

Nurses' Perception of Conscience and Effects of Their Fear of Compassion on Their Caring Behaviors

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Research Article

Keywords: Nursing, conscience, fear of compassion, caring behaviors

Posted Date: September 18th, 2025

DOI: <https://doi.org/10.21203/rs.3.rs-7130773/v1>

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Additional Declarations: No competing interests reported.

Abstract

Background

This study aimed to investigate the effects of nurses' perception of conscience and fear of compassion on their caring behaviors, as well as the relationships among these variables.

Method

The data of this descriptive, cross-sectional and correlational study were collected from 203 nurses working in a state hospital in western Turkey between July 2024 and December 2024. The data were collected using the the Personal Information Form, Perceptions of Conscience Questionnaire, Fear of Compassion Scale and Caring Behaviors Inventory via face-to-face interviews. In the descriptive statistics, numbers, percentages, arithmetic mean and standard deviation were used. The independent samples t-test and F test were used to compare sociodemographic data, whereas Pearson correlation analysis was used to analyze the correlation between the scales. A backward regression model was used to determine the independent variables which affected the participants' caring behaviors.

Results

The results of the study revealed that there was a negative moderate relationship between the nurses' caring behaviors and their levels of fear of compassion ($p < 0.01$), and a positive weak relationship between their caring behaviors and their levels of perception of conscience ($p < 0.05$). There was a negative weak relationship ($p < 0.05$) between their levels of fear of compassion and perception of conscience. According to the backward regression model established in the study, the nurses' levels of fear of compassion affected their caring behaviors by 26.3%.

Conclusion

It is recommended that regular in-service online or face-to-face training and psychosocial interventions should be planned to reduce the level of fear of compassion.

Introduction

Compassion is defined as an emotion that arises when someone witnesses another person's suffering and creates a desire in the person to help the suffering person (Goetz et al., 2010). Nas (2020) discussed the concept of compassion as an individual's awareness of the pain suffered by both themselves and others, and taking action to relieve the pain (Nas, 2020). Although compassion is one of the positive emotions, Rockliff et al. (2008) first defined the concept of "Fear of Compassion". In this case, when a person shows compassion, he or she perceives it as weakness and submission (Gilbert et al. 2012). Some individuals perceive compassion as a threat (Rockliff et al., 2008) and, accordingly, begin to fear the negative emotions and situations they may experience when they treat themselves or others compassionately or caringly (Çevik and Tanhan, 2020), which is defined as Fear of Compassion in the literature (Gilbert et al. 2012). Fear of compassion is one's fear of experiencing negative emotions and situations due to being compassionate and merciful towards oneself or others (Joeng, 2014; Çevik and Tanhan, 2020). In addition, fear of compassion is the fear of being compassionate towards himself or herself and others and the resistance of the person in being compassionate towards himself or herself and others (Gilbert et al. 2012, Whetsel, 2017). In other words, fear of compassion is being unwilling or inadequate to be compassionate towards others (Joeng, 2014), It is also the person's not willing to receive compassion from others, or not being able to be compassionate or not willing to be compassionate towards himself or herself (Whetsel, 2017). Individuals with fear of compassion are afraid of not only being devoid of compassion but also having the feeling of compassion (Gilbert et al. 2010). Therefore, the person experiences emotional blindness towards himself or herself and others (Gilbert et al. 2012). Fear of compassion manifests itself in the following three dimensions: fear of being compassionate towards others, fear of receiving compassion from others, and fear of being compassionate towards oneself. (Gilbert et al. 2012, Whetsel, 2017).

Hospitals are one of the places where patients and their relatives often experience bad times, feel helpless, and need conscientious and compassionate approaches (Adiguzel et al., 2024). In order to meet these needs, nurses are expected to provide compassionate, conscientious, and culturally sensitive care to patients and their families (Polat and Erdem 2017, Ghafourifard, Zamanzadeh, Valizadeh, et al. 2022; Takmak and Karaçar 2025). It is known that conscience plays an effective role in the emergence of compassion (Çam and Tamer Şişman, 2023; Dalgıç and Gürses, 2018). According to the definition made by the Turkish Language Association (TLA), conscience refers to "the power that pushes a person to make a judgment about his or her own behavior and enables the person to make direct and spontaneous judgments about his or her own moral values" (TLA, 2023). Conscience has been defined as "internalized moral principles that make the person decide whether actions taken or thought are right or wrong" (Ozcan, 2022). In conflicting ethical situations, healthcare professionals resort to the sense of conscience that allows them to distinguish right from wrong and directs them to take the right action, and they perceive their own conscience as a guide in coping with these challenging situations (Kadioğlu, 2015; Aksoy et al., 2019).

Nurses provide conscientious and compassionate care by establishing a bond with the individuals they care for, understanding their suffering, and helping them (Crawford et al., 2014). Compassion, which is also defined as sadness or pity one feels for a bad situation happens to another human being or living being, is an emotion that emerges when someone else's suffering is witnessed and triggers the desire to help (Goetz et al., 2010). It is also persons' understanding and kindness towards themselves (Neff, 2003), recognizing the distress they or others experience and taking action to reduce this distress (Nas and Sak, 2021). However, there are some factors preventing nurses from providing compassionate and conscientious care.

One of these factors may be nurses' fear of compassion (Pehlivan and Güner, 2020). In a previously performed study, it was stated that nurses' conscientious intelligence levels affect their care behaviors (Ozcan, 2022). In another study, nurses' fear of compassion was determined to affect their caring behaviors (Takmak and Karaçar, 2025). Khanjani et al. (2021) determined that nurses who felt compassion for others experienced less burnout. In the same study, it was reported that fear of compassion for others, fear of receiving compassion from others, and fear of self-compassion were closely associated with the level of burnout. In the literature, the number of studies conducted on fear of compassion and perception of conscience in nurses is limited. On the other hand, in the literature, there is a gap regarding studies in which the effects of nurses' perception of conscience and fear of compassion on their caring behaviors are investigated. The present study is thought to be the first in the literature in this respect and thus is expected to contribute to future studies. The aim of the researchers in the present study was to determine the effects of nurses' perception of conscience and fear of compassion on their caring behaviors.

Methods

Study design and setting

In this descriptive, cross-sectional, nurses working in a public hospital in western Turkey between July 2024 and December 2024 were included, data were collected through face-to-face interviews.

Before the study was conducted, ethical approval was obtained from the Yalova University Human Research Ethics Committee (decision date: June 24, 2024, decision number: 2024/159). Before all participants filled out the data collection tools, they were verbally informed about the study, and their written consent was obtained. All the nurses included in the present study volunteered to participate in the study.

Inclusion criteria: being able to communicate, being able to read and understand Turkish, and having nursing education

Exclusion criteria: Not filling in the data collection tools completely, being reluctant to answer the research questions, and being on sick leave or unpaid leave.

Sampling and study respondents

The population of the study consisted of 300 nurses working in the aforementioned hospital.

The minimum sample size for a correlation test was calculated as 200 nurses using the Power Analysis & Sample Size (PASS version: 11.0.10) statistical program (power: 80%, alpha: 0.05).

However, data were collected from 203 people in order to avoid missing data. All the nurses working in the hospital were listed according to their surnames, and 203 nurses corresponding to the numbers in the list were randomly selected and included in the study. None of the nurses was excluded from the study due to missing data.

Data collection tools

The data were collected with the Personal Information Form, Perceptions of Conscience Questionnaire, Fear of Compassion Scale, and Caring Behaviors Inventory.

Personal Information Form

The eight-item form was developed by the researchers to determine the participants' socio-demographic and nursing-related characteristics (Adiguzel et al., 2024).

Perceptions of Conscience Questionnaire:

The Perceptions of Conscience Questionnaire (PSQ) was developed by Dahlqvist et al. in 2007 (Dahlqvist et al., 2007). The validity and reliability study of the Turkish version of PSQ was performed by Aksoy et al. (2019). There are 13 items and 2 factors (Factor 1: Sensitivity, Factor 2: Authority) in the Turkish version of the PSQ. Responses given to the items are rated on a six-point Likert type scale ranging from 1 (strongly disagree) to 6 (strongly agree). There is no cut-off score on the PSQ. The lowest and highest possible scores that can be obtained from the PSQ are 13 and 78, respectively. The higher the score obtained from the PSQ is, the higher the respondent's level perception of conscience is. In the Turkish validity and reliability study of the PSQ, the Cronbach's Alpha coefficient was $\alpha=0.84$ (Aksoy et al., 2019).

Fear of Compassion Scale (FCS):

The FCS was developed by Nas and Sak (2021) to determine the fear of compassion levels of adults (those who were over 18 years of age). In the FCS, there are 2 dimensions and 20 items, whose responses are rated on a five-point Likert-type scale ranging from 1 to 5. There are no reverse scored items (Nas and Sak, 2021). The first 11 items of the FCS are in the first dimension (Fear of Compassion for Others) and the next 9 items are in the second dimension (Fear of Compassion for Oneself). The minimum and maximum possible scores that can be obtained from the FCS are 20 and 100, respectively. The higher the score obtained from the FCS is, the higher the respondent's level of fear of compassion is. Either the overall FCS or the each of the two dimensions can be scored.

Caring Behaviors Inventory-24 (CBI-24):

The CBI-24 is used to compare nurses' self-evaluations and patient perceptions. The validity and reliability study of the Turkish version of the CBI-24 was conducted by Kurşun and Kanan in 2010 (Kurşun and Kanan, 2010). The scale consists of 24 items and the following 4 dimensions: assurance (8 items = 16, 17, 18, 20, 21, 22, 23, 24), knowledge and skills (5 items = 9, 10, 11, 12, 15), respectfulness (6 items = 1, 3, 5, 6, 13, 19) and connectedness (5 items = 2, 4, 7, 8, 14). Responses given to the items are rated on a six-point Likert-type scale ranging from 1 to 6 (1 = never, 2 = almost never, 3 = sometimes, 4 = usually, 5 = often, 6 = always).

Data collection

The data were collected from the participating nurses by the researchers during the working hours of the day three days a week through face-to-face interviews. During data collection, the participants were not allowed to fill out the questionnaires whenever they wanted to avoid their being influenced by the other participants. The researcher interviewed each nurse for 15-20 minutes and collected the data herself.

Data Analysis

The researchers performed the statistical analyses using the IBM SPSS (Statistical Package for the Social Sciences) for Windows (SPSS Statistics Base v23, IBM). The analysis of the boxplot demonstrated that there were no extreme values in the PSQ, FCS and CBI-24. The skewness and kurtosis values for all the three scales ranged between -2 and +2, indicating that the data were normally distributed. For the internal consistency of the scale items, Cronbach's coefficients were used to analyze the data. P values less than 0.05 were considered statistically significant. In the descriptive statistics, numbers, percentages, arithmetic mean, and standard deviation were used. The independent samples t-test and F test were used to compare sociodemographic data, and Pearson correlation analysis was used to analyze the correlation between the scales. A backward regression model was used to determine the independent variables affecting the participants' caring behaviors.

Results

The mean age of the participants was 35.82 ± 8.92 (min: 20, max: 56) years. Of them, 89.7% (n: 182) were women, 78.3% (n: 159) were university graduates, and 69.5% (n: 141) were married. The scores that the nurses obtained from the items and dimensions of the data collection tools, and the skewness and kurtosis values related to the normal distribution of the scales were given in Table 1. The mean scores they obtained from the Fear of Compassion Scale, Perceptions of Conscience Questionnaire and Caring Behaviors Inventory-24 were 13.75 ± 5.39 , 59.63 ± 12.73 and 21.52 ± 2.29 , respectively.

Table 1
Mean Scores the Participating Nurses Obtained from the Fear of Compassion Scale, Perceptions of Conscience Questionnaire and Caring Behaviors Inventory-24

Scales and Dimensions		Min-max	Mean $\pm$ S.D	Skewness	Kurtosis
Fear of Compassion Scale (FCS)	Fear of Compassion for Others Dimension Score	11-40	18.91 ± 6.07	0.600	-.143
	Fear of Compassion for Oneself Dimension Score	9-35	13.75 ± 5.39	1.320	1.583
	Total FCS Score	20-64	32.67 ± 9.71	0.651	0.080
Perceptions of Conscience Questionnaire (PCQ)	Sensitivity Dimension Score	17-66	51.57 ± 10.72	-.565	-.263
	Authority Dimension Score	2-12	8.05 ± 2.74	-.284	-.544
	Total PCQ Score	19-78	59.63 ± 12.73	-.458	-.319
Caring Behaviors Inventory-24 (CBI-24)	Assurance Dimension Score	3-6	5.36 ± 0.60	-1.041	1.054
	Knowledge and Skills Dimension Score	3-6	5.64 ± 0.53	-1.980	4.385
	Respectfulness Dimension Score	3-6	5.29 ± 0.62	-.855	0.438
	Connectedness Dimension Score	3-6	5.21 ± 0.72	-.792	-.004
	Total CBI-24 Score	12-24	21.52 ± 2.29	-1.124	1.465

There was a negative moderate relationship ($r = -.513$; $p = 0.000$) between the scores the participants obtained from the Fear of Compassion Scale and the scores they obtained from the Caring Behaviors Inventory-24. There was a negative low-level relationship ($r = -.169$; $p = 0.016$) between the scores the participants obtained from the Fear of Compassion Scale and the scores they obtained from the Perceptions of Conscience Questionnaire. The relationships between the dimensions of all the scales were presented in Table 2.

Table 2
Relationship between the scores obtained from the scales and their dimensions by the participants (N = 203)

	Fear of Compassion Scale (FCS)	<i>Fear of Compassion for Others Dimension (FCS)</i>	<i>Fear of Compassion for Oneself Dimension (FCS)</i>	Perceptions of Conscience Questionnaire (PCQ)	<i>Sensitivity Dimension (PCQ)</i>	<i>Authority Dimension (PCQ)</i>	Caring Behaviors Inventory- 24 (CBI- 24)	<i>Assurance Dimension (CBI-24)</i>	<i>Knowledge and Skills Dimension (CBI-24)</i>	
Fear of Compassion Scale Total	-									
Fear of Compassion for Others Dimension	r:0.866 p:0.000*	-								
Fear of Compassion for Oneself Dimension	r: .826 p:0.000*	r: .433 p:0.000*	-							
Perceptions of Conscience Questionnaire - Total	r: - .169 p:0.016*	r:-.108 p:0.123	r:-.182 p:0.009*	-						
Sensitivity Dimension	r:-.168 p:0.017*	r:-.108 p:0.125	r:-.181 p:0.010*	r: .987 p:0.000*	-					
Authority Dimension	r:-.127 p:0.071	r:-.081 p:0.252	r:-.081 p:0.252	r: .780 p:0.000*	r: .669 p:0.000*	-				
Caring Behaviors Inventory-24 total	r:-.513 p:0.000*	r:-.451 p:0.000*	r:-.416 p:0.000*	r: .182 p:0.010*	r: .180 p:0.010*	r: .139 p:0.047*	-			
Assurance Dimension	r:-.509 p:0.000*	r:-.479 p:0.000*	r:-.377 p:0.000*	r: .181 p:0.010*	r: .173 p:0.014*	r: .166 p:0.018*	r: .921 p:0.000*	-		
Knowledge and Skills Dimension	r:-.408 p:0.000*	r:-.277 p:0.000*	r:-.422 p:0.000*	r: .137 p:0.052	r: .142 p:0.043*	r: .078 p:0.270	r: .842 p:0.000*	r: .757 p:0.000*	-	
Respectfulness Dimension	r:-.476 p:0.000*	r:-.425 p:0.000*	r:-.378 p:0.000*	r: .169 p:0.016*	r: .173 p:0.013*	r: .105 p:0.136	r: .956 p:0.000*	r: .840 p:0.000*	r: .716 p:0.000*	-
Connectedness Dimension	r:-.479 p:0.000*	r:-.449 p:0.000*	r:-.357 p:0.000*	r: .174 p:0.013*	r: .167 p:0.017*	r: .153 p:0.030*	r: .932 p:0.000*	r: .783 p:0.000*	r: .664 p:0.000*	r
*:p < 0.05										

The comparison of the scores obtained by the participants from the overall scales and their dimensions demonstrated that of the participants, married ones obtained significantly higher scores from the Sensitivity dimension of the Perceptions of Conscience Questionnaire (52.65 ± 10.75) than did the single ones (49.11 ± 10.33) ($t = 2.190$; $p:0.030$). Of the participants, those whose length of service in nursing was 5–10 years obtained significantly higher scores from the Fear of Compassion Scale (36.66 ± 11.57) than did those whose length of service in nursing was 15 years and above (31.34 ± 8.78) ($F = 2.747$; $p:0.044$). Of the participants, those who worked in the operating theatre obtained significantly higher scores from the Fear of Compassion Scale (39.63 ± 10.48) than did those who worked in the inpatient wards (31.58 ± 9.16) ($F = 4.520$; $p:0.004$). Conversely, those who worked in the inpatient wards obtained significantly higher scores from the Caring Behaviors Inventory (21.77 ± 2.21) than did those who worked in the operating theatre (19.88 ± 2.35) ($F = 6.682$; $p:0.000$). There were no significant differences between the scores the participants obtained from the scales and their dimensions in terms of the variables such as age, education level, sex, reasons for choosing the profession and type of work schedule.

According to the analysis of the factors affecting the caring behaviors of the participants, the Fear of Compassion Scale and Perceptions of Conscience Questionnaire, and four dimensions of both scales (fear of self-compassion, fear of compassion for others, sensitivity, authority) were included in the model. The factors affecting the caring behaviors of the participants were investigated using the backward regression method. According to the backward regression method, the most appropriate model was determined at the third step. The results of the ANOVA indicating the significance of the established regression model were given in Table 3. When the significance for the regression model was taken into account, the established model was accepted to be significant at 95% reliability ($p < 0.001$). In the established regression model, significant independent variables (fear of self-compassion, fear of compassion for others) explained the caring behaviors at a rate of 26.3%. According to the regression table values given in Table 4, scores obtained from the fear of self-compassion and fear of compassion for others dimensions had a statistically significant effect on the Caring Behaviors Inventory score (p values 0.000; 0.000, respectively).

Table 3
ANOVA Results for Regression Model

	Sum of Squares	df	Mean Square	F	p
Regression	279.382	2	139.691	35.759	< 0.001
Residual	781.290	200	3.906		
Total	1060.672	202			

Table 4
Coefficients in the Regression Model

	Unstandardized Beta	Coefficients Std. Error	Standardized Coefficients Beta	t	p	%95 Confidence Interval	
						Lower Bound	Upper Bound
Constant	25.493	0.491		51.924	< 0.001	24.525	26.461
Fear of Compassion for Others	-0.126	0.025	-.333	-4.954	0.000	-.176	-.076
Fear of Compassion for Oneself	-0.115	0.029	-.272	-4.034	0.000	-.172	-.059

Discussion

The results of the present study demonstrated that there was a negative moderate relationship between the participants' caring behaviors and fear of compassion levels ($r = -0.513$; $p < 0.001$), a positive weak relationship between their caring behaviors and perception of conscience levels ($r = 0.182$; $p = 0.010$), and a negative weak relationship ($r = -0.169$; $p = 0.016$) between their fear of compassion and perception of conscience levels. In other words, they displayed caring behaviors more as their levels of fear of compassion decreased and perception of conscience increased. In addition, their perception of conscience levels decreased as their fear of compassion levels increased. In the regression model established in the present study, fear of compassion for oneself and fear of compassion for others affected the participants' caring behaviors by 26.3%.

Compassion enables nurses to show empathy and understanding towards their patients (Koca and Erten, 2024). However, nurses who constantly witness the suffering of patients may develop a fear of compassion. "Fear of compassion" is a very important concept that should be taken into account in nursing care. Fear of compassion generally refers to an individual's concern about being emotionally affected or exhausted while he or she helps or provides support to another person (Khanjani et al., 2021). Fear of compassion is observed quite frequently in healthcare professionals, especially in nurses, because they often are faced with emotionally challenging situations due to their profession. Since nursing is a profession that requires empathy and compassion, nurses are at high risk of experiencing emotional burnout. In a study conducted with 216 nurses in Iran, a positive relationship was determined between fear of compassion and profession-related burnout (Khanjani et al., 2021). Nurses who experience fear of compassion may avoid establishing a deep bond with patients, which may prevent patients' emotional needs from being met adequately. Nurses who have a fear of compassion may also limit their abilities to establish empathy. The care provided by nurses with limited empathy and compassion may become mechanical and superficial. In addition, nurses with a high level of fear of compassion may set too many boundaries between themselves and the patient while they help the patient and provide support. Such boundaries may weaken their communication with the patient. In a study, it was demonstrated that nurses' caring behaviors were more related to their fear of self-compassion than their fear of compassion for others (Takmak and Karaçar, 2025). In some studies in which the effect of compassion on care was investigated, it was concluded that nurses' high levels of compassion positively affected the quality of nursing care they provided (Kıvanç, 2020; Yağık, 2020). In the literature, the number of studies conducted on fear of compassion and caring behaviors is quite limited. Thus, more research should be conducted on this subject.

According to the results of the present study, in the participants, as the level of fear of compassion increased, the level perception of conscience decreased, and as the level of perception of conscience decreased, so did caring behaviors. Nurses can resort to their conscience because they believe that their conscience enables them to take the right action in cases where they experience uncertainty and that they can use their conscience as a guide in ethical decision-making processes (Cleary and Horsfall, 2013). Conscience plays an important role when nurses fulfill their ethical and professional responsibilities (Gustafsson et al., 2010).

The decrease in levels of perception of conscience in nurses who have a fear of compassion may be due to the conflicts between their personal values and professional responsibilities. This tension can cause nurses to have difficulty in decision-making processes, to experience job dissatisfaction, and to become emotionally exhausted. Ozcan (2022) stated that nurses' conscientious intelligence levels affected their caring behaviors positively. According to Güleç (2022), there was a significant and positive relationship between conscience levels and caring behaviors (Güleç, 2022). In their study, Yıldız et al. stated that nurses with conscientious personality traits made fewer mistakes while they provided medical care (Çiriş Yıldız et al, 2024). Both compassion fatigue and conscientious tension can lead to emotional exhaustion in nurses, which can negatively affect their job performance and the quality of patient care they provide. Since the number of studies conducted on this subject is rather limited, more research should be conducted on the issue.

In the present study, the married participants obtained significantly higher scores from the sensitivity dimension of the Perceptions of Conscience Questionnaire than did the single participants, which suggests that the social roles and responsibilities of married individuals may cause them to display a

more sensitive approach, especially to the needs of others. Similarly, in Gün's study conducted with nurses (2023), married nurses obtained higher scores from the sensitivity sub-dimension of the Perceptions of Conscience Questionnaire, which is probably because married nurses reflect the roles such as providing care, taking responsibility, and empathizing they assume in their daily lives on their professional attitudes (Gün, 2023).

In the present study, of the participants, those whose length of service in nursing was 5–10 years had higher levels of fear of compassion than did those whose length of service in nursing was 15 years or more. In other words, their level of fear of compassion decreased as their length of service in nursing increased. As reported in a study, nurses with less than 2 years of professional experience had a high level of fear of compassion (Takmak and Karaçar, 2025). Sak et al., (2023) reported that the level of fear of compassion was significantly higher in young, single, and childless nurses. Nurses with more professional experience may have developed more skills in coping with stress by increasing their emotional resilience. Professional experience may also increase nurses' empathy skills, which may reduce the level of their fear of compassion.

In the present study, of the participants, those who worked in the operating theatre obtained significantly higher scores from the Fear of Compassion Scale than did those who worked in the inpatient wards. Similarly, in Takmak and Karaçar's study (2025), nurses working in operating theaters experienced fear of compassion at a higher level. In another study, nurses working in risky units such as operating theaters had higher levels of compassion fatigue than did nurses working in other units (Koca and Erten 2024). Operating theaters are high-stress areas that require high levels of attention, quick decision-making, coordination within the team, and technical skills. In these places, tolerance for errors is quite low. This stress can cause nurses working in operating theaters to become emotionally exhausted, and they are frequently faced with emergency and life-threatening situations. Such situations can prevent these nurses from empathizing and increase their fear of compassion levels. They also have long and irregular working hours, which can increase their physical and emotional fatigue levels, and thus causes them to suffer from compassion fatigue and, in turn, to develop fear of compassion.

Nurses working in inpatient services have longer, more regular and multi-dimensional interactions with their patients, which enables them to assume a more active role in the processes of providing both physical care and emotional support.

Conclusion

The results of the present study revealed that there was an association between the participating nurses' caring behaviors, and their levels of fear of compassion and perceptions of conscience. They displayed caring behaviors less and their perceptions of conscience decreased as their level of fear of compassion increased. Of the participants, those who worked in the operating theatre or had 5–10 years of professional experience had higher levels of fears of compassion. It is recommended that education and psychosocial interventions should be planned to reduce the level of fear of compassion, and that more comprehensive studies should be conducted to determine individual and institutional factors that make it difficult to implement compassionate care.

Limitations

The study has some limitations. The study sample included only some of the nurses working in a state hospital in a single province; thus, the results are applicable only to the nurses surveyed, and they cannot be generalized to all nurses.

Abbreviations

PSQ: The Perceptions of Conscience Questionnaire

FCS: Fear of Compassion Scale

CBI-24: Caring Behaviors Inventory-24

Declarations

- **Ethics approval and consent to participate:** In this study conducted in accordance with the Declaration of Helsinki, before the study was conducted, ethical approval was obtained from the Yalova University Human Research Ethics Committee (decision date: June 24, 2024, decision number: 2024/159). Written informed consent was obtained from all participants.
- **Consent for publication:** Not applicable
- **Availability of data and materials:** All data generated or analyzed during this study are included in this published article and its supplementary information files. No additional external datasets were used.
- **Competing Interests:** There is no conflict of interest between the authors.
- **Funding:** the study did not receive any financial support.
- **Authors' contributions:** Concept and design: Ş.Ö., V. A. Data collection: Ş.Ö., V. A. Data analysis and interpretation: Ş.Ö., V. A. Manuscript writing: Ş.Ö., V. A. Critical review: Ş.Ö., V. A.
- **Acknowledgements:** No additional acknowledgements.

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