally, designing behavioural experiments in which clients themselves offer compassion to others or asking clients to reflect on

their own previous experiences of giving compassion may help them recognize that caring can be driven by connection and empathy rather than pity for the person in distress.

The present study carries novel clinical implications by identifying a potential additional factor underlying the maintenance of SAD as a future target for treatment. Fears of receiving compassion may prevent therapeutic recovery for individuals with SAD, as receiving self-compassion and support from others have been shown to be highly effective emotion regulation tools for reducing symptoms (Arch, Landy, Schneider, Koban, & Andrews-Hanna, 2018; Cândea & Szentágotai-Tătar, 2018; Harwood & Kocovski, 2017; Rapee, Peters, Carpenter, & Gaston, 2015; Reinelt et al., 2014; Williams, Morelli, Ong, & Zaki, 2018). Thus, using impression-management safety behaviours to avoid receiving compassion from others may impede effective stress management by blocking access to helpful emotion regulation strategies that rely on social support (Levy-Gigi & Shamay-Tsoory, 2017; Marroquin & Nolen-Hoeksema, 2015; Nils & Rimé, 2012). Learning to accept others' compassion as genuine and well-intentioned may reduce perceptions of social threat for individuals with SAD, encouraging them to reveal their authentic selves for developing deeper and more meaningful relationships.

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Declarations of interest

None.

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Table 1

Descriptive Statistics

	M	*SD*	**Scale range**
NSPS	80.27	19.69	27 - 135
FOCS-R	24.18	10.08	0 - 52
SAFE	93.21	18.28	32 - 160
Impression management	37.97	7.87	11 - 55
Avoidance	42.68	9.45	15 - 75

Note: NSPS = Negative Self-Portrayal Scale, FOCS-R = Fears of Compassion Scale (fears of receiving compassion), SAFE = Subtle Avoidance Frequency Examination.

Table 2

Zero-order Correlations Between Study Variables

	FOCS -R	SAFE	SAFE- IM	SAFE-A
NSPS	.42**	.69**	.58**	.64**
FOCS-R	-	.47**	.40**	.45**
SAFE		-	.81**	.90**
SAFE-IM			-	.56**
SAFE-A				-

Note: NSPS = Negative Self-Portrayal Scale, FOCS-R = Fears of Compassion Scale

(fears of receiving compassion), SAFE = Subtle Avoidance Frequency

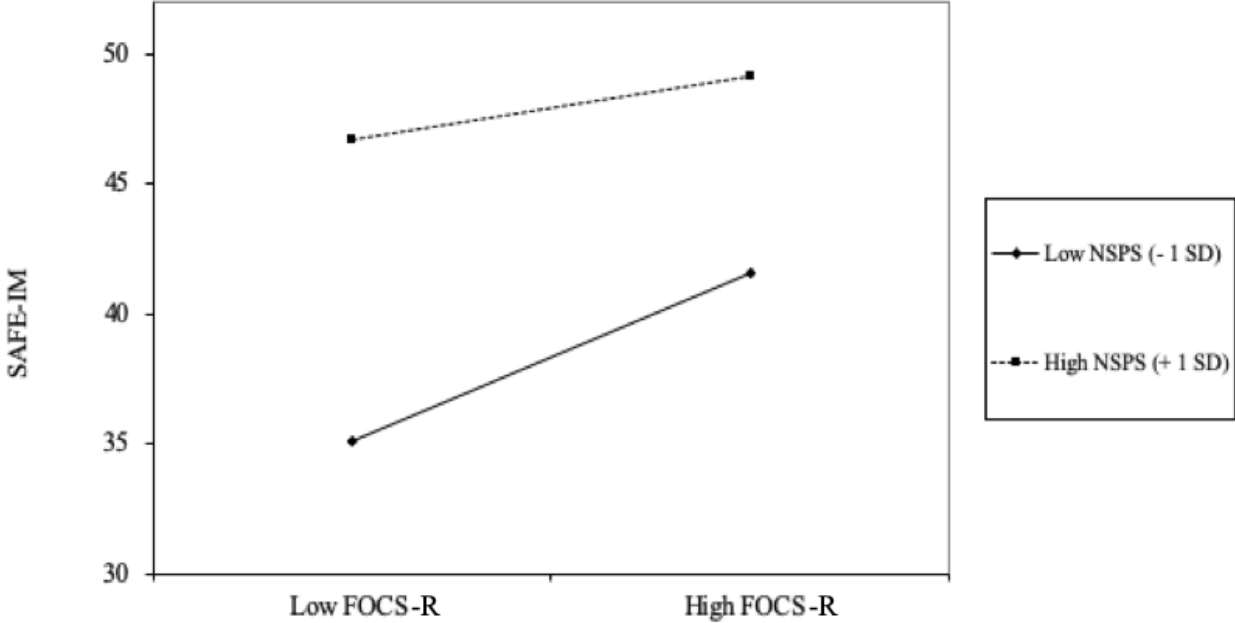Examination, A = Avoidance items, IM = Impression Management items.

**p* < .001

Table 3

Multiple Linear Regression Predicting Use of Safety Behaviours Overall and by Subtype

DV	Step	IV	*B*	SE *B*	*p* value	*F* change	ΔR^2
SAFE	1	(Constant)	93.213	1.091	< .001		
		NSPS	0.636	0.056	< .001	130.978**	.469
	2	(Constant)	93.213	1.052	< .001		
		NSPS	0.549	0.059	< .001		
		FOCS-R	0.401	0.116	.001	12.000*	.040
	3	(Constant)	93.348	1.127	< .001		
		NSPS	0.544	0.061	< .001		
		FOCS-R	0.405	0.117	.001		
		NSPS x FOCS-R	-0.002	0.005	.733	0.117	.000
SAFE-IM	1	(Constant)	42.680	0.597	< .001		
		NSPS	0.305	0.030	< .001	100.475**	.404
	2	(Constant)	42.680	0.579	< .001		
		NSPS	0.260	0.033	< .001		
		FOCS-R	0.205	0.064	.002	10.419**	.039
	3	(Constant)	43.124	0.611	< .001		
		NSPS	0.244	0.033	< .001		
		FOCS	0.222	0.063	.001		
		NSPS x FOCS-R	-0.005	0.003	.040	4.306**	.016
SAFE-A	1	(Constant)	37.973	0.527	< .001		
		NSPS	0.230	0.027	< .001	73.420**	.332
	2	(Constant)	37.973	0.517	< .001		
		NSPS	0.198	0.029	< .001		
		FOCS-R	0.150	0.057	.009	6.923**	.030
	3	(Constant)	37.911	0.554	< .001		
		NSPS	0.200	0.030	< .001		
		FOCS	0.147	0.057	.011		
		NSPS x FOCS-R	0.001	0.002	.750	0.102	.000

Note: NSPS = Negative Self-Portrayal Scale, FOCS-R = Fears of Compassion Scale (fears of receiving compassion), SAFE = Subtle Avoidance Frequency Examination, A = Avoidance items, IM = Impression Management items. All predictors have been mean centred; *p* < .01, **p* < .001

Figure 1

Moderating Effect of Negative Self-Portrayal on the Relationship Between Fears of Receiving Compassion and Use of Impression Management Safety Behaviours in Individuals with Social Anxiety Disorder

Note: NSPS = Negative Self-Portrayal Scale, FOCS-R = Fears of Compassion Scale (fears of receiving compassion), SAFE-IM = Subtle Avoidance Frequency Examination – Impression Management