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Compassion Focused Imagery Reduces Fears of Compassion Irrespective of Attachment

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The present study evaluated the efficacy of a brief compassion-focused imagery intervention for reducing fears of compassion. This study also examined whether individual differences in attachment would influence treatment effectiveness. We randomly assigned a nonclinical sample of 125 community-dwelling adults to a control group or an intervention group. Those in the intervention group completed a brief intervention involving daily compassionate imagery exercises for 1 week. Those who completed the intervention demonstrated significant reductions in fears of compassion for others, fears of compassion from others, and fears of self-compassion, irrespective of differences in attachment. These findings support the efficacy of compassion-focused imagery exercises in reducing fears of compassion across attachment patterns, suggesting their potential value for enhancing mental well-being.

Public Significance Statement

By evaluating a brief compassionate imagery intervention, this study demonstrates the potential utility of a brief self-administrable intervention for alleviating fears of compassion in those with secure and insecure attachments alike. Our findings indicated that fears of compassion from others, compassion for others, and self-compassion were all reduced by the intervention. This provides a valuable, easy-to-implement tool that could be utilized to alleviate fears of compassion—a construct which is known to be associated with reduced mental well-being.

Keywords: fears of compassion, compassion-focused therapy, compassionate mind training, attachment, individual differences

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Over the last 50 years, researchers have consistently identified that individual differences in attachment have significant implications for mental well-being (Bowlby, 1969; Hazan & Shaver, 1987; Mikulincer & Shaver, 2007). Adult attachment patterns can be described in terms of two continuous dimensions: anxiety and avoidance (Fraley et al., 2015). Attachment-related anxiety reflects individual differences in how people monitor and appraise the availability and accessibility of attachment figures, with those higher in anxiety being more likely to expect rejection and inconsistent support from others. Attachment-related avoidance reflects individual differences in how people manage attachment-related thoughts and

feelings, with those higher in avoidance typically experiencing greater discomfort with closeness and intimacy (Brennan et al., 1998).

Those with insecure attachments are more vulnerable to mental illbeing and have greater difficulties regulating emotions and in interpersonal relationships, including difficulties soothing negative emotions and greater reports of experiencing negative affect in relationships (Kirkpatrick & Hazan, 1994; M. B. Levy & Davis, 1988; Mikulincer & Shaver, 2019; Simpson et al., 1996). A factor believed to partially account for these difficulties in insecurely attached individuals is fear of compassion (Gilbert, 2014; Varley et al., 2024). The term “fear of compassion” refers to a phenomenon in

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Deanna Varley played a lead role in data curation, formal analysis, investigation, project administration, software, visualization, writing—

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which some people experience discomfort, aversion, or fear when giving or receiving compassion or experiencing other affiliative emotions (Gilbert et al., 2011). The detrimental impacts of fears of compassion are far-reaching, leading to poorer mental health and preventing individuals from experiencing feelings of safety, reassurance, and soothing in social and affiliative contexts, including in close interpersonal relationships (Gilbert et al., 2011; Kirby et al., 2019).

These effects are also present across multiple contexts and can be experienced not only in relation to receiving compassion from others, but also in relation to self-compassion, and extending compassion to others (Gilbert et al., 2011). This is problematic given that affiliative experiences are a key mechanism for regulating feelings of threat, stress, and social isolation (Depue & Morrone-Strupinsky, 2005; Gilbert, 2000, 2007, 2009a, 2010; Mikulincer & Shaver, 2007).

Importantly, a recent meta-analysis identified significant associations between attachment and fears of compassion across all three contexts—receiving compassion, self-compassion, and giving compassion (Varley et al., 2024). Specifically, greater attachment anxiety and avoidance were both significantly associated with all three types of fears of compassion. Interestingly, this association was consistent across both clinical and nonclinical populations, indicating that insecurely attached people frequently experience elevated fears of compassion irrespective of whether they have a mental health diagnosis. This is significant because compassionate experiences are integral to healthy interpersonal relationships and the regulation of negative emotions (Depue & Morrone-Strupinsky, 2005; Gilbert, 2000, 2007, 2009a, 2010; Mikulincer & Shaver, 2007). Consequently, it is critical these fears are addressed in those who experience them, including those with insecure attachments. However, most therapies do not aim to address these fears and can even be less effective for more insecurely attached people compared to more securely attached people (Bowlby, 1969; Cortés-García et al., 2020; Dagan et al., 2018; Daniel, 2006; K. N. Levy et al., 2018; Nielsen et al., 2019; Zhang et al., 2022). One promising intervention for specifically addressing fears of compassion in both those with insecure and secure attachments is compassion-focused therapy (CFT; Gilbert, 2009a). Gilbert (2009a) developed CFT in response to his observations that some people struggle to be self-compassionate and experience difficulty feeling soothed in the context of cognitive therapies. CFT is an integrative therapeutic modality informed by applied neuroscience, attachment theory, and evolutionary, clinical, and social psychology (Gilbert, 2010, 2014; Kirby & Petrocchi, 2023). It is also the only psychotherapy that directly targets the cultivation of compassion as the primary method for alleviating distress (Gilbert, 2014; Kirby et al., 2019). It has been established as an effective therapy, with a meta-analysis of 47 controlled trials of CFT identifying increases in self-compassion and compassion for others, and reductions in negative mental health outcomes including depression and self-criticism (Petrocchi et al., 2024).

CFT is also a promising option for reducing fears of compassion in insecurely attached individuals because it is both informed by attachment theory and directly targets underlying causes of these fears. According to the attachment theory, healthy relationships with caring others allow children to develop a sense of the attachment figure being a “secure base” from which they can safely explore, and a “a safe haven” to which they can return for care when needed (Bowlby, 1969, 1982). As securely attached children develop, this

sense of having a supportive attachment figure becomes internalized as a positive internal model of the self and others (Bowlby, 1973), later allowing adults to function as their own secure base. However, if an individual cannot develop a secure attachment in childhood, this does not occur.

CFT addresses these core developmental targets by helping people develop an internalized secure base, creating more positive internal models of the self and others (Gilbert, 2013). This allows people to cultivate abilities to engage with feared and avoided experiences—including compassionate experiences—thus allowing them to experience compassion more easily. To do this, CFT uses techniques to increase compassionate motivation and to reduce fears, blocks, and resistances to compassion. For example, studies indicate that CFT approaches including compassionate imagery exercises successfully reduce fears of compassion (Matos et al., 2017, 2022; Savari et al., 2021).

However, these interventions may not be suitable or accessible for some people. While CFT interventions vary in length and clinician involvement, they are typically delivered by a clinician as a long-term open-ended therapy or as a multiweek intervention, with manualized and empirically studied versions often involving 12 weekly modules (see Craig et al., 2020; Kirby & Petrocchi, 2023, for reviews). The application of multiweek or long-term clinician-administered therapy presents a major challenge as those with elevated fears of compassion are less likely to present for clinician-administered therapy and are less likely to remain in therapy if they do (Gilbert, 2010). Further, insecure attachment has been linked to elevated fears of compassion even in those without a clinical/mental health diagnosis (Varley et al., 2024). Thus, those with insecure attachments may benefit from an intervention to reduce fears of compassion even if they do not require or choose to access long-term, intensive, or clinician-administered therapy for diagnosable mental health concerns. Indeed, it is known that a formal clinical diagnosis for a mental illness is not required to be negatively affected by factors that negatively impact overall mental well-being (Collins et al., 2023; Haller et al., 2014). Consequently, investigation of a brief, accessible intervention for fears of compassion that could be easily self-administered or implemented as an adjunct to early stage clinician-administered CFT would be beneficial. This would be particularly helpful as there is already evidence that those with high fears of self-compassion may particularly benefit from compassion-focused interventions (see Liu et al., 2023) and brief, self-administered interventions can be useful for those more likely to have negative attitudes or responses to therapist-administered treatments (Mains & Scogin, 2003), including those with insecure attachments (Daniel, 2006).

However, despite CFT being informed by attachment theory and utilizing techniques for reducing fears of compassion, it has not been confirmed whether CFT approaches are comparatively effective across individual differences in attachment or whether such treatments should be refined to suit attachment insecurities. This is significant, as it is imperative to tailor interventions to individual needs (Norcross & Wampold, 2011). Indeed, attachment styles influence responses in therapy and have been identified as a characteristic that ought to be investigated as a basis on which therapies should be adapted to individual needs (Norcross & Wampold, 2011). Understanding how CFT influences fears of compassion across differences in attachment is therefore crucial. An empirical exploration of the efficacy of CFT techniques across individual differences in attachment would provide valuable insights into the adaptability of this approach and possible

areas of optimization necessary to address unique needs across attachment patterns.

Overall, investigating the effects of a brief self-administered CFT intervention for fears of compassion across individual differences in attachment would allow us to confirm its suitability, and foster an understanding of how attachment may influence its outcomes. This study therefore aimed to provide preliminary information regarding whether compassion-focused interventions are comparatively effective for reducing fears of compassion across individual differences in attachment by investigating whether the effects of a brief self-administered CFT intervention were moderated by attachment anxiety, avoidance, or a combination of the two.

The Present Study

To address our aim, we examined whether attachment anxiety, avoidance, or their interaction moderated the effects of a brief 1-week self-administered CFT intervention on fears of compassion. A community sample of participants completed a baseline survey of self-report measures of attachment and all three types of fears of compassion. Next, participants were randomly assigned to one of two groups: an intervention group that were asked to listen to a 10-min guided CFT exercise once daily for 7 days, or a waitlist control group. After 7 days, all participants completed a second assessment of fears of compassion. The exercise used was a CFT imagery exercise known as “cultivating the compassionate self.” This exercise is a core practice in CFT and uses imagery techniques focused on imagining what it would be like to feel and act as one’s “compassionate self,” thus practicing and developing compassion-based competencies and greater comfort with compassionate experiences.

Imagery exercises are believed to be effective for reducing fears of compassion because asking clients to imagine themselves being compassionate allows them to avoid debating whether they have these qualities or the ability to develop them. Instead, such exercises allow them to focus on exploring how a compassionate version of themselves would feel, think, and behave (Kolts et al., 2016). In this way, imagery exercises can help those who may initially feel uncomfortable with compassionate feelings to practice these feelings and develop compassionate ways of feeling, reasoning, and behaving that can be applied later in their daily lives and future experiences (Kolts et al., 2016).

Moreover, imagery exercises can be physiologically powerful (Singer, 2006), with images being capable of stimulating the same physiological responses as real events. Thus, if individuals can practice switching their attention to compassionate ways of thinking via imagery, this can help these individuals stimulate the physiological and motivational systems responsible for soothing, making these more accessible later, and thereby reducing aversive responses to compassion (Gilbert, 2009b).

Gilbert (2009c) has also argued that compassion-focused imagery can be used to enhance an inner sense of security by stimulating the affect regulation system partially responsible for facilitating effective social affiliation with others, giving and receiving care, and feelings of well-being (referred to as “the soothing system”). If compassion-focused imagery successfully stimulates the soothing system and promotes an inner sense of security, it is likely that this would lead to reductions in all three types of fears of compassion.

We, therefore, predicted that postintervention, relative to preintervention, those in the intervention group would report fewer fears of

compassion across all three types of fears of compassion—fears of self-compassion, compassion for others, and compassion from others. In contrast, we anticipated that those in the waitlist control group would show no significant differences between their preintervention and postintervention scores. This was the first study to review whether effects of a CFT intervention may vary across individual differences in attachment anxiety and avoidance. Given this paucity of prior research, combined with the disparity between findings showing those with insecure attachments experience greater difficulties in psychotherapy (Daniel, 2006; K. N. Levy et al., 2018; Nielsen et al., 2019) and CFT being promising as an intervention for those with insecure attachments, we did not predefine hypotheses regarding whether the effects of the intervention would be moderated by attachment anxiety, avoidance, or an interaction between anxiety and avoidance. Rather, we intended to use exploratory analyses to provide preliminary information regarding the efficacy of CFT techniques across differences in attachment.

Method

Participants

Selection of our sample size was guided by an a priori power analysis using G*Power (Faul et al., 2007) for linear multiple regression with seven predictors, including group, attachment anxiety, avoidance, and their interaction terms. We estimated power for multiple regression as our analyses use an ordinary least squares regression approach (see Montoya, 2019). We estimated the sample size required to detect a medium effect ($f^2 = 0.15$) as identified in similar previous research (Matos et al., 2017), with 80% power at $\alpha = .05$. This suggested a required minimum sample of 103 participants.

We recruited 146 participants via a public university research participation scheme. Eligible participants were at least 18 years old, fluent in English, meditation-naïve, and owned a smartphone available for their use in the study.

After providing consent, participants were randomly assigned to either an intervention group ($N = 70$) or waitlist control group ($N = 76$) to be provided with access to the CFT materials after the study. After recruitment, nine participants withdrew from the study. Three withdrew from the intervention group—one due to a natural disaster, one due to work commitments, and one did not specify their reason. Six withdrew from the control group—two due to a natural disaster, one due to busyness, and three did not specify. A further five participants from the intervention group and seven participants from the control group were excluded due to missing attachment or fears of compassion data.

Our final sample was a nonclinical sample of 125 community-dwelling adults ($M_{\text{age}} = 24.56$, $SD = 7.77$)—62 in the intervention group (47 women, 14 men, one nonbinary; $M_{\text{age}} = 24.70$, $SD = 8.03$), and 63 in the control group (52 women, 11 men; $M_{\text{age}} = 24.40$, $SD = 7.58$). In the control group, the self-reported racial distribution consisted of 31 Asian participants, 22 White participants, one Aboriginal/Torres Strait Islander person, and eight participants who did not disclose. In the intervention group, the self-reported racial distribution consisted of 37 Asian participants, 22 White participants, and four participants who did not disclose. In the control group, 22 participants reported having a high school level education, 27 reported holding a bachelor’s degree, five a master’s degree, one a doctorate level degree, three reported less than a high school level education, one reported holding an associate’s degree, and four

reported holding another type of qualification (e.g., trade certification). In the intervention group, 25 reported having a high school level education, 24 held a bachelor's degree, nine a master's degree, one an associate's degree, and four another type of qualification.

There were no significant differences in age, $t(123) = 0.19$, $p = .850$, or gender distribution across groups, $\chi^2 = 1.60$, $p = .448$. In addition, Kruskal–Wallis H tests showed no significant gender-related differences in attachment anxiety, $\chi^2(2) = 2.51$, $p = .285$; avoidance, $\chi^2(2) = 1.74$, $p = .418$; or preintervention scores in fears of self-compassion, $\chi^2(2) = 0.20$, $p = .903$; fears of compassion for others, $\chi^2(2) = 0.55$, $p = .759$; or fears of compassion from others, $\chi^2(2) = 0.43$, $p = .806$.

Measures and Materials

Attachment

To assess attachment, participants completed the global version of the Experiences in Close Relationships–Relationship Structures Scale (Fraley et al., 2011). Participants indicated agreement to nine items (e.g., “I’m afraid that other people may abandon me”) on a 7-point Likert scale (1 = *strongly disagree*, 7 = *strongly agree*). The scale provides two continuous subscale scores—one for attachment anxiety and another for avoidance. Higher scores indicate greater attachment anxiety and avoidance, respectively. The Experiences in Close Relationships–Relationship Structures Scale has good internal consistency for both the anxious and avoidant subscales (Cronbach’s $\alpha = .80$ and $.88$, respectively; Fraley et al., 2011). Internal consistency in this study was good for the anxious subscale (Cronbach’s $\alpha = .89$) and acceptable for the avoidant subscale (Cronbach’s $\alpha = .78$).

Fears of Compassion

Participants completed all three Fears of Compassion subscales (Gilbert et al., 2011) measuring fears of compassion for others, compassion from others, and self-compassion. Each subscale includes 10, 13, and 15 items, respectively (e.g., “Wanting others to be kind to oneself is a weakness”), rated on a 5-point Likert scale (0 = *do not agree at all*, 4 = *completely agree*). Internal consistency is good for fears of compassion for others and from others subscales (Cronbach’s $\alpha = .84$ and $.85$) and excellent for fears of self-compassion ($\alpha = .92$; Gilbert et al., 2011). Internal consistency in this study was good for the fears of compassion for others subscale when measured preintervention and excellent postintervention (Cronbach’s $\alpha = .83$ and $.90$), good for the fears of compassion from others subscale at preintervention and excellent postintervention (Cronbach’s $\alpha = .88$ and $.91$), and excellent for the fears of compassion for self-subscale at preintervention and postintervention (Cronbach’s $\alpha = .91$ and $.92$).

CFT Imagery Exercise

Participants in the intervention group were asked to complete a guided CFT imagery exercise called “cultivating the compassionate self” once daily for 7 days at any convenient time during their day. To facilitate this, participants were sent daily reminders via SMS at 8.00 a.m. each day with a link to an audio recording of the exercise. Studies show this exercise increases parasympathetic activity and reduces activity in neural networks associated with threat (Kim et al., 2020). This exercise is a core technique used in

CFT (Kirby & Petrocchi, 2023; Kolts et al., 2016) and prompts participants to establish a grounding body posture (shoulders back, chest open, feet flat on floor), engage in soothing rhythm breathing, and imagine themselves embodying qualities of compassionate motivation (a committed desire to be helpful and relieve suffering in the self and others), wisdom to understand one’s experiences, and strength to act compassionately. The imagery exercise then guides participants to imagine what it would be like to act in compassionate ways.

We recorded whether and how frequently participants streamed the audio from the hosting server by capturing unique Internet Protocol address information. We used this information to ensure all participants in the intervention group engaged with the imagery exercise at least once across the week. See the additional online material at https://osf.io/g9zh8?view_only=63678ae6cba84c0e9476716d1d778487 for the audio recording.

Procedure

First, participants attended the laboratory for an in-person session. Participants were provided with written information about the study before providing written consent if they agreed to participate. Participants were randomly assigned to either the intervention or control group. After this, all participants completed a demographic questionnaire and measures of attachment and fears of compassion.

Next, participants in the intervention group received standardized verbal instructions (see additional online material at https://osf.io/2w3xz/?view_only=63678ae6cba84c0e9476716d1d778487) for completing the CFT exercise. They were informed they would receive a daily text message at 8:00 a.m. for the next 7 days providing a link to an audio recording of the guided CFT exercise and were asked to listen to it once daily for the next 7 days, starting the next day. Participants were advised that we would measure the number of times they engaged with the exercise by capturing unique Internet Protocol address information when they streamed the audio recording. Participants in the control group did not receive any instructions to complete any CFT exercises throughout the week. After 7 days, all participants returned to the laboratory to complete measures of fears of compassion again and receive compensation for their time (\$20 AUD/hr for a total of \$40–60). Those in the control group were then given access to the CFT exercise.

Data Analysis

To investigate whether attachment anxiety, avoidance, or their interaction moderated the effects of a brief 1-week self-administered CFT intervention on fears of compassion, we conducted a moderation analysis for two instance repeated measures designs using multiplicative moderation (Montoya, 2019). This analysis computes a pre–post difference score by subtracting postintervention outcome scores from preintervention outcome scores. Thus, positive scores reflect decreases in outcome scores from preintervention to postintervention. This analysis then examines whether specified moderators predict the difference score (Judd et al., 2001). Significant interactions were probed at 1 SD above and below the mean for continuous moderators (attachment anxiety and avoidance), and at both levels of the dichotomous moderator (group). Analyses were conducted in R (Version 4.2.2; R Core Team, 2022) using the mod2rm package (Forstmann, 2022). Group was coded such that the control

group was the reference category (0 = control, 1 = intervention). Both continuous moderator variables were mean centered.

Transparency and Openness

This study was conducted as part of a larger preregistered protocol (https://osf.io/wfn4g/?view_only=d8c7b67c4dba492abc6518ce8c5c2860). The hypotheses and analysis plan were planned but not preregistered. Data, materials, and R code for analyses are available in the additional online material (https://osf.io/2w3xz/?view_only=63678ae6cba84c0e9476716d1d778487). Ethical approval for this study was provided by a university Human Research Ethics Committee. We report how we determined our sample size, all data exclusions, all manipulations, and all measures in the study.

Results

Descriptive Statistics

While tests for baseline differences are no longer believed necessary for verifying successful randomization (see Altman, 1985; Senn, 2013), following convention, we conducted independent groups *t* tests to review whether there were group differences for preintervention scores of fears of compassion, attachment anxiety, or avoidance (see Table 1). We identified no significant differences. We also reviewed whether the effect of the intervention was moderated by gender and identified no moderating effect of gender (see Supplemental Materials).

On average, participants in the intervention group completed a CFT exercise on 4 of the 7 days of the intervention period (*SD* = 2.31). Means and standard deviations for attachment and fears of compassion scores are in Table 2. Correlations between variables are in Table 3.

Fears of Self-Compassion

Overall, there was a significant decrease in fears of self-compassion from preintervention (*M* = 19.95, *SD* = 11.75) to postintervention (*M* = 16.32, *SD* = 11.12), $t(124) = 4.31, p < .001$. This effect was moderated by group (see Table 4). Conditional effects indicated that, holding attachment anxiety and avoidance constant at their means, difference scores in the intervention group significantly differed from zero ($\beta = 5.78, SE = 1.15, t = 5.02, p < .001, 95\% CI [3.50, 8.06]$), showing a significant decrease over time, but that difference scores in the control group had no significant difference from zero, suggesting no significant difference in fears of self-compassion over time for those in the control group ($\beta = 1.36, SE = 1.15, t = 1.18, p = .240$,

95% CI [−0.92, 3.64]). There were no moderating effects involving attachment anxiety or avoidance.

Fears of Compassion for Others

Overall, there was a significant decrease in fears of compassion for others from preintervention (*M* = 21.32, *SD* = 7.19) to postintervention (*M* = 18.86, *SD* = 8.50), $t(124) = 4.32, p < .001$. This effect was moderated by group (see Table 5). Conditional effects indicated that, holding attachment anxiety and avoidance constant at their means, difference scores in the intervention group significantly differed from zero ($\beta = 4.89, SE = 0.77, t = 6.32, p < .001, 95\% CI [3.36, 6.43]$), showing a significant decrease over time, but that difference scores in the control group had no significant difference from zero, suggesting no significant difference over time in the control group ($\beta = 0.24, SE = 0.78, t = 0.31, p = .760, 95\% CI [−1.31, 1.79]$). There were no moderating effects involving attachment anxiety or avoidance.

Fears of Compassion From Others

Overall, there was a significant decrease in fears of compassion from others from preintervention (*M* = 19.96, *SD* = 9.69) to postintervention (*M* = 17.54, *SD* = 10.25), $t(124) = 4.12, p < .001$. This effect was moderated by group (see Table 6). Conditional effects indicated that, holding attachment anxiety and avoidance constant at their means, difference scores in the intervention group significantly differed from zero ($\beta = 4.98, SE = 0.88, t = 5.63, p < .001, 95\% CI [3.23, 6.73]$), showing a significant decrease over time, but that difference scores in the control group had no significant difference from 0, suggesting no significant difference over time in the control group ($\beta = 0.42, SE = 0.89, t = 0.47, p = .639, 95\% CI [−1.35, 2.19]$). There were no moderating effects involving attachment anxiety or avoidance.

Discussion

Individuals with insecure attachments tend to experience greater discomfort or fear in response to compassionate and other affiliative experiences (Varley et al., 2024). This is problematic, as such fears of compassion are associated with poorer mental well-being and greater difficulty experiencing feelings of safety, reassurance, and soothing in social and affiliative contexts (Gilbert, 2010; Gilbert et al., 2011; Kirby et al., 2019). These negative outcomes necessitated investigation of an intervention to reduce fears of compassion, especially for those with insecure attachments. Consequently, we aimed to investigate the effectiveness of a brief, self-administered CFT intervention for reducing fears of compassion and to examine whether the effects of this intervention were moderated by attachment anxiety, avoidance, or their interaction with each other.

As anticipated, those who completed the brief CFT intervention showed significant reductions in all three types of fears of compassion after the intervention. In contrast, those in the control group showed no significant differences over time in any type of fears of compassion. This pattern of effects was consistent across differences in attachment, indicating that the CFT intervention reduced fears of compassion in a similar manner irrespective of participants' attachments.

This indicates that the self-administered CFT exercise used in this study is a valuable practice for reducing fears of compassion and

Table 1

*Results of Independent Groups *t* Tests Checking for Differences Between the Control and Intervention Groups Prior to the Intervention*

Variable	<i>t</i> (<i>df</i>)	<i>p</i>
Attachment anxiety	0.63(123)	.529
Attachment avoidance	−0.40(123)	.689
Fears of self-compassion	1.21(123)	.228
Fears of compassion for others	0.73(123)	.470
Fears of compassion from others	1.23(123)	.221

Table 2
Descriptive Statistics Preintervention and Postintervention

Variable	Preintervention		Postintervention	
	Control (N = 63)	Intervention (N = 62)	Control (N = 63)	Intervention (N = 62)
	M (SD)	M (SD)	M (SD)	M (SD)
Attachment anxiety	4.14 (1.71)	4.32 (1.46)		
Attachment avoidance	3.69 (1.03)	3.61 (0.99)		
Fears of self-compassion	18.62 (11.29)	21.15 (12.04)	17.32 (11.07)	15.34 (11.13)
Fears of compassion for others	20.73 (6.06)	21.63 (7.72)	20.61 (7.51)	16.83 (9.23)
Fears of compassion from others	19.17 (9.39)	21.29 (9.85)	18.82 (10.87)	16.19 (9.65)

demonstrates that even a very brief, self-administered CFT intervention can bring about significant reductions in fears of compassion. This finding aligns with the previous research identifying that CFT approaches reduce fears of compassion (Matos et al., 2017, 2022; Savari et al., 2021) and suggests that CFT succeeds in its aims to develop compassion-focused competencies that allow people to engage with compassionate and affiliative experiences more easily (Kolts et al., 2016).

Our findings also extend on previous research by demonstrating that significant reductions in all three types of fears of compassion can be achieved in a very brief timeframe with the implementation of one simple self-administered CFT exercise. This demonstrates the potential utility of CFT as an effective short-term, self-administered intervention. This is promising, given there is a substantial need for accessible, cost-effective interventions (Mains & Scogin, 2003), particularly for those who may encounter more difficulty accessing, engaging in, and benefitting from face-to-face interventions. This is also particularly relevant for those with insecure attachments, as such individuals often form less effective therapeutic alliances (Daniel, 2006) and have elevated fears of compassion (Varley et al., 2024), which are believed to make it more difficult to engage in traditional clinician-led therapy (Gilbert, 2010; Varley et al., 2024).

Indeed, our finding that a brief CFT imagery intervention was effective irrespective of differences in attachment suggests that this intervention is suitable for reducing fears of compassion in those with insecure and secure attachments alike. This finding is particularly significant as insecure attachment is associated with elevated fears of compassion (Varley et al., 2024), and those with insecure attachments often report poorer outcomes in response to therapeutic interventions than those with secure attachments (Daniel, 2006;

K. N. Levy et al., 2018; Nielsen et al., 2019). Thus, our results support the suggestions of Gilbert (2009c, 2013), who proposed that imagery techniques would be suitable for those with insecure attachments.

It is possible that the positive characteristics of the studied CFT imagery exercise may account for the absence of attachment-related differences in its effectiveness as these characteristics may be beneficial irrespective of individual differences in attachment and may mitigate reasons other therapies are sometimes less effective for those with greater attachment insecurity. Specifically, more insecurely attached individuals sometimes benefit less from cognitive therapies because they struggle to feel comforted by adaptive thoughts generated to counteract maladaptive thoughts (a central technique of cognitive therapies like cognitive behavioral therapy; Gilbert, 2009c; Stott, 2007). Gilbert (2009c) suggested that activation of a soothing physiological affect regulation system is necessary to feel comforted. However, early experiences can hinder development of soothing affect regulation systems, leading them to be underactive or less accessible for more insecurely attached people (Bowlby, 1969, 1973, 1980; Gilbert, 2009c; Liotti, 2000, 2002). Specifically, when early attempts to seek comfort or closeness from others are punished or ignored, these experiences become associated with yearning, grief or feelings of threat. Thus, future needs for comfort or closeness can reactivate these associated negative feelings, leading to fears of compassion. To address these challenges, Gilbert (2009c, 2013) proposed that stimulating this soothing system through CFT imagery techniques may alleviate issues encountered by more insecurely attached individuals with other therapies by reducing activation of threat response systems. This is corroborated by research demonstrating that CFT imagery exercise used in this study increases parasympathetic activity and reduces

Table 3
Correlations Between Attachment Anxiety, Attachment Avoidance, and Fears of Compassion T1 and T2

Variable	1	2	3	4	5	6	7	8
1. Attachment anxiety	—							
2. Attachment avoidance	.07	—						
3. Fears of self-compassion (T1)	.40***	.17	—					
4. Fears of compassion for others (T1)	.18*	.03	.35***	—				
5. Fears of compassion from others (T1)	.40***	.20*	.67***	.49***	—			
6. Fears of self-compassion (T2)	.34***	.14	.68***	.32***	.54***	—		
7. Fears of compassion for others (T2)	.12	.03	.20*	.67***	.36***	.52***	—	
8. Fears of compassion from others (T2)	.37***	.20*	.50***	.45***	.74***	.73***	.63***	—

Note. N = 125. Attachment anxiety and avoidance were only measured preintervention. T1 = preintervention; T2 = postintervention.

* $p < .05$. *** $p < .001$.

Table 4

Results of Two-Instance Moderation Analysis Testing for Moderating Effects of Group, Anxiety, Avoidance, and Their Interactions on Difference Scores in Fears of Self-Compassion

Parameter	β	SE	<i>t</i>	<i>p</i>	95% CI
Fears of self-compassion					
$F(7, 117) = 1.54, SE = 9.04, p = .160, R^2 = 0.03$					
Intercept	-2.98	2.59	-1.15	.251	[-8.11, 2.14]
Group	4.38	1.63	2.68	.008**	[1.15, 7.61]
Anxiety	-0.28	1.58	-0.18	.857	[-3.41, 2.84]
Avoidance	-2.54	2.68	-0.95	.345	[-7.86, 2.77]
Group $\times$ Anxiety	0.57	1.05	0.55	.587	[-1.51, 2.65]
Group $\times$ Avoidance	1.95	1.66	1.18	.242	[-1.34, 5.23]
Anxiety $\times$ Avoidance	-0.34	1.47	-0.23	.819	[-3.24, 2.57]
Group $\times$ Anxiety $\times$ Avoidance	0.28	0.93	0.30	.762	[-1.57, 2.13]

Note. SE = standard error; CI = confidence interval.

** $p < .01$.

activity in neural networks associated with threat (Kim et al., 2020). Combined with an emphasis on developing compassionate motivations and ways of thinking, these characteristics provide benefits to both securely and insecurely attached individuals and likely explain why attachment-related differences were not observed in the effectiveness of the CFT imagery exercise for reducing fears of compassion.

It is also notable that our results indicate that a compassionate self-imagery exercise is not only effective for reducing discomfort with self-compassion, but also for reducing discomfort receiving compassion from others and giving compassion to others. This finding can be explained in relation to insights from attachment theory. According to Bowlby (1969, 1982), lacking an internal sense of safety results in continued activation of the attachment system, which drives one to seek proximity and support from close others. Bowlby also believed that ongoing activation of the attachment system inhibits activation of other behavioral systems, including the caregiving system. This disrupts one's ability to provide effective caregiving to others and is understood to cause those with attachment insecurity to feel distress when others require caregiving (Gillath et al., 2005; Varley et al., 2024). Only when a sense of security is attained can one effectively activate the caregiving system (Gillath et al., 2005).

It is also understood that an internal sense of security and positive self-image enhances one's trust in potential caregivers and their support, confidence in being worthy of support, and comfort with

emotional vulnerability (Bartholomew & Horowitz, 1991; Gillath et al., 2005; Varley et al., 2024). Thus, it is plausible that the self-compassionate imagery exercise reduced fears of compassion to others and from others because improving one's internal self-image and sense of security via self-compassion facilitates healthy functioning of the caregiving behavioral system. This furthers support to the suggestions of Gilbert (2009c, 2013) that imagery exercises can develop a greater internalized sense of security, consequently making it easier for those who practice such exercises to feel comfortable with giving and receiving compassion, irrespective of differences in attachment.

Overall, these results are particularly encouraging given that insecure individuals are more likely to experience elevated fears of compassion compared to secure individuals (Varley et al., 2024). Reducing fears of compassion allows greater access to feelings of soothing, calm and contentedness (Gilbert, 2013), and is therefore likely to have positive flow-on effects for mental well-being (Kirby et al., 2019).

Practical and Theoretical Implications

Our results provide preliminary evidence that would support further development and implementation of such CFT techniques as accessible, self-administrable interventions. Given that fears of compassion are a major barrier to accessing traditional therapy, and

Table 5

Results of Two-Instance Moderation Analysis Testing for Moderating Effects of Group, Anxiety, Avoidance, and Their Interactions on Difference Scores in Fears of Compassion for Others

Parameter	β	SE	<i>t</i>	<i>p</i>	95% CI
Fears of compassion for others					
$F(7, 118) = 2.99, SE = 6.13, p = .006^{**}, R^2 = 0.10$					
Intercept	-4.36	1.75	-2.49	.014*	[-7.82, -0.89]
Group	4.62	1.10	4.19	<.001***	[2.44, 6.80]
Anxiety	1.08	1.07	1.02	.311	[-1.03, 3.20]
Avoidance	-0.61	1.81	-0.33	.740	[-4.21, 3.00]
Group $\times$ Anxiety	-0.68	0.71	-0.96	.341	[-2.08, 0.73]
Group $\times$ Avoidance	0.34	1.12	0.30	.765	[-1.89, 2.56]
Anxiety $\times$ Avoidance	-0.94	0.99	-0.95	.345	[-2.91, 1.03]
Group $\times$ Anxiety $\times$ Avoidance	0.63	0.63	0.99	.322	[-0.62, 1.88]

Note. SE = standard error; CI = confidence interval.

* $p < .05$. *** $p < .001$.

Table 6

Results of Two-Instance Moderation Analysis Testing for Moderating Effects of Group, Anxiety, Avoidance, and Their Interactions on Difference Scores in Fears of Compassion From Others

Parameter	β	SE	<i>t</i>	<i>p</i>	95% CI
Fears of compassion from others $F(7, 118) = 2.27, SE = 6.99, p = .033^*, R^2 = 0.07$					
Intercept	-4.09	2.00	-2.05	.043*	[-8.05, -0.13]
Group	4.53	1.26	3.60	<.001***	[2.04, 7.02]
Anxiety	-0.40	1.22	-0.33	.743	[-2.81, 2.01]
Avoidance	-2.33	2.07	-1.12	.263	[-6.44, 1.78]
Group $\times$ Anxiety	0.22	0.81	0.27	.786	[-1.38, 1.82]
Group $\times$ Avoidance	1.47	1.28	1.14	.255	[-1.07, 4.00]
Anxiety $\times$ Avoidance	-0.83	1.13	-0.73	.466	[-3.03, 1.42]
Group $\times$ Anxiety $\times$ Avoidance	0.63	0.72	0.87	.387	[-0.80, 2.06]

Note. SE = standard error; CI = confidence interval.

* $p < .05$. *** $p < .001$.

there is a significant need for accessible, cost-effective interventions (Mains & Scogin, 2003), it would be advisable for future research to further develop and test CFT approaches as a brief, self-administered intervention that could be accessed by those who may not need clinician-administered therapy, or for those who are not ready or are unable to engage in face-to-face psychotherapy. For example, if further research confirms our findings and establishes this kind of CFT program improves fears of compassion and other mental well-being outcomes, a brief online CFT program could be advertised for nonclinical populations who may not require longer term clinician-administered therapy, or potentially for those who find face-to-face therapy intimidating, uncomfortable, or inaccessible. Alternatively, if further work shows that the same benefits extend to this kind of intervention offered with the support of a therapist, clinicians working with clients with insecure attachments or notable fears of compassion could recommend this kind of intervention as an adjunct to traditional therapy that could be completed between sessions to support progress and engagement.

Our results also have significant implications for attachment theory and research. In particular, our findings suggest that compassion-focused approaches offer a promising avenue for helping those with insecure attachments to develop a greater sense of felt security. This is significant, as helping those with insecure attachments to foster feelings of security is associated with greater prosocial behavior (Gillath et al., 2005; Mikulincer et al., 2005) and emotional well-being (McGuire et al., 2018). Moreover, a recent meta-analysis identified that attachment security priming—which aims to increase a sense of security—did not lead to long-lasting improvements in behavioral, affective, cognitive, or emotional outcomes (Gillath et al., 2022). Given this, our results suggest that it would be pertinent for future research to investigate whether compassion-focused approaches may lead to long-lasting improvements in one's sense of felt security with positive effects on behavioral, affective, cognitive, and emotional outcomes.

Strengths and Limitations

While our results provide promising evidence for a brief CFT intervention for fears of compassion, our study was not without limitations. First, our study only assessed fears of compassion immediately before and after the intervention. While the intervention

was associated with significant reductions in fears of compassion immediately after the intervention, it is unclear if such reductions would be maintained over time. Given this, future research should investigate whether reductions in fears of compassion after a CFT intervention are maintained at follow-up assessments.

Further, the effect of the intervention was not compared to an active control group, meaning we cannot rule out a possible placebo effect or make inferences about the effectiveness of the intervention compared to other therapeutic interventions. Future research ought to compare the effects of the CFT intervention to one or more active control groups to provide stronger evidence of its effectiveness for reducing fears of compassion.

The generalizability of the present findings should also be considered as we utilized a nonclinical sample of mostly women. While we identified no gender-related differences in fears of compassion at both preintervention and postintervention, and no gender-related differences in the effect of the intervention for reducing fears of compassion, other research has identified that men report greater fears of self-compassion than women (Gilbert et al., 2011) and that those with a mental health-related diagnosis report greater fears of self-compassion, giving compassion and receiving compassion than those without mental health difficulties (Merritt & Purdon, 2020). Consequently, further work is required to investigate whether the effectiveness of the intervention may vary in different samples including in clinical samples and samples with different gender distributions.

In addition, it ought to be noted that, on average, participants in the intervention group only completed a CFT exercise on 4 of the 7 days of the intervention period. While this relatively low dosage did lead to reductions in fears of compassion over a brief intervention period of 7 days, future research ought to investigate whether a higher dosage or longer intervention period may lead to stronger changes.

Further, our results combined with insights from previous research suggest that implementing CFT approaches in psychotherapy may increase the likelihood of individuals forming effective therapeutic alliances with clinicians, attaining positive therapeutic outcomes, and remaining engaged in therapy (Gilbert, 2010). However, we did not directly assess these outcomes. A longitudinal study of an ongoing clinician-led CFT intervention would be necessary to confirm whether reductions in fears of compassion would indeed translate into these other positive outcomes.

Despite these limitations, our study had several notable strengths. First, our study investigated the influence of one core CFT exercise. This was an important methodological choice, as Gilbert (2009c, 2013) has specifically proposed that imagery exercises help individuals develop a greater internalized sense of security, likely making them suitable for those with insecure attachments. Thus, testing the effects of only one imagery exercise allowed us to be confident that the attained reductions in fears of compassion were attributable to the imagery exercise, rather than to other CFT techniques or a broad combination of CFT exercises. This knowledge could guide customization of treatment approaches to align with the specific needs and challenges of those vulnerable to fears of compassion, such as those with insecure attachments.

Further, our study was the first investigation of a CFT intervention to review possible moderating effects of attachment. While CFT was developed with specific reference to attachment theory and its proponents have long believed it would be suitable for those with insecure attachments (Gilbert, 2010, 2013, 2014; Kirby & Petrocchi, 2023), our study was the first to directly investigate this and provides important evidence for these claims.

Conclusion

We identified that a brief, self-administered CFT intervention involving 1 week of daily engagement with a self-compassionate imagery exercise significantly reduced fears of self-compassion, fears of compassion for others, and fears of compassion from others. We demonstrated that these results were consistent across individual differences in attachment, indicating that this type of intervention is suitable for those with secure and insecure attachments alike. These findings provide encouraging evidence for the suitability of CFT approaches for those with insecure attachments, especially given that those with insecure attachments are more likely to experience elevated fears of compassion (Varley et al., 2024). These findings suggest that this type of CFT intervention reduces fears of compassion even in a brief timeframe and without necessitating face-to-face clinician guidance. We recommend that future research further develops and investigates the efficacy and feasibility of such approaches as brief, self-administrable interventions or, potentially, as adjuncts to traditional therapy.

Our findings also contribute to our understanding of the interplay between the attachment and caregiving systems, as hypothesized by Bowlby (1969, 1982). Specifically, our findings indicate that one's internal self-image is not only relevant to the experience of self-compassion. Rather, our findings imply that one's internal self-image also has significant effects on one's ability to feel comfortable both giving and receiving compassion. This indicates that CFT approaches provide a promising avenue for helping individuals to establish more positive internal self-representations, with positive flow-on effects for both intra- and interpersonal outcomes.

References

- Altman, D. G. (1985). Comparability of randomised groups. *Statistician*, 34(1), 125–136. <https://doi.org/10.2307/2987510>
- Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology*, 61(2), 226–244. <https://doi.org/10.1037/0022-3514.61.2.226>
- Bowlby, J. (1969). *Attachment and loss* (Vol. I). Basic Books.
- Bowlby, J. (1973). *Attachment and loss: Volume II: Separation, anxiety and anger*. The Hogarth Press; The Institute of Psycho-Analysis.
- Bowlby, J. (1980). *Attachment and loss: Vol. III. Loss—Sadness and depression*. Hogarth Press.
- Bowlby, J. (1982). Attachment and loss: Retrospect and prospect. *American Journal of Orthopsychiatry*, 52(4), 664–678. <https://doi.org/10.1111/j.1939-0025.1982.tb01456.x>
- Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). Self-report measurement of adult attachment: An integrative overview. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment theory and close relationships* (pp. 46–76). The Guilford Press.
- Collins, B., Downing, J., Head, A., Comerford, T., Nathan, R., & Barr, B. (2023). Investigating the impact of undiagnosed anxiety and depression on health and social care costs and quality of life: Cross-sectional study using household health survey data. *BJPsych Open*, 9(6), Article e201. <https://doi.org/10.1192/bjo.2023.596>
- Cortés-García, L., Takkouche, B., Rodríguez-Cano, R., & Senra, C. (2020). Mediation mechanisms involved in the relation between attachment insecurity and depression: A meta-analysis. *Journal of Affective Disorders*, 277, 706–726. <https://doi.org/10.1016/j.jad.2020.08.082>
- Craig, C., Hiskey, S., & Spector, A. (2020). Compassion focused therapy: A systematic review of its effectiveness and acceptability in clinical populations. *Expert Review of Neurotherapeutics*, 20(4), 385–400. <https://doi.org/10.1080/14737175.2020.1746184>
- Dagan, O., Facompré, C. R., & Bernard, K. (2018). Adult attachment representations and depressive symptoms: A meta-analysis. *Journal of Affective Disorders*, 236, 274–290. <https://doi.org/10.1016/j.jad.2018.04.091>
- Daniel, S. I. (2006). Adult attachment patterns and individual psychotherapy: A review. *Clinical Psychology Review*, 26(8), 968–984. <https://doi.org/10.1016/j.cpr.2006.02.001>
- Depue, R. A., & Morrone-Strupinsky, J. V. (2005). A neurobehavioral model of affiliative bonding: Implications for conceptualizing a human trait of affiliation. *Behavioral and Brain Sciences*, 28(3), 313–350. <https://doi.org/10.1017/S0140525X05000063>
- Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, 39(2), 175–191. <https://doi.org/10.3758/BF03193146>
- Forstmann, M. (2022). *mod2rm: Moderation analysis for two-instance repeated measures* (Version 0.2.1, R package) [Computer software]. <https://CRAN.R-project.org/package=mod2rm>
- Fraley, R. C., Heffernan, M. E., Vicary, A. M., & Brumbaugh, C. C. (2011). The Experiences in Close Relationships-Relationship Structures questionnaire: A method for assessing attachment orientations across relationships. *Psychological Assessment*, 23(3), 615–625. <https://doi.org/10.1037/a0022898>
- Fraley, R. C., Hudson, N. W., Heffernan, M. E., & Segal, N. (2015). Are adult attachment styles categorical or dimensional? A taxometric analysis of general and relationship-specific attachment orientations. *Journal of Personality and Social Psychology*, 109(2), 354–368. <https://doi.org/10.1037/pspp0000027>
- Gilbert, P. (2000). Social mentalities: Internal “social” conflict and the role of inner warmth and compassion in cognitive therapy. In P. Gilbert & K. G. Bailey (Eds.), *Genes on the couch: Explorations in evolutionary psychotherapy* (pp. 118–150). Brunner-Routledge.
- Gilbert, P. (2007). Evolved minds and compassion in the therapeutic relationship. In P. Gilbert & R. L. Leahy (Eds.), *The therapeutic relationship in the cognitive behavioral psychotherapies* (pp. 106–142). Routledge/Taylor & Francis Group.
- Gilbert, P. (2009a). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment*, 15(3), 199–208. <https://doi.org/10.1192/apt.bp.107.005264>
- Gilbert, P. (2009b). The nature and basis for compassion focused therapy. *Hellenic Journal of Psychology*, 6(20), 273–291.

- Gilbert, P. (2009c). Evolved minds and compassion-focused imagery in depression. In L. Stopa (Ed.), *Imagery and the threatened self: Perspectives on mental imagery and the self in cognitive therapy* (pp. 206–231). Routledge/Taylor & Francis Group.
- Gilbert, P. (2010). An introduction to compassion focused therapy in cognitive behavior therapy. *International Journal of Cognitive Therapy*, 3(2), 97–112. <https://doi.org/10.1521/ijct.2010.3.2.97>
- Gilbert, P. (2013). Attachment theory and compassion focused therapy for depression. In A. N. Danquah & K. Berry (Eds.), *Attachment theory in adult mental health: A guide to clinical practice* (pp. 35–47). Routledge/Taylor & Francis Group.
- Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology*, 53(1), 6–41. <https://doi.org/10.1111/bjc.12043>
- Gilbert, P., McEwan, K., Matos, M., & Rivis, A. (2011). Fears of compassion: Development of three self-report measures. *Psychology and Psychotherapy: Theory, Research and Practice*, 84(3), 239–255. <https://doi.org/10.1348/147608310X526511>
- Gillath, O., Karantzas, G. C., Romano, D., & Karantzas, K. M. (2022). Attachment security priming: A meta-analysis. *Personality and Social Psychology Review*, 26(3), 183–241. <https://doi.org/10.1177/10888683211054592>
- Gillath, O., Shaver, P. R., & Mikulincer, M. (2005). An attachment-theoretical approach to compassion and altruism. In P. Gilbert (Ed.), *Compassion* (pp. 133–159). Routledge.
- Haller, H., Cramer, H., Lauche, R., Gass, F., & Dobos, G. J. (2014). The prevalence and burden of subthreshold generalized anxiety disorder: A systematic review. *BMC Psychiatry*, 14(1), Article 128. <https://doi.org/10.1186/1471-244X-14-128>
- Hazan, C., & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology*, 52(3), 511–524. <https://doi.org/10.1037/0022-3514.52.3.511>
- Judd, C. M., Kenny, D. A., & McClelland, G. H. (2001). Estimating and testing mediation and moderation in within-subject designs. *Psychological Methods*, 6(2), 115–134. <https://doi.org/10.1037/1082-989X.6.2.115>
- Kim, J. J., Parker, S. L., Doty, J. R., Cunningham, R., Gilbert, P., & Kirby, J. N. (2020). Neurophysiological and behavioural markers of compassion. *Scientific Reports*, 10(1), Article 6789. <https://doi.org/10.1038/s41598-020-63846-3>
- Kirby, J. N., Day, J., & Sagar, V. (2019). The ‘flow’ of compassion: A meta-analysis of the fears of compassion scales and psychological functioning. *Clinical Psychology Review*, 70, 26–39. <https://doi.org/10.1016/j.cpr.2019.03.001>
- Kirby, J. N., & Petrocchi, N. (2023). Compassion focused therapy—What it is, what it targets, and the evidence. In A. Finlay-Jones, K. Bluth, & K. Neff (Eds.), *Handbook of self-compassion* (pp. 417–432). Springer. https://doi.org/10.1007/978-3-031-22348-8_23
- Kirkpatrick, L. A., & Hazan, C. (1994). Attachment styles and close relationships: A four-year prospective study. *Personal Relationships*, 1(2), 123–142. <https://doi.org/10.1111/j.1475-6811.1994.tb00058.x>
- Kolts, R. L., Gilbert, P., & Hayes, S. C. (2016). *CFT made simple: A clinician's guide to practicing compassion-focused therapy*. New Harbinger Publications.
- Levy, K. N., Kivity, Y., Johnson, B. N., & Gooch, C. V. (2018). Adult attachment as a predictor and moderator of psychotherapy outcome: A meta-analysis. *Journal of Clinical Psychology*, 74(11), 1996–2013. <https://doi.org/10.1002/jclp.22685>
- Levy, M. B., & Davis, K. E. (1988). Lovestyles and attachment styles compared: Their relations to each other and to various relationship characteristics. *Journal of Social and Personal Relationships*, 5(4), 439–471. <https://doi.org/10.1177/0265407588054004>
- Liotti, G. (2000). Disorganized attachment, models of borderline states and evolutionary psychotherapy. In P. Gilbert & K. G. Bailey (Eds.), *Genes on the couch: Explorations in evolutionary psychotherapy* (pp. 232–256). Brunner-Routledge.
- Liotti, G. (2002). The inner schema of borderline states and its correction during psychotherapy: A cognitive-evolutionary approach. *Journal of Cognitive Psychotherapy*, 16(3), 349–366. <https://doi.org/10.1891/jcop.16.3.349.52521>
- Liu, S., Wei, M., & Russell, D. (2023). Effects of a brief self-compassion intervention for college students with impostor phenomenon. *Journal of Counseling Psychology*, 70(6), 711–724. <https://doi.org/10.1037/cou0000703>
- Mains, J. A., & Scogin, F. R. (2003). The effectiveness of self-administered treatments: A practice-friendly review of the research. *Journal of Clinical Psychology*, 59(2), 237–246. <https://doi.org/10.1002/jclp.10145>
- Matos, M., Duarte, C., Duarte, J., Pinto-Gouveia, J., Petrocchi, N., Basran, J., & Gilbert, P. (2017). Psychological and physiological effects of compassionate mind training: A pilot randomised controlled study. *Mindfulness*, 8(6), 1699–1712. <https://doi.org/10.1007/s12671-017-0745-7>
- Matos, M., Duarte, C., Duarte, J., Pinto-Gouveia, J., Petrocchi, N., & Gilbert, P. (2022). Cultivating the compassionate self: An exploration of the mechanisms of change in compassionate mind training. *Mindfulness*, 13(1), 66–79. <https://doi.org/10.1007/s12671-021-01717-2>
- McGuire, A., Gillath, O., Jackson, Y., & Ingram, R. (2018). Attachment security priming as a potential intervention for depressive symptoms. *Journal of Social and Clinical Psychology*, 37(1), 44–68. <https://doi.org/10.1521/jscp.2018.37.1.44>
- Merritt, O. A., & Purdon, C. L. (2020). Scared of compassion: Fear of compassion in anxiety, mood, and non-clinical groups. *British Journal of Clinical Psychology*, 59(3), 354–368. <https://doi.org/10.1111/bjc.12250>
- Mikulincer, M., & Shaver, P. R. (2007). Boosting attachment security to promote mental health, prosocial values, and inter-group tolerance. *Psychological Inquiry*, 18(3), 139–156. <https://doi.org/10.1080/10478400701512646>
- Mikulincer, M., & Shaver, P. R. (2019). Attachment orientations and emotion regulation. *Current Opinion in Psychology*, 25, 6–10. <https://doi.org/10.1016/j.copsyc.2018.02.006>
- Mikulincer, M., Shaver, P. R., Gillath, O., & Nitzberg, R. A. (2005). Attachment, caregiving, and altruism: Boosting attachment security increases compassion and helping. *Journal of Personality and Social Psychology*, 89(5), 817–839. <https://doi.org/10.1037/0022-3514.89.5.817>
- Montoya, A. K. (2019). Moderation analysis in two-instance repeated measures designs: Probing methods and multiple moderator models. *Behavior Research Methods*, 51(1), 61–82. <https://doi.org/10.3758/s13428-018-1088-6>
- Nielsen, S. K. K., Hageman, I., Petersen, A., Daniel, S. I. F., Lau, M., Winding, C., Wolitzky-Taylor, K. B., Steele, H., & Vangkilde, S. (2019). Do emotion regulation, attentional control, and attachment style predict response to cognitive behavioral therapy for anxiety disorders?—An investigation in clinical settings. *Psychotherapy Research*, 29(8), 999–1009. <https://doi.org/10.1080/10503307.2018.1425933>
- Norcross, J. C., & Wampold, B. E. (2011). What works for whom: Tailoring psychotherapy to the person. *Journal of Clinical Psychology*, 67(2), 127–132. <https://doi.org/10.1002/jclp.20764>
- Petrocchi, N., Ottaviani, C., Cheli, S., Matos, M., Baldi, B., Basran, J. K., & Gilbert, P. (2024). The impact of compassion-focused therapy on positive and negative mental health outcomes: Results of a series of meta-analyses. *Clinical Psychology: Science and Practice*, 31(2), 230–247. <https://doi.org/10.1037/cps0000193>
- R Core Team. (2022). *R: A language and environment for statistical computing* (Version 4.2.1) [Computer software]. R Foundation for Statistical Computing. <https://www.R-project.org/>
- Savari, Y., Mohagheghi, H., & Petrocchi, N. (2021). A preliminary investigation on the effectiveness of compassionate mind training for students with major depressive disorder: A randomized controlled trial. *Mindfulness*, 12(5), 1159–1172. <https://doi.org/10.1007/s12671-020-01584-3>
- Senn, S. (2013). Seven myths of randomisation in clinical trials. *Statistics in Medicine*, 32(9), 1439–1450. <https://doi.org/10.1002/sim.5713>

- Simpson, J. A., Rholes, W. S., & Phillips, D. (1996). Conflict in close relationships: An attachment perspective. *Journal of Personality and Social Psychology*, 71(5), 899–914. <https://doi.org/10.1037/0022-3514.71.5.899>
- Singer, J. L. (2006). *Imagery in psychotherapy*. American Psychological Association. <https://doi.org/10.1037/11366-000>
- Stott, R. (2007). When head and heart do not agree: A theoretical and clinical analysis of Rational-Emotional Dissociation (RED) in cognitive therapy. *Journal of Cognitive Psychotherapy*, 21(1), 37–50. <https://doi.org/10.1891/088983907780493313>
- Varley, D., Sherwell, C. S., Fu, M., & Kirby, J. N. (2024). A multi-level meta-analytic review of attachment and fears of compassion. *Personality and Individual Differences*, 218, Article 112477. <https://doi.org/10.1016/j.paid.2023.112477>
- Zhang, X., Li, J., Xie, F., Chen, X., Xu, W., & Hudson, N. W. (2022). The relationship between adult attachment and mental health: A meta-analysis. *Journal of Personality and Social Psychology*, 123(5), 1089–1137. <https://doi.org/10.1037/pspp0000437>
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QUESTIONNAIRE

C5(26)

Compassion Focused Imagery Reduces Fears of Compassion Irrespective of Attachment

INSTRUCTIONS

- Read through the article and answer the multiple-choice questions provided below.
- **Some questions may have more than one correct answer;** in which case you must mark **all** the correct answers.

Question 1: Attachment-related anxiety reflects individual differences in how people monitor and appraise the availability and accessibility of attachment figures, with those higher in anxiety being more likely to expect which of the following? Select **BOTH** correct options.

- A: Acceptance
- B: Rejection
- C: Inconsistent support from others
- D: Consistent support from others

Question 2: _____ reflects individual differences in how people manage attachment-related thoughts and feelings, with those higher in _____ typically experiencing greater discomfort with closeness and intimacy.

- A: Attachment-related anxiety; avoidance
- B: Attachment-related avoidance; anxiety
- C: Attachment-related anxiety; anxiety
- D: Attachment-related avoidance; avoidance

Question 3: _____ refers to a phenomenon in which some people experience discomfort, aversion, or fear when giving or receiving compassion or experiencing other affiliative emotions.

- A: "Fear of compassion"
- B: "Fear of avoidance"
- C: "Fear of failure"
- D: "Fear of anxiety"

Question 4: The detrimental impacts of fears of compassion are far-reaching, leading to poorer mental health and preventing individuals from experiencing which of the following? Select all correct options.

- A: Feelings of independence through emotional detachment
- B: Feelings of safety
- C: Feelings of reassurance
- D: Soothing in social and affiliative contexts, including in close interpersonal relationships

Question 5: Compassionate experiences are integral to which of the following? Select **BOTH** correct options.

- A: Healthy interpersonal relationships
- B: Promotion of emotional suppression and detachment
- C: Regulation of positive emotions
- D: Regulation of negative emotions

Question 6: Compassion-focused therapy (CFT) is the only psychotherapy that directly targets the cultivation of compassion as the primary method for alleviating distress and has been established as an effective therapy, with a meta-analysis of 47 controlled trials of CFT identifying which of the following?

- A: Increase in self-compassion and compassion for others
- B: Reductions in negative mental health outcomes
- C: Reductions in depression and self-criticism
- D: None of the above

Question 7: CFT uses techniques to increase compassionate motivation and to reduce fears, blocks, and resistances to compassion.

- A: TRUE
- B: FALSE

Question 8: Imagery exercises can be physiologically powerful, with images being capable of stimulating the same physiological responses as real events.

- A: TRUE
- B: FALSE

Question 9: Which of the following are correct regarding compassion-focused imagery?

- A: Enhances emotional dependence on others
- B: Can be used to enhance an inner sense of security by stimulating the affect regulation system
- C: Increases parasympathetic activity
- D: Reduces activity in neural networks associated with threat

Question 10: Individuals with _____ tend to experience greater discomfort or fear in response to compassionate and other affiliative experiences.

- A: Secure attachments
- B: Dependent attachments
- C: Isolated attachments
- D: Insecure attachments

Question 11: Those who completed the brief CFT intervention showed significant reductions in _____ after the intervention.

- A: Fears of self-compassion
- B: Fears of compassion for others
- C: Fears of compassion from others
- D: All three types of fears of compassion

Question 12: Gilbert (2009) suggested that activation of a soothing physiological affect regulation system is necessary to feel comforted. Specifically, when early attempts to seek comfort or closeness from others are punished or ignored, these experiences become associated with which of the following? Select all three correct options.

- A: Fears of failure in the future
- B: Yearning, grief or feelings of threat
- C: Future needs for comfort or closeness can reactivate these associated negative feelings
- D: Fears of compassion in the future

Question 13: CFT imagery exercise used in this study increases parasympathetic activity and reduces activity in neural networks associated with threat and is effective in doing which of the following? Select all three correct opinions.

- A: Reducing discomfort with self-compassion
- B: Reducing discomfort when receiving compassion from others
- C: Reducing self-compassion
- D: Giving compassion to others

Question 14: Lacking an internal sense of safety results in continued activation of the attachment system. All of the following is true regarding the attachment system, **EXCEPT**?

- A: Drives one to seek proximity and support from close others.
- B: Effectively activates the caregiving system
- C: Inhibits activation of other behavioural systems, including the caregiving system
- D: Is understood to cause those with attachment insecurity to feel distress when others require caregiving

Question 15: An internal sense of security and positive self-image enhances one's trust in potential caregivers and their support, confidence in being worthy of support, and comfort with emotional vulnerability.

- A: TRUE
- B: FALSE

THE END



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ANSWER SHEET

C5(26)

Compassion Focused Imagery Reduces Fears of Compassion Irrespective of Attachment

*Time spent on activity						hour		min				
	A	B	C	D	E		A	B	C	D	E	
1						8						
2						9						
3						10						
4						11						
5						12						
6						13						
7						14						
						15						

How relevant was the content of this activity to your scope of practice?			
			
Not at all	Somewhat	Mostly	Extremely

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