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PSYCHOLOGICA

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Editorial
Compassion: Research, applications and multi-cultural considerations

Marcela Matos[1] and Marco Pereira[2]

Compassion is an ancient concept but novel hot topic across the social sciences, from psychology, to sociology, to health, to communication and media, to politics and beyond. Burgeoning research has demonstrated the benefits of compassion for mental health and emotion regulation (e.g., MacBeth & Gumley, 2012; Matos et al., 2022), physiological health (e.g., Fredrickson et al., 2013; Kim et al., 2020; Klimecki et al., 2014), and interpersonal and social relationships (e.g., Crocker & Canevello, 2012; Yarnell & Neff, 2013). In particular, self-compassion has been shown to be a protective factor, increasing resilience to common mental health issues (e.g., shame, self-criticism; MacBeth & Gumley, 2012; Muris & Petrocchi, 2017) and promoting wellbeing (Zessin et al., 2015). In addition to compassion offering wellbeing benefits, compassion and self-compassion can also be cultivated and enhanced through interventions, in diverse populations and contexts, where they have been shown to promote well-being and to diminish mental health difficulties (e.g., depression, anxiety, stress, shame, self-criticism) (e.g., Craig et al., 2020; Ferrari et al., 2019; Kirby et al., 2017).

Given the global challenges facing our world and the need for collective action, and inspired by the notion in evolutionary science that a conscious evolution toward a more compassionate world is possible (see Wilson, 2020), this special issue of the journal *Psychologica* presents research, applications and multi-cultural considerations related to compassion. In this special issue, several researchers and clinicians, including prominent names in the field and history of compassion, such as Prof. Paul Gilbert, made valuable contributions to expand the science of compassion and disseminate this knowledge into community, educational, clinical and public health

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settings. These studies are focused on different cultures (Portuguese, Australian, Singaporean), populations (clinical and nonclinical), age groups (adolescents and adults), clinical conditions (Borderline Personality Disorder, Social Anxiety Disorder Hoarding Disorder), and applications (compassion-based programs for adolescents and adults, for distinct clinical conditions and with different formats). Let us give you a short-guided tour through the headlines of this special issue.

"What is Compassion?" is a central question to this science field, however, there are several conceptualizations of compassion, arising from different models and approaches, and definitions of compassion may vary between cultures and amongst researchers, clinicians, and lay people. Aiming to address this critical query, in the first paper Marcela Matos, Paul Gilbert, Stan Steindl and colleagues define compassion from the perspective of Compassion Focused Therapy (CFT), distinguish it from other commonly related concepts (e.g., empathy, sympathy, kindness) and examine people's understanding of compassion via semantic associations and recalled subjective experiences of compassion. In addition, this paper explores cultural differences in people's understanding of compassion by comparing data from Portuguese, Australian and Singaporean samples collected among these countries' adult general population.

The following three papers focus on the importance of cultivating compassion in adolescence. Given the early onset of borderline features and the developmental trajectory of borderline personality disorder, intervening with adolescents that show emergent and persistent borderline features is critical. In a cross-sectional study, Diogo Carreiras, Paula Castilho and Marina Cunha examine the mediator role of self-compassion on the association between self-disgust and borderline features in Portuguese adolescents. Their findings revealed that self-compassion mediates the impact of self-disgust on borderline features, and hence highlight that cultivating self-compassion competencies can be a potential positive regulation mechanism for self-disgust's effect on borderline features in adolescents.

Even though there is evidence supporting the practice of sports can be linked to mental health difficulties, as well as evidence documenting the benefits of compassion, acceptance and mindfulness skills in athletes, research of the efficacy of an intervention targeting these processes in adolescent athletes is lacking. The second paper on this topic aims to fill this gap in the literature and presents the study protocol of a Mindfulness, Acceptance and Compassion-Based Programme for adolescent athletes. In their paper, Sara Oliveira, Marina Cunha, António Rosado and Cláudia Ferreira describe a controlled non-randomized trial to test a novel integrative intervention for adolescent athletes derived from contextual-behavioral therapies: the PLAYwithHEART programme. The goal of this novel programme is to foster mindfulness, acceptance and self-compassion skills and to reduce shame

and self-criticism in athletes, and therefore to diminish the experience of anxiety in sport and improve athletes' quality of life and competencies to deal with the challenges and demands of sport contexts.

Compassion Focused Therapy (Gilbert, 2020) is an evidence-based approach to psychotherapy that integrates clinical, social, developmental and evolutionary psychology, psychophysiology and neuroscience, along with the wisdom traditions, and targets physiological processes directly involved in the capacity to engage in a supportive way with one's own suffering. CFT aims at fostering long term changes in one's compassionate response by developing their inner ability to feel safe and supported. Evidence supporting the benefits of CFT in different clinical conditions and mental health symptoms is mounting (e.g., Craig et al., 2020), however, there is a dearth of research investigating its therapeutic gains for social anxiety disorder (SAD) in adolescence. In the third paper targeting adolescents, Diana Vieira Figueiredo, Paula Vagos and colleagues, present preliminary data on the efficacy of an online CFT intervention for SAD in adolescence: the CFT@TeenSAD, based on data collected throughout treatment. This study found evidence of a continuous decrease in the severity of social anxiety symptoms during treatment, with trajectories of change being similar across gender. Their findings provide preliminary but encouraging support for the benefits of this online CFT intervention in the treatment of SAD in adolescents.

The last paper of this special issue is related to the relevance and development of a CFT approach for Hoarding Disorder (HD). Firstly, Chia-Ying Chou and Troy DuFrene provide an overview of the current standard of treatment for HD and describe the rationale for developing CFT as an alternative treatment option. Secondly, they offer a detailed introduction to the group CFT protocol for Hoarding Disorder they developed: the CFT-HD, describing the theoretical framework, its treatment structure and content of modules. Moreover, they review existing evidence of CFT for HD and ongoing studies, outlining their hypotheses and implications for the future research and treatment of HD.

In conclusion, this special issue provides a look into some of the latest advances in our understanding of compassion, its scientific exploration and promising clinical application in distinct developmental stages, clinical conditions and cultures. This collection of papers will hopefully inspire innovation in research and serve to inform the transfer of knowledge into community, educational, clinical and public health settings, and hence contribute to the dissemination of the science of compassion in favor of cultivating compassion to increase our individual and collective wellbeing.

Our sincere acknowledgement to all the authors who contributed with their knowledge to this special issue. We hope that our readers will learn as much

as we did from your work, and that may be inspired to think about innovative compassion-based research. Finally, it is also our profound wish that many other authors across the world may join us in the future.

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What is compassion?
A multicultural study on the semantic associations and subjective experiences of compassion • pág. 11-50
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What is compassion? A multicultural study on the semantic associations and subjective experiences of compassion

Marcela Matos[1], Paul Gilbert[2], Elsa Gonçalves[3], Inês Melo[4], Tahlia Baumann[5], Rebecca Xin Qi Yiu[6] and Stanley R. Steindl[7]

Abstract

Empirical research has documented the benefits of compassion for mental health, psychosocial and physiological wellbeing. Yet, definitions of compassion vary amongst theoretical approaches, researchers, clinicians and lay people. The meaning and nature of compassion can be misunderstood and become linked to fears, blocks and resistances to compassion. The current paper defines compassion from the perspective of compassion focused therapy (CFT) and distinguishes it from other commonly related concepts, using a qualitative methodological approach. Participants' understanding of compassion was explored through their selection of the words they associated with compassion and self-compassion, and descriptions of recalled experiences of giving and receiving compassion, with cultural

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differences further examined. A sample of 584 adult participants was recruited from general community populations in Australia (n = 296), Portugal (n = 183) and Singapore (n = 105) and completed a self-report questionnaire assessing the meaning and the subjective experiences of compassion. Empathy, Kindness and Understanding were the three words participants most frequently associated with 'Compassion'. The most frequent three words selected by participants associated with 'Self-compassion' were Acceptance, Strength and Understanding. Various cultural differences among countries were identified and discussed. The findings also clarified participants' experiences of compassion for others, receiving compassion from others and self-compassion, identified similarities and differences between countries, and revealed a significant proportion of people who were unable to recollect/describe compassion experiences (across the three flows). The findings are discussed in light of a CFT framework and clinical implications for CFT practitioners are derived.

Keywords: compassion; self-compassion; compassion focused therapy; semantic association; subjective experiences; qualitative data.

O que é a Compaixão? Um estudo multicultural sobre as associações semânticas e experiências subjetivas de compaixão

Resumo

Estudos empíricos têm documentado os benefícios da compaixão para a saúde mental, bem-estar psicossocial e fisiológico. No entanto, as definições de compaixão variam entre abordagens teóricas, investigadores, clínicos e leigos. O significado e a natureza da compaixão podem ser mal compreendidos e ligados a medos, bloqueios e resistências à compaixão. O presente artigo define a compaixão a partir da perspetiva da terapia focada na compaixão (TFC) e distingue-a de outros conceitos comumente associados, usando uma abordagem metodológica qualitativa. A compreensão dos participantes sobre o que é a compaixão foi explorada através da seleção das palavras que eles associavam com compaixão e auto-compaixão, e das suas descrições de experiências passadas de dar e receber compaixão, com diferenças culturais sendo também examinadas. Uma amostra de 584 participantes adultos foi recrutada da comunidade geral na Austrália (n = 296), Portugal (n = 183) e Singapura (n = 105), e completou um questionário de auto-resposta que avaliava o significado e as experiências subjetivas de compaixão. Empatia, Bondade e Compreensão foram as três palavras que os participantes mais frequentemente associaram a 'Compaixão'. As três palavras mais frequentemente selecionadas pelos participantes associadas à 'Auto-compaixão' foram Aceitação, Força e Compreensão. Várias diferenças culturais entre os países foram identificadas e discutidas. As descobertas também esclareceram as experiências dos participantes

de compaixão pelos outros, receber compaixão de outros e auto-compaixão, identificaram semelhanças e diferenças entre países e revelaram que uma proporção significativa de pessoas não conseguiu lembrar/descrever experiências de compaixão. Os resultados são discutidos à luz da abordagem de TFC e são derivadas implicações clínicas para psicoterapeutas de TFC.

Palavras-chave: compaixão; auto-compaixão; terapia focada na compaixão; associação semântica; experiências subjetivas; dados qualitativos.

INTRODUCTION

There is a long history of recognition that being motivated by compassion can have far-reaching impacts on our minds and social relationships (Dalai Lama, 1995; Lampert, 2005; Ricard, 2015). In the last 30 years, study of the biopsychosocial dynamics of compassion has burgeoned (see Gilbert, 2017; Seppälä et al., 2017). Various ways of training people to develop their compassion competencies and motives have also proliferated (e.g., Ash et al., 2021; Condon & Makransky, 2020; Gilbert, 2009, 2014; Gilbert & Simos, 2022; Jazaieri et al., 2013; Kirby et al., 2017; Neff & Germer, 2013; Singer & Engert, 2019). Compassion focused therapy (CFT; Gilbert, 2014) is one of these interventions that aims to cultivate a compassionate motivation in order to alleviate and prevent suffering in oneself and others. Nevertheless, differences in how compassion should be conceptualised and defined remain, and definitions of compassion vary amongst researchers, clinicians, and lay people (Gilbert, 2017, 2020; Mascaro et al., 2020). In fact, often the nature of compassion is misunderstood and certain meanings and associations of the word 'compassion' can lead to fears, blocks and resistances to compassion and self-compassion in the context of CFT. The current paper will elaborate on the definition of compassion from the perspective of CFT, outline the components and competencies of compassion according to the CFT model, and suggest distinctions between compassion and other commonly related concepts. The paper will then explore people's understanding of compassion via their selection of the words they associate with compassion and self-compassion, and more detailed descriptions they provide of recalled experiences of giving and receiving compassion, and examine possible cultural differences.

CFT is an approach to psychotherapy that integrates clinical, social, developmental and evolutionary psychology, psychophysiology and neuroscience, along with the wisdom traditions (e.g., Buddhist philosophy) (Gilbert, 2010, 2014). As a psychotherapy, CFT incorporates assessment, case formulation and treatment planning, as well as psychoeducation, skills training and experiential exercises (Gilbert & Simos, 2022). First developed to work specifically with shame and self-criticism

(Gilbert & Irons, 2005), CFT has now been trialed with a range of clinical presentations, such as borderline personality disorder, eating disorders, depression, psychosis, and substance use (Craig et al, 2020). Two systematic reviews have found that CFT demonstrates positive outcomes, leading to increases in self-compassion and decreases in mental health symptoms (Craig et al, 2020; Leaviss & Uttley, 2015). While evidence from randomised controlled trials is growing, more needs to be done (Craig et al., 2020).

At the heart of CFT is the cultivation of a compassionate motivation. CFT therapists guide their clients towards cultivating compassion across three flows: being compassionate towards others, being open to receiving compassion from others, and offering compassion to oneself, or self-compassion (Gilbert, 2020). Often, CFT begins with a thorough examination of the question 'What is compassion?'. Different perspectives abound in the scientific literature, with compassion being conceptualised variously as a motivation, a disposition, a feeling, an attitude or as a multidimensional construct (Jazaieri et al., 2013; Seppälä et al., 2017; Strauss et al., 2016). Definitions of compassion and self-compassion also vary amongst the different compassion-based interventions (see Gilbert, 2017, Kirby, 2016 and Strauss et al., 2016 for a review of compassion definitions). For example, mindful self-compassion (MSC; Neff & Germer, 2013), compassion cultivation training (CCT; Jazaieri et al., 2013), cognitively based compassion training (CBCT; Pace et al., 2009), and cultivating emotional balance (CEB; Kemeny et al., 2012) all offer nuanced definitions that vary. As an evolutionary-based approach to psychotherapy, CFT views compassion as an innate motivation that evolved from caring motivational systems common to mammals, and defines compassion broadly as *a sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it* (Gilbert, 2014; Gilbert & Choden, 2013).

This definition of compassion used in CFT incorporates two components. First is the *sensitivity to suffering in self and others*, which is conceptualised as *compassionate engagement*, that is, paying attention to, noticing, and being sensitive to pain, distress and suffering. The second component, *with a commitment to try to alleviate and prevent it*, is considered *compassionate action*. Compassion involves not only noticing the distress, but responding to it, approaching the distress rather than avoiding, and taking some sort of action that is helpful. Compassion, like other evolved motives, is therefore a stimulus-response algorithm incorporating a feature detector (detecting signs of suffering) and a response action (taking helpful action to either alleviate or prevent suffering) (Gilbert, 2009, 2014, 2020).

However, the compassion algorithm can be both facilitated and inhibited, and people undertaking CFT can often experience the emergence of fears, blocks and resistances (FBRs) to compassion across the three flows (Gilbert et al., 2011), FBRs are examples of inhibitors to compassion (Gilbert & Mascaro, 2017) as they may hinder the access to and activation of compassion motivational systems. *Fears* of compassion relate to the

avoidance or fear response that individuals can have to compassion (e.g., compassion is perceived weak, self-indulgent, self-pitying, or too personally distressing; Gilbert & Mascaro, 2017). *Blocks* to compassion are more linked to situational factors, where the person may want to be compassionate but cannot do so because of a lack of resources, time, availability and so on. *Resistances* to compassion occur when a person could be compassionate but chooses not to be because they cannot see the value of compassion (Steindl et al., 2022). One reason for these FBRs is the varied definitions and negative connotations they might have towards the word 'compassion' (Kirby et al., 2019). People vary widely in their sense and understanding of compassion and what it is, and will often confound compassion with other concepts, such as kindness (Gilbert et al., 2019). They can also use certain terms interchangeably, such as compassion, sympathy and empathy (Sinclair et al., 2017, or have an unclear definition of what compassion is (González-Hernández et al., 2021). Some may see compassion and self-compassion as simply being nice, soft, too much like pity or self-pity, too indulgent or self-indulgent, or they may see compassion as a weakness that makes them vulnerable (see Gilbert & Mascaro, 2017 for a review). Fears of compassion (i.e., FBRs) play an important role in mental health, being highly correlated with shame, self-criticism and depression (Kirby et al., 2019 for a review), and can become obstacles to progress and therefore an important therapeutic focus in CFT (Gilbert, 2020).

According to the CFT broad definition of compassion described above, the two components of compassion, engagement and action, draw upon 12 clearly defined competencies in CFT (i.e., six for compassionate engagement and six for compassionate action). The six competencies of compassionate engagement have been described in detail by Gilbert (2009, 2010, 2014). Compassionate engagement begins with *sensitivity* as a competency of awareness and noticing. This then triggers a physiological and emotional response where one feels *sympathy* towards the sufferer, or sympathetic emotions in response to the distress and suffering, which may involve feeling moved by the suffering as well as concerned, distressed or alarmed (Eisenberg, et al., 2015). Given the sometimes distressing nature of becoming aware of and moved by suffering, the third competency of compassionate engagement is *distress tolerance*, such that the sympathetic concern does not become personal distress and therefore motivate the person to avoid or turn away from the suffering to reduce their own distress (Gilbert, 2010). With a sympathetic response and the ability to tolerate the distress that may come along with that, the fourth competency of compassionate engagement is *empathy*, or the ability to resonate with (affective empathy; emotional contagion) and understand (cognitive empathy; perspective taking; mentalising) the emotions, motives and experiences of the person who may be suffering (Decety & Cowell, 2014). Compassionate engagement also involves the fifth competency of *non-judgement*, which refers to

the ability to approach suffering and the sufferer without criticising, condemning or shaming, and the sixth competency of *care for well-being*, or a connection with a fundamental caring motivation (Gilbert, 2009, 2010, 2014).

The six competencies of compassionate action involve bringing *attention* to the steps to take to be helpful or alleviate or prevent suffering, using *reasoning* skills to help identify the best course of action, developing a suite of helpful *behaviours* ranging from calming or soothing to active or even forceful, practicing *sensory* focusing skills and exercises to cultivate a calm and insightful mind, as well as *feelings* associated with care, courage, affiliation and safeness, and using *imagery* to develop, practice and apply compassion in daily life (Gilbert, 2009, 2010, 2014).

In amongst all of these competencies are important qualities of: *wisdom*, arising from a non-blaming, non-shaming understanding of the nature of life and suffering and how much of what we experience is shaped by our genes and social experiences; *strength* and *courage* arising from grounding the body and creating a sense of inner stillness, stability and determination; and a *caring-commitment* arising from wisdom, strength and courage, and cultivating a heartfelt wish to alleviate and prevent suffering and the conditions that give rise to suffering, as well as a desire to be caring, supportive and helpful to oneself and others (Gilbert, 2009, 2020).

There are a number of words or concepts that can be confounded with the word 'compassion'. From a CFT perspective, it can be useful to explore these with clients to ensure there is a shared understanding about what is meant by compassion and cultivating a compassionate motivation. For example, compassion is not a feeling, but can be textured by all sorts of feelings: warmth, tenderness, nervousness, sorrow, anger, determination, and many others. Rather, compassion is a motivation, orienting humans towards engaging with distress and suffering in self and others, and trying to alleviate or prevent that suffering through helpful action (Gilbert, 2020).

Compassion is also not the same as love or kindness. There are many types of love, and while compassion may involve a universal, unconditional love, it has been distinguished from compassion in that love involves appreciation of the other person's positive attributes, and often through a mutual sharing of positive events (Shaver et al., 1987), while compassion is a response to suffering (Stellar & Keltner, 2014). Furthermore, loving someone need not be a prerequisite for compassion, which may be directed to those we don't love or like, or perhaps even those we loathe; our enemies. So too, compassion may be directed to those parts of ourselves we dislike or loathe. Kindness refers to actions intended to benefit others (Curry et al., 2018). Compassion refers to a sensitivity to suffering and taking action to try to alleviate or prevent that suffering. Compassionate action may be a specific form of kindness, and is also intended to benefit others, but kindness doesn't always involve a compassionate motivation per se, with the defining feature of compassion, unlike kindness, being the presence of suffering (Gilbert et al., 2019).

While compassion draws on the skill of empathy, it is not the same as empathy. As mentioned above, empathy is the ability to sense and understand the feelings and perspectives of somebody else, or the different parts of ourselves. Empathy as a competency can be brought to a range of motivations, sometimes even competitive or cruel motivations. In compassion, we create an empathic bridge between self and other, or self and self, to engage with suffering and take helpful action. Singer and Klimecki (2014) summarise the psychological and neurological distinctions between empathy and compassion.

Compassion is not pity. Although the 1474 Oxford English Dictionary saw "pity" as synonymous with "compassion", more recently, negative connotations of superiority and contempt have become attached to the word "pity" (Kimble, 2004). Unlike pity, compassion motivates us to take helpful action. Where pity might look at a suffering person and say, "Oh, the poor thing," compassion rolls up its sleeves and says, "Right...what can I do to help?". In this same sense, compassion is not simply being nice. Compassionate action can be delivered nicely, but not necessarily. Think of a child reaching for a saucepan of boiling water. Compassion motivates us to act, but with blunt, sharp urgency. Compassion is not always nice, agreeable or pleasing. But it is always wise, strong, courageous and committed to being helpful, and commonly involves working with a calm and insightful mind (Gilbert & Mascaro, 2017).

People worry that compassion, especially self-compassion, is indulgent, letting ourselves or others off the hook to simply feel good. Such negative beliefs about self-compassion can lead to less self-compassionate responding despite self-compassion being related to better coping and greater self-improvement (Chwyl et al., 2020). But compassion is not about allowing ourselves or others to indulge in pleasure. It is about health and well-being, and living a good life, and many people also identify certain advantages to self-compassion, such as individuals with anorexia nervosa reporting that self-compassion results in improved health, personal development, growth and coping, improved outlook and enhanced social relationships (Kelly et al., 2021). Sometimes, this is the much tougher road, although compassion is delivered in a non-blaming, non-shaming, non-attacking and non-condemning way. Compassion involves the wisdom, strength, courage and commitment to make choices that support health and well-being (Kirby & Gilbert, 2017). As such, compassion is not weak, but rather strong, grounded, stable and determined, and CFT invites us to consider with respect to compassion across the three flows, "may I be helpful, rather than harmful, to myself and others".

Finally, compassion is not easy and does not always feel good. Compassionate engagement means being sensitive to suffering, and balancing sympathy and empathy with distress tolerance. Compassionate action means trying to be helpful, and working out just what might be the best way to alleviate or prevent suffering. Rather than being easy, the components and competencies of compassion require awareness, wisdom, strength, stability, courage, care, commitment, determination, and

practice. None of this necessarily feels good. Compassion is about alleviating and preventing suffering. And it focuses on our well-being now and into the future. As a result, compassion for others and ourselves can involve making the tough decisions, doing the hard yards, and sometimes sacrificing what might feel good now for what is good in the long term. Think of a compassionate parent: "Eat your vegetables, do your homework, brush your teeth". Compassion wants what is good for us!

Thus, CFT focuses on cultivating compassion across the three flows, based on cultivating the competencies of compassionate engagement and action and frequently circling back to qualities of wisdom, strength, courage and a caring-commitment. However, definitions of compassion vary amongst researchers, clinicians and lay people. In fact, often the nature of compassion is misunderstood and the meanings and associations of the word 'compassion' can lead to FBRs to compassion and self-compassion in the context of CFT. The aims of the current paper are to (a) explore peoples' semantic associations with compassion, distinguishing compassion to others and self-compassion, with the specific aim to identify which words people usually associate with compassion; (b) examine possible cultural differences in the words associated with compassion by comparing participants' responses in three different countries (Singapore, Australia and Portugal); (c) explore recalled memories of personal experiences of compassion for others, receiving compassion from others and self-compassion; and (d) examine possible cultural differences in recalled memories of personal experiences of compassion, by comparing participants responses in three different countries (Singapore, Australia and Portugal). From the findings of the current study, we aim to offer a number of clinical considerations for CFT therapists as they develop a shared understand with clients regarding the question of 'What is compassion?'.

METHODS

Participants

Five hundred and eighty-four participants aged 17 to 73 years took part in this study (*M*age = 26.84, *SD* = 13.24, 72.4% females), which were recruited from the general community population of three different countries: Australia, Portugal and Singapore. The sample included 296 participants from Australia (*M*age = 25.44, *SD* = 12.99, 75.7% females), 183 from Portugal (*M*age = 22.44, *SD* = 4.84, 82.7% females), and 105 from Singapore (*M*age = 34.45, *SD* = 15.56, 55.2% females). Three participants identified their gender as "other".

Participants included undergraduate students from the University of Queensland (UQ), Australia, who were granted one course credit for their participation using the Student Research Participation Scheme, and from the University of Coimbra (UC), Portugal. The remaining participants were recruited from the community in Australia, Portugal and Singapore via word-of-mouth and advertising through social media.

Procedures

Prior to data collection, ethical clearance for the Australian and Singaporean sample collection was provided through UQ's Psychology Student Research Ethics (Ethics clearance number: 18-PSYCH-4-76-JMC) and, for the Portuguese sample, by the Ethical and Deontology Committee of Research from the Faculty of Psychology and Educational Sciences of the University of Coimbra [CEDI_FPCEUC_28-11-2019]. In the present study, qualitative data were used through a multi-method approach - online (through the publication of the questionnaire on social networks) and in paper (face-to-face). Firstly, participants gave their informed consent while they were informed that their cooperation was voluntary, that their answers were confidential and only used for the purpose of the study and that they could withdraw from the study whenever they want. Then they were asked to complete the self-report questionnaire.

Participants were eligible for the study if they were a student at the university, including first-year students who were aged 17 years and above, or members of the general community (in Australia, Portugal and Singapore) aged 18 years and above. Participants completed questionnaires that were disseminated via an online link, which was constructed on Qualtrics™ (Qualtrics International Inc, Provo, Utah, USA) through UQ's School of Psychology website, and on LimeSurvey™, through the UC Institutional account. The questionnaire ended with a debrief page that consisted of further information about the study, relevant references, and support services should there be any elevated physical or mental discomfort after participating in the study.

Measures

Demographics

Participants' gender (male, female, or other), age (in years), and country of both origin and residence were collected via a demographics questionnaire. Participants

were asked to state the country of birth and the country in which they currently resided. These questions were asked due to the multi-cultural backgrounds and high prevalence of migrants in Australia, Portugal and Singapore. Country of residence instead of nationality was used to distinguish Australian, Portuguese and Singaporean participants.

Meaning and Experiences of Compassion

A self-report questionnaire, the *Meaning and Experiences of Compassion Questionnaire* (Steindl & Matos, 2018), assessing the meaning and the subjective experiences of compassion was developed by the authors S. S. and M. M. In the first part, participants were asked to select the three words, from a set of twenty-nine, that best described what compassion and self-compassion meant to them. Participants were instructed to choose three words related to the meaning of compassion (to others) and three words associated with the meaning of self-compassion. The list of twenty-nine words associated with the meaning of compassion/self-compassion was generated by the authors based on a review of existing compassion definitions and related concepts in the literature of the topic, and on their clinical and training experience in CFT. Participants were given the possibility of choosing another word (i.e., Other) they thought best described the meaning of compassion/self-compassion but was not listed amongst the twenty-nine words in the questionnaire, and asked to specify it.

The second part of the questionnaire explored subjective experiences of compassion across the three flows: expressing compassion towards others, receiving compassion from others and directing compassion to oneself. Participants were asked to write about their personal experiences of compassion, being as detailed as possible. For each experience, they were instructed to describe their inner experience (how they felt) as well as the situation itself. Three open questions assessed personal experiences of compassion for each of the three flows. The instructions were as follows: Compassion to others – "Please describe in detail a recent moment when you experienced compassion for others, this could be a situation where you expressed compassion towards others."; Compassion from others – "Please describe in detail a recent moment when you experienced compassion from others, this could be a situation where you experienced compassion expressed towards you from someone else."; Self-compassion – "Please describe in detail a recent moment when you experienced self-compassion, this could be a situation where you were compassionate towards yourself when you were experiencing a difficult situation.".

The qualitative self-report measure was first developed in English (and used to collect the Australian and Singaporean samples), and translated to Portuguese by the author M. M. and a bilingual speaker.

Data analysis

Descriptive analyses were conducted to assess the frequencies and percentages of responses of qualitative data in the total sample and for each country. In each sample, the frequency for each compassion-related word corresponds to the total number of participants who selected that word amongst the three words that, for them, best described the meaning of compassion/self-compassion. This frequency was computed by summing the number of participants who selected the word amongst the three word options related to the meaning of compassion/self-compassion. The percentage for each word was then calculated based on that frequency in relation to the *N* of the sample.

Thematic analysis was used to identify, analyse and report patterns (themes) within the qualitative data regarding compassion experiences (Braune & Clarke, 2006). There was a familiarization with the data as the transcriptions that were read and re-read and a CFT framework was used to identify and analyze patterns and code the data. Initial codes were generated systemically across the data set. Once codes had been ascribed, potential themes were identified, reviewed and defined based on relevant theory. For experiences of compassion to others and receiving compassion from others, response categories were then organized in major (concerning to whom one was being compassionate to, or who was being compassionate towards the self) and minor (regarding the type of situation that involved directing compassion to others or receiving compassion from others) themes. For experiences of self-compassion, response categories were organized into themes related to the type of situation where one was compassionate towards oneself. When participants' descriptions of their experiences did not fell into the CFT framework definition of compassion (i.e., that did not involve the components of compassionate engagement and/or compassionate action, or the competencies of compassion), were too generic and vague, reflected fears, blocks and resistances (FBRs) to compassion, or when people couldn't recall an experience, they were coded within the major category of "Not compassion experience". These responses were then coded into minor sub-categories specifying which of the above-mentioned case applied. We chose to present a selection of de-identified participant quotations to support the final themes/major categories within a tabular form, rather than including these data within the text directly (Table 1).

Table 1
Major themes identified with selected supporting quotations of experiences of compassion from participants qualitative responses to the questionnaire

Theme	Quotation
Experiences of compassion to others	
Compassion for a grieving person	"Recently my friend's grandmother passed away. I felt a great empathy for her as my grandmother also recently passed. I showed her compassion by sitting with her and talking about how she felt and making sure she was ok."
	"A friend had recently lost her dog. I empathised greatly with her as I had lost a pet as well and new that it was equivalent to losing a very good friend. I was very sad for her and her experience but I was always available to listen and put a smile on her face and whenever she smiled or thanked me for listening I felt very content that I could help her."
Compassion for friends	"I reached out to a friend who recently separated from her husband (I invited her over to my house). As she talked I felt moved by her pain and suffering (I felt sad). I have felt motivated to spend more time with her than I would normally do so, cook meals for her & check in on her with messages etc."
	"When my friend was stressed about University work. I tried my best to understand how she was feeling and tried to say words of encouragement to her. I also tried to help her come up with ideas on how she could get on top of her work so she would be less stressed. I like helping people so once I had talked to her and she started to feel a lot better, this made me feel happy and glad I could do something to help her."
Compassion for strangers	"When I go to the city, I often see homeless people sleeping on the streets. Last winter, I saw an elderly homeless man who had a dog with him. I felt really sad for him and his pet dog as it was really cold during that time. I also saw that he didn't have a lot of clothing yet he held his dog close to him (inside his jacket) to keep his dog warm. My friends and I felt really sad and decided to buy some hot coffee and food for him and his dog. He thanked us a lot and showed gratitude."
	"I heard of a mother of 5 children who had fled domestic violence and was living in a caravan park. She had nothing and needed something to cook food on for her children, food, bedding etc. I found items from my home, plus bought an electric hot plate, toasted sandwich maker and some fresh food to be passed on to her. I did not meet this person, nor did I want anything in return, as I can imagine what it would be like if I was in the same situation."
Compassion for a family member(s)	"When a sibling was upset, I felt compassionate towards them and tried to see the world from their perspective. I felt warm and loving and like I was being helpful in some way by sharing the experience with them, rather than leaving them to experience the negative emotions alone. It is good to feel as though you can aid another person in some way."
	"One day my mother came home and said she had a rough day at work, so I asked her about her day and listened to her, paying full attention and being supportive. I felt that by being compassionate to others, it really helps you to connect with them."

Table 1 (continued)

Major themes identified with selected supporting quotations of experiences of compassion from participants qualitative responses to the questionnaire

Compassion for colleagues	"Once a colleague was new to the workplace, and I noticed she was being bullied by the current employees, I heard one employee complain she was nowhere to be found so I looked for her in the bathroom to see if she was okay. She was very upset and I talked to her and consoled her."
	"A work colleague sent an email to all those that were affected that she would attend to overdue work as soon as she could but was away all week due to a sick child. I felt that maybe she had her own feelings of guilt or stress and as a parent myself to let her know that she should be kind to herself and quoted to her something to remind herself of 'The obligation for working mothers is a very precise one: the feeling that once ought to work as if one did not have children, while raising one's children as if one did not have a job'. I received a very nice email back that she really appreciated the thought on that day. My own feelings were that she felt my own compassion."
Compassion for a partner	"My partner has experienced a lot of stress recently due to work and assignments for university. I have been compassionate towards him and supported and comforted him at every opportunity. When I can do this in-person, I hug him and talk with him about what he's going through and ways to try and alleviate the stress as well as give him supportive encouragement. In these moments, I feel sympathetic and empathetic towards him as well as upset and sad that he has to experience these negative emotions; I feel incredibly motivated to do whatever I can to help him."
	"My girlfriend has some on and off issues with her family and recently they have been getting sometimes really bad and awful. I try my best to console and help her whenever I can, and do whatever I can in order to help her. Whether it be just being there for her or trying to take her mind off things. Just doing this made me feel like I was just helpful and kind and it gave me strength to know that I can at least do this for her."
Not a compassionate situation	"I guess I feel compassionate when i try to help someone worse off. Can't really think of an example. But I feel like when it happens i want to be compassionate and help, but i also feel some guilt if i am better off than someone. (i.e. someone is worse off than me). But i still try to be compassionate."
	"When a friend's mum passed away. Even though I hadn't experienced such a situation myself, I put myself in her shoes in order to understand how she would feel."
	"My friend's dog passed away and she was very upset, I also felt sad and somewhat angry at life."
	"During my volunteer placement, I attempted to show compassion by undertaking the tasks given and understanding and listening to what the supervisor was saying. Despite there being an age difference, personal conversation was also shared."
	"I have compassion for someone i love, i feel grateful and lucky to have this person in my life."

Table 1 (continued)

Major themes identified with selected supporting quotations of experiences of compassion from participants qualitative responses to the questionnaire

Experiences of receiving compassion from others	
Receiving compassion in a grieving situation	"I had lost my grandmother and one of my teachers pulled me aside after class and asked how I was going and offered for me to talk to them about it if I ever needed. I felt extremely grateful as they were the only person outside of the family to offer that and I felt that they truly cared about me."
	"A close friend of mine committed suicide and so many friends and family came over and comforted me and let me know that they were there for me and made sure that I was ok and they helped to cheer me up and get me doing normal daily things in order to not keep wallowing in my sadness for too long."
Receiving compassion from friends	"I recently talked to someone about stresses I'd been feeling in my life. Today they called me to check how I was doing. I felt supported and safer, knowing that there was something thinking about me and how I am doing."
	"When I was dealing with some personal problems and was in a state where I did not know what to do, my friends helped me and were there for me and we talked through what I could do to fix the situation. They said words of encouragement and tried to understand where I was coming from. After I talked to them, I felt much better than I did before."
Receiving compassion from strangers	"When I was ill, several strangers came to my rescue and assisted me, looking for any way to help me and monitoring me to make sure I was okay. While I felt very embarrassed, it was good to know that there a people out there who care and this made me feel safe and hopeful for the future. It restored my faith that people are capable of great compassion and inspired me to do better and be more open when people needed emotional and physical support."
	"I was picking up my daughter from school, and my determined toddler was throwing a tantrum because I would not let him walk on the road, he fell down and cut his mouth. He was screaming, and bleeding (slightly) from the lips. I was so mortified for making a scene at the school, and was feeling inadequate as a mum for letting it happen. However, I was totally overwhelmed when so many parents who I had never talked to stepped in to help by offering water, tissues, and even an ice block for him!"
Receiving compassion from a family member(s)	"I experienced compassion from a family member when I was feeling incredibly ill and had to travel on the plane for 8+ hours. They comforted me and assured me that I could get through the experience, and that things would be better once we reached our destination. Although I was feeling terrible at the time, this compassion helped me feel loved and supported, gaining a sense of courage to continue."
	"Recently, I had had some issues on my health and it affected my feeling very much as everything was uncertain before the medical reports were out. My family showed very good support and accompanied me to face it positively. At the end, there was not really any problem. Their attitude to understand the problem (i.e. find out the problem - see the doctor), to face the problem, if any, to accept it and to let go something out of our control helped a lot. Even if I still worried, I felt I could handle the problem easier with my family's support."

Table 1 (continued)

Major themes identified with selected supporting quotations of experiences of compassion from participants qualitative responses to the questionnaire

Receiving compassion from colleagues	"I experienced compassion from others when I had a panic attack at work because it was very busy. I was very stressed out and therefore kept doing things incorrectly which in turn made me more stressed and negative. I eventually broke and my work mates helped me to recover. They took over what I was doing until I was calm and okay to go back to work. The manager sat with me in a quiet place and helped me to cope and calm down by giving me strategies to work with my anxiety." "I think define 'compassionate experiences towards me' as situations where people take time out of their personal schedule just to hear me out, listen to where I'm at, and give me guidance. One such situation was when my mentor Skyped me a week ago to ask how I was and to give tips on employability, goal-setting. I felt really encouraged. More than the practicality and soundness of the advice she gave, I was just encouraged by the fact that there was someone willing to listen."
Receiving compassion from a partner	"I fell over and thought I had damaged my knee badly, and my partner helped me through it. Although I was in pain, I felt comfortable and supported, and encouraged to breathe through the experience." "I was stressed out about my job. My boyfriend sat down with me, listened to why I was unhappy with my job and helped me to come up with solutions."
Not a compassionate situation	"I usually won't tell my friends my concerns because I like to keep them to myself and I feel insecure when others know my problems. However, when I do tell my friends my problems I feel a bit relieved I guess." "Nothing really, except perhaps a conversation where someone expressed care, acknowledgement about how I had managed and got through past, difficult, experiences as a parent. The same acknowledgement or feeling I draw on, myself. Nothing big. To be honest, I rely on myself not others, for kindness and compassion." "Had food with friends. Friends gave me last piece. Felt really touched that my best friends let me have the last piece of food. I will treasure them forever."
Experiences of Self-compassion	
Self-compassion in a grieving situation	"Recently a family member died and I allowed myself to feel the emotions of grief associated with this loss rather than focusing on something else as I normally would and attempting to push it from my mind. This was self-compassion as it allowed me closure and time to grieve for the person." "A day recently when grief for loved ones I've lost was particularly over whelming. I felt heartbroken, lost and scared about the future I gave myself permission to stay in bed. I made myself be honest with my husband and say I'm having a bad day and why. I did things that made me happy, indulged myself. I had a nice bath, drank tea and ate chocolate, read a book and listened to music Took time for myself."

Table 1 (continued)

Major themes identified with selected supporting quotations of experiences of compassion from participants qualitative responses to the questionnaire

	"I guess a self-compassion i experienced would be the realization of what makes me uncomfortable and eliminating that from my life. A couple of weeks ago, I had an argument with a friend and it made me realize that sometimes it's easier to just let go of any negativity in my life rather than hold onto someone and try and change them. I was able to grow as a person and realize my self-worth more when I was able to rid the negativity from my life."
Self-compassion when facing problems with friends	"I was surfing and getting frustrated with myself and the surf, I was at the beach with a group of friends and we were all surfing. We got separated and I was by myself, while paddling in to move back up the beach I was thinking I wonder where my friends are and I know they are going to ask how the surf was, in my mind I started to relay what I would say back which was pure negativity. I then started to tell myself that the surf while being tricky to stay in one spot, was fun and I managed to catch waves rather than paddling around and not catching anything. Those few words had pushed my negative thoughts out of my mind and rather than being angry and negative when I met up with everyone I was happy."
Self-compassion when facing academic problems	"When I was working on difficult assessment and felt as though I wasn't doing enough, I tried to be compassionate towards myself by not pushing myself to the point of overwhelm. When assuring myself that no matter what, I was enough, I felt stronger and more capable. Showing compassion to myself during stressful times allowed me to preserver even though it was difficult. I am beginning to recognise my feelings and experience every situation fully, enabling me to let go and love the experience for what it is, an opportunity for growth."
	"Receiving exam results and realising why I had fallen short, why that was ok and how I could do better. I felt a sense of relief and a motivation to make a change."
Self-compassion when facing personal problems	"I have been feeling bad about my weight for a while as I have stopped running. I have re-focused my attention to being healthy and not giving myself a hard time. As a result I have enjoyed exercising a lot more and have appreciated how much better I feel when I eat well. Removing the pressure of avoiding 'treat' food has meant I've eaten less of it because I am more mindful and supportive of myself when I want to have something."
	"I was panicking about running late and I began to feel a sense of self-loathing. I stepped back and looked at myself, rationalising that being late does not make me a bad person and it was understandable. I was warm and spoke to myself in a soothing, quiet voice to calm myself down."

Table 1 (continued)

Major themes identified with selected supporting quotations of experiences of compassion from participants qualitative responses to the questionnaire

Self-compassion when facing family problems	"Recently I was having a rough time in agreeing with what my parents had to say about certain aspects of my life. It led me to be quite upset and I felt so emotionally drained at that point. I made a decision that day that I wasn't going to let that get me down and instead use it to fuel my motivation and desire to excel in my studies. I tried to calm myself down and do the things that usually relax me like listening to music, and just having that moment to realise that it's okay for me to be upset and have a little cry because that's all part of being human and part of being able to stay emotionally resilient and move on."
Self-compassion when facing health problems	"When I was told I had to take at least a month off dancing because of injury I was very upset. I experienced self-compassion when I told myself it was okay to feel upset but it will be fine and worth it when the injury is finally fixed." "I have been down with a skin condition since young and my doctor told me I will never be healed from it. When it gets bad sometimes, I encouraged myself and do things that I love to distract myself. I feel more relaxed and less anxious."
Self-compassion when facing problems with a partner	"I used warm & friendly (encouraging) self-talk when faced with relationship difficulties. This took me from a feeling of distress to one of calmness." "Recently, my anxiety had caused me to feel anxious and worried about my relationship with my partner and how he perceived me. This led to many paranoid feelings of self-doubt and fear of the future of our relationship. However, I was able to direct compassion towards myself as I sat down and properly thought through the situation and reasoned with my anxiety. I tried to be as non-judgmental towards myself as I could and tried to be as tolerant of my anxiety as possible, which ultimately made me feel proud and content with myself."
Self-compassion when facing work problems	"Difficult work situation - silenced any critical voice and reassured that action taken was the right thing to do even though difficult." "I was really stressed and overwhelmed recently with the immense workload I had, and I was overworking myself extensively. Once I realised the upset state I was in, I recognised that I needed a break and allocated the entire night off from university work and just relaxed, watched TV and did whatever I wanted to do - which I hadn't done in a while. Doing this for myself was almost like a sigh of relief, since I never really am self-compassionate on a daily basis."

Table 1 (continued)

Major themes identified with selected supporting quotations of experiences of compassion from participants qualitative responses to the questionnaire

Self-compassion when facing a failure/setback	"When I realized that I had failed the physical tests, I felt a huge revolt, but with calm and seeing everything I had done so far, I was proud of myself and started to feel self-compassion. Internally I accepted my failure, I had the courage to fight for it and so I had to feel good about my performance and deal with this failure. I became aware that it was not the end of the world and that better things could come." "When I failed at the driving test, at first I felt really bad and stupid because the mistakes I made were absurd. However, in the end I managed to reason well and it was clear to me that I could pass the next time. I have the skills and I won't make the same mistakes again. So, I was able to calm myself down and change from a negative to a more realistic perspective, having a little more self-confidence."
Not a self-compassion situation	"I felt happy with my makeup" "When I was sick and still had to perform at a high level of sport." "I feel like I have been fairly compassionate towards myself to a point i start to ignore my responsibilities or either leave them to last minute to finish." "Self-compassion makes me feel weak, I'm much more critical of myself. An example of my sort of self-compassion would be when my grandmother died suddenly a few months ago. Family members were crying but I just stood there playing on my phone, I kept telling myself that it's stupid to cry, she was old and it was going to happen eventually, don't be a little bitch about it. I still haven't cried over her death. Don't feel much about it." "I can't remember the last time i felt compassionate about myself." "I really feel empty inside and I feel like no one truly understands me." "I don't think I have any experiences of self-compassion. I don't exactly hate who I am, but I usually hate what I do." "I'm not very good at being self-compassionate."

RESULTS

Semantic associations of compassion

The frequencies and percentages for words associated with the meaning of compassion to others in the total sample and per country are presented in Table 2. In the total sample, the three words most frequently chosen by participants to describe what compassion is were Empathy (50.7%), Kindness (41.1%) and Understanding (40.4%). Following those, Sensitivity (25.2%), Support (19.4%), Care (14.6%), Acceptance (12.5%), Non-judgment (11.6%), Love (11.5%) and Respect (6.9%) were amongst the top ten words most frequency selected to define what compassion is. The least frequent (< 2%) words chosen to describe the meaning of compassion were Coping, Motivation and Flexibility.

Table 2
Frequencies and percentages of selected words associated with the meaning of compassion in the total sample (N = 584) and per country (Australia n = 296; Portugal n = 183; Singapore n = 105)

Words	Total sample (*N* = 584)		Australia sample (*n* = 296)		Portugal sample (*n* = 183)		Singapore sample (*n* = 105)	
	Frequency (*n*)	%	Frequency (*n*)	%	Frequency (*n*)	%	Frequency (*n*)	%
Kindness	240	41.1	145	48.99	40	21.86	55	52.38
Strength	33	5.65	21	7.09	2	1.09	10	9.52
Care	85	14.55	62	20.95	8	4.37	15	14.29
Sensitivity	147	25.17	68	22.97	56	30.60	23	21.90
Courage	18	3.08	9	3.04	6	3.28	3	2.86
Understanding	236	40.41	127	42.91	71	38.80	38	36.19
Openness	21	3.59	14	4.73	3	1.64	4	3.81
Empathy	296	50.68	122	41.22	124	67.76	50	47.62
Action	20	3.42	10	3.38	9	4.92	4	3.81
Motivation	5	0.86	5	1.69	0	-	0	-
Sympathy	24	4.11	22	7.43	4	2.19	3	2.86
Wisdom	17	2.91	9	3.04	2	1.09	6	5.71
Mindfulness	12	2.05	8	2.70	0	-	2	1.90
Tolerance	30	5.14	4	1.35	25	13.66	1	0.95
Nurturance	13	2.23	9	3.04	3	1.64	1	0.95
Commitment	13	2.23	2	0.68	6	3.28	5	4.76
Acceptance	73	12.5	34	11.49	23	12.57	15	14.29
Non-judgment	68	11.64	35	11.82	23	12.57	10	9.52
Helpfulness	36	6.16	9	3.04	21	11.48	6	5.71

Table 2 (continued)

Frequencies and percentages of selected words associated with the meaning of compassion in the total sample (N = 584) and per country (Australia n = 296; Portugal n = 183; Singapore n = 105)

Warmth	38	6.51	23	7.77	5	2.73	10	9.52
Love	67	11.47	33	11.15	11	6.01	23	21.90
Coping	1	0.00	0	-	0	-	1	0.95
Support	113	19.35	63	21.28	40	21.86	10	9.52
Respect	40	6.85	16	5.41	18	9.84	6	5.71
Flexibility	7	1.20	2	0.68	5	2.73	0	-
Tenderness	27	4.62	10	3.38	16	8.74	1	0.95
Awareness	21	3.60	12	4.05	3	1.64	6	5.71
Attention	14	2.40	3	1.01	10	5.46	1	0.95
Connection	16	2.74	8	2.70	8	4.37	0	-
Other	9	1.54	2	0.68	6	3.28	1	0.95
Missing	4	0.68	0	-	1	0.55	0	-

When examining the data for each country, participants from Australia chose Kindness (49%), Understanding (42.9%) and Empathy (42.2%) as the three words that best describe the meaning of compassion to others. Sensitivity (23%), Support (21.3%), Care (21%), Non-judgment, (11.8%), Acceptance (11.5%), Love (11.2%) and Warmth (7.8) were part of the ten most frequently selected words. The least frequent (< 2%) words to be picked were Coping, Flexibility, Attention and Tolerance.

In the Portuguese sample, participants selected Empathy (67.7%), Understanding (38.8%) and Sensitivity (30.6%) as the top three words best described the meaning of compassion to others. Amid the ten words most frequently indicated were also Kindness (21.9%), Support (21.9%), Tolerance (13.7%), Acceptance (12.6%), Non-judgment (12.6%), Helpfulness (11.5%), and Respect (9.8%). Mindfulness, Motivation, Wisdom, Strength, Awareness, Nurturance, and Openness were the less frequent (< 2%) selected words to describe compassion.

In the Singaporean sample, Kindness (52.4%), Empathy (47.6%) and Understanding (36.2%) were the three words most frequently chosen to best describe the meaning of compassion to others. Sensitivity (21.9%), Love (21.9%), Care (14.3%), Acceptance (14.3%), Strength (9.5%), Non-judgment (9.5%), Warmth (9.5%) and Support (9.5%) were part of the ten words most frequently designated by participants. The least frequent (< 2%) words to be selected were Mindfulness, Connection, Flexibility, Motivation, Attention, Tenderness, Coping, and Nurturance.

In the option Other amid the three words that best described the meaning of compassion, participants from Australia specified Selflessness and Vulnerable, Portuguese participants nominated Comfort, Gentleness and Solidarity, and one participant in Singapore designated the Trust.

Semantic associations of self-compassion

The frequencies and percentages for words associated with the meaning of self-compassion in the total sample and per country are reported in Table 3. In the total sample, the most frequent three words selected by participants to describe what self-compassion is were Acceptance (40.7%), Strength (21.6%) and Understanding (20.7%). Amongst the top ten words most frequency chosen to define self-compassion were also Awareness (18.7%), Care (18.5%), Courage (17.3%), Love (17.1%), Mindfulness (16.9%), Kindness (16.3%) and Motivation (11.3%). The least frequent (< 2%) words chosen to describe the meaning of self-compassion were Helpfulness and Connection.

Table 3
Frequencies and percentages of selected words associated with the meaning of self-compassion in the total sample (N = 584) and per country (Australia n = 296; Portugal n = 183; Singapore n = 105)

Words	Total sample (*N* = 584)		Australia sample (*n* = 296)		Portugal sample (*n* = 183)		Singapore sample (*n* = 105)	
	Frequency (*n*)	%	Frequency (*n*)	%	Frequency (*n*)	%	Frequency (*n*)	%
Kindness	95	16.27	66	22.30	12	6.56	17	16.19
Strength	126	21.58	64	21.62	43	23.50	19	18.10
Care	108	18.49	75	25.34	20	10.93	13	12.38
Sensitivity	52	8.90	30	10.14	12	6.56	10	9.52
Courage	101	17.29	48	16.22	35	19.13	18	17.14
Understanding	121	20.72	66	22.30	27	14.75	28	26.67
Openness	40	6.85	22	7.43	11	6.01	7	6.67
Empathy	36	6.16	19	6.42	5	2.73	12	11.43
Action	27	4.62	17	5.74	2	1.09	8	7.62
Motivation	66	11.30	26	8.78	29	15.85	11	10.48
Sympathy	17	2.91	8	2.70	4	2.19	5	4.76
Wisdom	42	7.19	19	6.42	13	7.10	10	9.52
Mindfulness	98	16.78	66	22.30	18	9.84	14	13.33
Tolerance	42	7.19	9	3.04	27	14.75	6	5.71
Nurturance	30	5.14	22	7.43	7	3.83	1	0.95
Commitment	14	2.40	7	2.36	3	1.64	4	3.81
Acceptance	234	40.07	99	33.45	94	51.37	41	39.05
Non-judgment	53	9.08	26	8.78	16	8.74	11	10.48
Helpfulness	5	0.86	2	0.68	2	1,09	1	0.95
Warmth	19	3.25	7	2.36	4	2,19	8	7.62
Love	100	17.12	49	16.55	26	14.21	25	23.81
Coping	56	9.59	28	9.46	20	10.93	8	7.62
Support	24	4.11	16	5.41	1	0.55	7	6.67
Respect	40	6.85	16	5.41	19	10.38	5	4.76
Flexibility	20	3.42	5	1.69	13	7.10	2	1.90

Table 3 (continued)
Frequencies and percentages of selected words associated with the meaning of self-compassion in the total sample (N = 584) and per country (Australia n = 296; Portugal n = 183; Singapore n = 105)

Tenderness	19	3.25	9	3.04	8	4.37	2	1.90
Awareness	116	19.86	29	9.80	62	33.88	15	14.29
Attention	14	2.40	8	2.70	6	3.28	0	-
Connection	11	1.88	4	1.35	4	2.19	3	2.86
Other	13	2.23	3	1.01	6	3.28	1	0.95
Missing	16	2.74	0	-	0	-	0	-

In regard to the data for each country, Australian participants nominated Acceptance (33.5%), Care (25.3%) and, equally with 22.3%, Kindness, Understanding and Mindfulness as the best words to describe the meaning of self-compassion. Strength (21.6%), Love (16.6%), Courage (16.2%), Sensitivity (10.1%) and Awareness (9.8%) also integrated the list of the ten most frequently selected words. The least frequent (< 2%) words to be chosen were Helpfulness, Connection and Flexibility.

In the Portuguese sample, Acceptance (51.4%), Awareness (33.9%) and Strength (23.5%) were the three words most frequently selected to describe the meaning of self-compassion. Following those, Courage (19.1%), Motivation (15.9%), Understanding (14.8%), Tolerance (14.8%), Love (14.2%), Care (10.9%) and Coping (10.9%) were amongst the top ten words most frequently elected to define what self-compassion is. The words Commitment, Action, Helpfulness and Support were the less frequently (< 2%) chosen to define self-compassion.

In the Singaporean sample, Acceptance (39.1%), Understanding (26.7%) and Love (23.8%) were the three words most frequently nominated to best describe the meaning of self-compassion. Strength (18.1%), Courage (17.4%), Kindness (16.2%), Awareness (14.3%), Mindfulness (13.3%), Care (12.4%) and Empathy (11.4%) were amidst the ten words most frequently selected by participants. The least frequent (< 2%) words to be associated with the meaning of self-compassion were Attention, Helpfulness, Nurturance, Tenderness and Flexibility.

Two per cent (n = 13) participants selected the option Other within the three words that best described the meaning of self-compassion. In this option, Australian participants specified the words Forgiveness, Gentleness, Patience and Resilience, Portuguese participants listed Self-love, Arrogance, Masochism and Respect one's pace, and one participant in Singapore nominated Pity.

Experiences of compassion

Of the total sample, 483 participants reported personal experiences of directing compassion to others, 472 described experiences of receiving compassion from others, and 449 narrated experiences of being compassionate to oneself.

Experiences of compassion to others

Frequencies and percentages for the major and minor categories of experiences of compassion to others are given in Table 4. In the total sample, the most frequent major categories of compassion to others experiences (i.e., whom one was being compassionate to) were situations where participants recalled being compassionate towards friends (31.5%) or strangers (21.3%), with around 8% of participants narrating experiences where directed compassion to other people that were mourning the loss of a loved one (7.9%) or where they were compassionate to a family member (7.5%). Experiences of being compassionate to a partner or to colleagues were less reported. Interestingly, a significant proportion of participants (27.3%) described experiences that did not meet the criteria for being considered a compassion to others experience. Table 1 presents a selection of de-identified participant quotations of the major themes of experiences of compassion to others.

In terms of the minor categories (i.e., type of situation), most participants narrated experiences where they were compassionate to a friend going through personal problems (21.3%), for strangers in various situations (12.6%), for other people in situations of grief and loss (7.9%) or for a family member facing various personal problems (7.2%). The remaining participants evoked experiences where they were compassionate to a friend struggling with an academic or work-related problem, to an elderly person struggling with a difficulty, in situations of voluntary work, to friends facing health problems or with financial difficulties, to a partner dealing with various personal problems, to colleagues with personal struggles, towards a homeless person or an animal suffering. From the participants who described experiences that did not meet the criteria for compassion to others, the vast majority narrated instances that could not be considered a compassion to others experience according to the CFT framework (68%), followed by those whose descriptions were too generic and vague (17%) or that reflected FBRs to being compassionate to others (8%), and those couldn't recall a situation where they had shown compassion to others (7%).

Table 4

Frequencies & percentages of major and minor categories of experiences of compassion to others in the total sample (N = 483) and per country (Australia n = 240; Portugal n = 173; Singapore n = 70)

Experiences of Compassion to Others	Total sample (N = 483)		Australia sample (n = 240)		Portugal sample (n = 173)		Singapore sample (n = 70)	
	Frequency (n)	%	Frequency (n)	%	Frequency (n)	%	Frequency (n)	%
Major categories								

Table 4 (continued)

Frequencies & percentages of major and minor categories of experiences of compassion to others in the total sample (N = 483) and per country (Australia n = 240; Portugal n = 173; Singapore n = 70)

Compassion for a grieving person	38	7.9	26	10.8	12	6.9	0	-
Compassion for friends	152	31.5	83	34.6	44	25.4	25	35.7
Compassion for strangers	103	21.3	37	15.4	45	26.0	21	30.0
Compassion for a family member(s)	36	7.5	20	8.3	14	8.1	2	2.9
Compassion for colleagues	11	2.3	8	3.3	2	1.2	1	1.4
Compassion for a partner	11	2.3	9	3.8	2	1.2	0	-
Not compassion to others experience	132	27.3	57	23.8	54	31.2	21	30.0
Minor categories								
Compassion in a grief situation	38	7.9	26	10.8	12	6.9	0	-
Compassion for friends with personal problems	103	21.3	55	22.9	32	18.5	16	22.5
Compassion for friends with academic or work problems	29	6.0	17	7.1	8	4.6	4	5.6
Compassion for friends with health problems	16	3.3	10	4.2	3	1.7	3	4.2
Compassion for friends with financial problems	4	0.8	1	0.4	1	0.6	2	2.8
Compassion for strangers	61	12.6	21	8.8	27	15.6	13	18.3
Compassion in voluntary work situations	18	3.7	9	3.8	7	4.0	2	2.8
Compassion for elderly people	19	3.9	5	2.1	9	5.5	5	7.0
Compassion for homeless people	5	1.0	2	0.8	2	1.2	1	1.4
Compassion for a family member(s) with personal problems	35	7.2	20	8.3	13	7.5	2	2.8
Compassion for colleagues	7	1.4	5	2.1	1	0.6	1	1.4
Compassion for colleagues with personal problems	5	1.0	3	1.3	2	1.2	0	-
Compassion for a partner with personal problems	11	2.3	9	3.8	2	1.2	0	-
Compassion for animals	2	0.2	0	-	0	-	1	1.4

Table 4 (continued)
Frequencies & percentages of major and minor categories of experiences of compassion to others in the total sample (N = 483) and per country (Australia n = 240; Portugal n = 173; Singapore n = 70)

Not compassion to others experience minor categories								
Not compassion to others	90	68.2	37	64.9	46	85.2	7	33.3
Generic/vague description	23	17.4	11	19.3	7	13.0	5	23.8
Lack of memory	9	6.8	1	1.8	1	1.9	7	33.3
FBRs of compassion	10	7.6	8	14.0	0	-	2	9.5

Key. FBRs: Fears, blocks and resistances of compassion

In regard to the data for each country, the most frequent type of experience described by Australian participants were situations of being compassionate towards friends (34.6%), strangers (15.4%) or people grieving the death of a significant other (10.8%). Experiences of directing compassion to a family member, to a partner, or a colleague were also narrated by Australian participants. In terms of the type of compassion experience, being compassionate to a friend dealing with personal problems (22.9%), to someone in a grieving situation (10.8%), to a family member struggling with a personal problem (8.3%), or to a friend facing an academic or work problem (7.1%) were the situations most frequently reported. Approximately 24% participants recalled experiences that could not be considered compassion experiences, with most of these corresponding to situations that didn't fell into the CFT conceptualization of compassion (64%), that were too unspecific (19%), or that reflected FBRs to compassion (14%).

In the Portuguese sample, experiences of being compassionate to strangers (26%) and to friends (25.4%) were the experiences recounted by the majority of participants. Participants also described situations where they were compassionate to a family member (8.1%) or to a bereaved person (6.9%). Experiences involving colleagues or a partner were less frequently reported. Regarding the minor categories, the most frequently reported experiences involved being compassionate to a friend facing personal problems (18.5%), to strangers in various situations (15.6%), to a family member struggling with a personal problem (7.5%), or to someone mourning the death of a love one (6.9%). Thirty-one per cent of participants described experiences that did not fell into the compassion experiences category. From these, the majority were experiences that didn't meet the criteria to be considered a compassion experience according to the CFT framework (85%), followed by situations that were described in an unclear way (13%).

In the Singaporean sample, the most frequently recalled experiences of compassion to others involved friends (35.7%) or strangers (30%). A small percentage

of participants also described experiences of being compassionate towards a family member or a colleague. In regard to the minor categories, experiences of being compassionate to a friend facing personal problems (22.5%), to strangers in various situations (18.3%), or to an elderly person struggling with a difficulty (7%) were amongst the most frequently narrated situations by Singaporeans. Around 30% recounted experiences that did not involve being compassionate to others. These participants either couldn't recall such experiences (33%), or narrated situations that did not correspond to the notion of what compassion is or entails (33%), that were too unspecific (24%) or that suggested FBRs to compassion (9.5%).

Experiences of receiving compassion from others

Table 5 presents the frequencies and percentages for the major and minor categories of experiences of receiving compassion from others. In the total sample, the most frequent major categories of experiences of receiving compassion to others (i.e., who was being compassionate towards the self) were situations where participants recalled receiving compassion from friends (44%) or from a family member (13%). Situations where strangers, (6.4%) a partner (5.5%) or colleagues (5.3%) directed compassionate towards oneself were also narrated by participants, along with experiences where one was the object of others compassion when mourning the loss of a significant other (5%). A significant number of participants (20.6%) recounted situations that did not meet the criteria for being considered a compassion experience. A selection of de-identified participant quotations of the major themes of experiences of receiving compassion from others can be found in Table 1.

In terms of the minor categories (i.e., type of situation), participants narrated experiences where they received compassion from a friend (29.9%) or from a family member (13.3%) when struggling with a personal problem, or when they received compassion from a friend in relation to an academic or work problem (8%) or a health problem (6.6%). The remaining participants narrated experiences where they received compassion from strangers or from their partner, in a grieving situation, from colleagues when facing an academic or work problem, from friends or colleagues in relation to a financial difficulty, or from strangers when dealing with a health issue. From those participants whose responses were coded as a 'Not receiving compassion experience', 40% were experiences that didn't meet the criteria to be considered a compassion experience according to the CFT framework, followed by situations that were described in an unclear way (32%), by instances where participants couldn't recall such an event (20.6%) and by experiences that reflected FBRs to receiving compassionate from others (7%).

Table 5

Frequencies & percentages of major and minor categories of experiences of receiving compassion from others in the total sample (N = 472) and per country (Australia n = 235; Portugal n = 168; Singapore n = 69)

Experiences of Receiving Compassion from Others	Total sample (*N* = 483)		Australia sample (*n* = 235)		Portugal sample (*n* = 168)		Singapore sample (*n* = 69)	
	Frequency (*n*)	%	Frequency (*n*)	%	Frequency (*n*)	%	Frequency (*n*)	%
Major categories								
Receiving compassion in a grieving situation	24	5.1	å12	5.1	12	7.1	0	-
Receiving compassion from friends	208	44.1	110	46.8	66	39.3	32	46.4
Receiving compassion from strangers	30	6.4	10	4.3	17	10.1	3	4.3
Receiving compassion from a family member(s)	62	13.1	35	14.9	20	11.9	7	10.1
Receiving compassion from colleagues	25	5.3	12	5.1	5	3.0	8	11.6
Receiving compassion from a partner	26	5.5	16	6.8	9	5.4	1	1.4
Not receiving compassion experience	97	20.6	40	17.0	39	23.2	18	26.1
Minor categories								
Receiving compassion in grief situations	24	5.1	12	5.1	12	7.1	0	-
Receiving compassion from friends in relation to an academic or work problem	38	8.1	28	11.9	5	3.0	5	7.2
Receiving compassion from friends in relation to a personal problem	141	29.9	66	28.1	53	31.5	22	31.9
Receiving compassion from friends in relation to a health problem	31	6.6	20	8.5	7	4.2	4	5.8
Receiving compassion from friends in relation to a financial problem	5	1.1	2	0.9	1	0.6	2	2.9

Table 5 (continued)
Frequencies & percentages of major and minor categories of experiences of receiving compassion from others in the total sample (N = 472) and per country (Australia n = 235; Portugal n = 168; Singapore n = 69)

Receiving compassion from strangers	28	5.9	9	3.8	16	9.5	3	4.3
Receiving compassion from strangers in relation to a health problem	2	0.4	1	0.4	1	0.6	0	-
Receiving compassion from a family member(s) in relation to a personal problem	63	13.3	36	15.3	20	11.9	7	10.1
Receiving compassion from colleagues in relation to an academic or work problem	15	3.3	4	1.7	4	2.4	7	10.1
Receiving compassion from colleagues in relation to a financial problem	3	0.6	2	0.9	1	0.6	0	-
Receiving compassion from a partner in relation to a personal problem	25	5.3	15	6.4	9	5.4	1	1.4
Not receiving compassion experience minor categories								
Not compassion from others	39	40.2	14	35.0	18	46.2	7	38.9
Generic/vague description	31	32.0	12	30.0	17	43.6	2	11.1
Lack of memory	20	20.6	9	22.5	3	7.7	8	44.4
FBRs of compassion	7	7.2	5	12.5	1	2.6	1	5.6

Key. FBRs: Fears, blocks and resistances of compassion

When examining the data for each country, the most frequent experiences described by participants from Australia were experiences of receiving compassion from friends (46.8%), followed by experienced where they had been the recipient of compassion from a family member (14.9%), from a partner (6.8%), from colleagues (5.1%) from strangers (4.3%), or when suffering with grief (5.1%). In terms of the minor categories, the most frequent situations were experiences of receiving

compassion when dealing with a personal problem from friends (28%) or a family member (15.3%), or from friends when facing an academic or work difficulty (11.9%) or a health problem (8.5%). Seventeen percent of participants narrated situations that did not correspond to a compassion experience. These were situations where participants' descriptions didn't fell into the CFT conceptualization of compassion (35%), that were too generic (30%), that they couldn't recall (12.5%) or that reflected FBRs to compassion (22.5%).

In the Portuguese sample, the most frequently recalled experiences involved receiving compassion from friends (39.3%), followed by receiving compassion from a family member (11.9%) or from strangers (10%). Other situations entailed being the recipient of compassion in a grieving situation (7%), from a partner (5.4%) or from colleagues (3%). Regarding the type of situation, Portuguese participants narrated experiences of receiving compassion when struggling with a personal problem from friends (31.5%) or from a family member (11.9%), or from strangers (9.5%). Around 23% of participants recounted situations that did not meet the criteria for being considered a compassion experience. Most of these participants either narrated situations that couldn't be considered receiving compassion from others (46%) or that were too unspecific (43.6%). A few participants couldn't recall experiences like these and one manifested FBRs to receiving compassion in their description.

In the Singaporean sample, the majority of participants reported situations where they had received compassion from a friend (46.4%), followed by from colleagues (11.6%) or a family member (10%). Less frequently recalled experiences involved receiving compassion from strangers or from a partner, and in grieving situations. In regard to the minor categories, experiences of being the recipient of a friend's (31.9%) or a family member's (10%) compassion when struggling with a personal problem, or of receiving compassion from a colleague (10%) or a friend (7.2%) in relation to an academic or work problem were the most frequently recalled situations. Twenty-six percent of participants described situations that could not be considered experiences of receiving compassion from others. From these, most either couldn't recall such a situation or recounted experiences that didn't correspond to receiving compassion from others (according to CFT). Two participants gave descriptions that were nonspecific and one that reflected FBRs to receiving compassion.

Experiences of self-compassion

Frequencies and percentages for experiences of self-compassion are presented in Table 6. In the total sample, the most frequent self-compassion experiences where situations where participants recalled being compassionate towards themselves

when struggling with an academic problem (23.5%) or a personal problem (21.6%). Other narrated experiences involved directing compassion towards oneself when facing a health problem (5%), a work problem (4.7%), a difficulty with a partner (3.3%), a family problem (2.2%), in a grieving situation (2%), when dealing with a problem with a friend(s) (1.8%) or when facing a more general failure or setback (1%). Surprisingly, 35% of participants recounted experiences that were not self-compassion. The majority of these participants described experiences that did not meet the criteria for being considered a self-compassion experience according to the CFT model (56.4%), couldn't recall being self-compassionate (17.2%), were afraid or resistant of directing compassion to themselves (15.4%) or were too vague in their descriptions (10.9%). A selection of de-identified participant quotations of the themes of experiences of self-compassion is given in Table 1.

Table 6
Frequencies & percentages of major categories of experiences of self-compassion in the total sample (N = 449) and per country (Australia n = 227; Portugal n = 151; Singapore n = 71)

Experiences of Self-compassion	Total sample (*N* = 449)		Australia sample (*n* = 227)		Portugal sample (*n* = 151)		Singapore sample (*n* = 71)	
	Frequency (*n*)	%	Frequency (*n*)	%	Frequency (*n*)	%	Frequency (*n*)	%
Self-compassion in a grieving situation	9	2.0	6	2.6	2	1.3	1	1.4
Self-compassion when facing problems with friends	8	1.8	3	1.3	2	1.3	3	4.2
Self-compassion when facing academic problems	105	23.5	68	30.0	25	16.6	12	16.9
Self-compassion when facing personal problems	97	21.6	44	19.4	39	25.8	14	19.7
Self-compassion when facing family problems	10	2.2	5	2.2	3	2.0	2	2.8
Self-compassion when facing health problems	23	5.1	19	8.4	2	1.3	2	2.8
Self-compassion when facing problems with a partner	15	3.3	7	3.1	6	4.0	2	2.8
Self-compassion when facing work problems	21	4.7	12	5.3	4	2.6	5	7.0
Self-compassion when facing a failure/setback	5	1.1	0	-	5	3.3	0	-
Not self-compassion experience	156	34.7	63	27.8	63	41.7	30	42.3

Table 6 (continued)
Frequencies & percentages of major categories of experiences of self-compassion in the total sample (N = 449) and per country (Australia n = 227; Portugal n = 151; Singapore n = 71)

Minor categories for not self-compassion experience								
Not self-compassion	88	56.4	21	33.3	54	85.7	13	43.3
Generic/vague description	17	10.9	9	14.3	7	11.1	1	3.3
Lack of memory	27	17.2	12	19.0	2	3.2	13	43.3
FBRs of self-compassion	24	15.4	21	33.3	0	-	3	10.0

Key. FBRs: Fears, blocks and resistances of compassion

When exploring the data of each country, the most frequent type of self-compassion experiences described by Australian participants were being self-compassionate when facing an academic problem (30%) or a personal problem (19.4%). Amongst other experiences less recalled were being compassionate towards oneself when struggling with a health difficulty, a work problem, problems with a partner, a family member or with friends or when mourning the loss of a significant other. Circa 28% of Australian participants narrated situations that did not correspond to self-compassion experiences. These participants recounted situations that were not self-compassion (33%), that reflected FBRs to being compassionate towards themselves (33%), couldn't remember such an event (19%) or were overly vague in their account (14%).

In the Portuguese sample, the most frequent self-compassion experiences recounted by participants were being self-compassionate when facing a personal problem (25.8%) or an academic problem (16.6%). Other experiences of self-compassion described comprised being compassionate for oneself when struggling with problems with a partner, when facing a failure or setback, when dealing with a work-related or a family problem, and also when facing a health issue, problems with a friend(s) or when grieving. Significantly, around 42% of participants narrated situations coded as 'Not self-compassion'. The vast majority of these responses could not be considered a self-compassion experience according to CFT (85.7%). Other descriptions were too unspecific (11%) or participants couldn't recall such a moment (3%).

In the Singaporean sample, experiences involving being compassionate towards oneself when facing a personal problem (19.7%) or an academic problem (16.9%) were the most frequent situations recalled by participants. Other experiences narrated by participants entailed being self-compassionate when facing a work problem, a difficulty with a friend(s), a family member or a partner, when struggling with a health problem or in a grieving situation. From the 42% of participants who described 'Not self-compassion' experiences, the majority either recounted

an event that didn't entail being to self-compassionate to oneself (according to the CFT model) (43%) or couldn't remember such a situation (43%). Other participants provided descriptions that reflected FBRs to being self-compassionate (10%) or were too generic in their narrative (3%).

DISCUSSION

The current study sought to explore peoples' semantic associations with compassion (to others) and self-compassion, and to examine recalled memories of personal experiences of compassion for others, receiving compassion from others and self-compassion. Furthermore, this study aimed to investigate possible cultural differences in these aspects by comparing participants' responses in three different countries (Singapore, Australia and Portugal).

The results of this study help elucidate the semantic associations that people in the general community hold regarding the word 'Compassion'. We found that, across the entire sample, people associate compassion most frequently with the words 'Empathy', 'Kindness' and 'Understanding', with over 40% of the sample selecting these among their top three words. From a CFT perspective, 'Empathy', selected by 50.7% of participants, is considered a competency of compassionate engagement (Gilbert, 2009, 2010, 2014). Empathy is the ability to understand the perspective of the person who is suffering, their feelings, thoughts and motives, as well as resonate affectively with that person's experience, thus building an empathic bridge to cultivate a compassionate motivation and help guide compassionate action (Gilbert, 2014). Of course, empathy enables us to resonate with positive and negative feelings, and can also be brought to various motivations, such as a competitive motivation. In the case of compassion, empathy helps us to understand and resonate with the suffering (Singer & Klimecki, 2014). In the CFT model, kindness is considered to be different to compassion. While people have been found to be able to differentiate kindness from compassion when given brief scenarios to consider (Gilbert et al, 2019), when asked to choose words they associate with compassion in our study, 'Kindness' was selected by 41.1% of participants. However, compassion is differentiated from kindness because of the necessary presence of suffering (Gilbert et al., 2019). Finally, 'Understanding' was selected by 40.4% of participants. To be understanding can reflect a mental process of comprehending another's situation and experience, or it may reflect an attitude towards that person of acceptance and tolerance. In a sense, selecting understanding may relate to aspects of the CFT model of compassion such as empathy, non-judgment, and wisdom.

Interestingly, despite the differences of kindness and compassion held by the CFT model, we found that 'Kindness' was the most frequently selected word in both the Australian (49%) and Singaporean (52%) samples. 'Empathy' (Australians 42.2%; Singaporeans 47.6%) and 'Understanding' (Australians 42.9%; Singaporeans 36.2%) were also in the top three selected words. However, the Portuguese sample most frequently selected 'Empathy' (67.7%), followed by 'Understanding' (38.8%) and 'Sensitivity' (30.6%), with kindness dropping to fourth most selected at 21.9%. 'Sensitivity' is considered an important part of the CFT model of compassion, in that it appears both in the definition of compassion and is also one of the six competencies of compassionate engagement (Gilbert, 2009, 2010, 2014). Nevertheless, the difference between the Portuguese sample and the Australian and Singaporean sample may reflect language differences. In Australia and Singapore, the official language is English, and the list of words used in this study was originally developed in English. The English words were then translated to Portuguese language by M.M. and a back-translation procedure by a bilingual speaker was used to ensure the words corresponded in both languages. It is, however, possible that cultural differences exist between these countries in terms of the meaning associated with 'Compassion,' 'Self-compassion' and our list of words, and these differences may underlie these findings.

The current study also explored people's semantic connotations of the word 'Self-compassion'. Across the entire sample, the most frequently selected words were 'Acceptance', 'Strength', and 'Understanding'. 'Acceptance', selected as a word associated with self-compassion by 40.07% of participants, seems very relevant to compassion, especially from the CFT perspective of 'Non-judgment', one of the six competencies of compassionate engagement (Gilbert, 2009, 2010, 2014). However, in our study 'Non-judgment' was selected by less than 10% of participants, suggesting that 'Acceptance' as a word was closer to their sense of self-compassion. Also, 'Acceptance' appears to be more specifically associated with self-compassion than compassion for others, as it was selected by only 12.5% of the total sample as a word associated with 'Compassion'. 'Strength', selected by 21.6% of participants to be associated with 'Self-compassion', is an important quality of compassion and self-compassion from the perspective of CFT. Again, it is interesting to note that this word was much more specifically associated with 'Self-compassion' compared with 'Compassion' where it was selected by 5.65% of the total sample. Conversely, 'Kindness' seemed less associated with 'Self-compassion' (16.27% of the total sample) than 'Compassion' (41.1% of the total sample). This finding is less relevant to the CFT model than perhaps the MSC model that posits 'self-kindness' as one of the three key aspects to their definition of self-compassion (along with mindfulness and common humanity; see Neff, 2003). 'Understanding', as discussed above, was the third most selected word for 'Self-compassion'.

In terms of each country, we found that 'Acceptance' was the most frequently selected word associated with 'Self-compassion' for the Australian, Portuguese and Singaporean participants. This may be a particularly helpful finding, tapping into people's intuitive wisdom around accepting oneself, one's thoughts and feelings, and one's context or environment as a way to alleviate suffering in oneself. Despite this consensus around the word 'Acceptance', our results also indicated diversity in the word associations participants across countries had with 'Self-compassion'. In the Australian sample, participants also nominated 'Care' (25.3%) and 'Kindness', 'Understanding', and 'Mindfulness' (all 22.3%). In the Portuguese sample participants nominated 'Awareness' (33.9%) and 'Strength' (23.5%). In the Singaporean sample participants nominated 'Understanding' (26.7%) and 'Love' (23.8%). This is also a useful finding, as it emphasises the importance of inquiry and discussion when introducing self-compassion in community-based programs or in individual or group therapy. Self-compassion (and, for that matter, compassion for others) are not just one singular thing across individuals, let alone countries. Individual, societal and cultural differences should be taken into account, especially in early conversations about compassion and self-compassion as part of CFT.

An important finding of the current study is that people's understanding of compassion and self-compassion may very well differ from that held by the CFT model. For example, words derived from the competencies of compassionate engagement held by CFT model, including sensitivity, empathy, tolerance, sympathy, and non-judgment, were all selected as words associated with self-compassion by less than 10% of participants. Thus, the psychoeducation aspect of CFT regarding what compassion is and the competencies it entails is extremely important. However, it should be delivered in a careful, delicate fashion, avoiding arguments at all costs, seeking an understanding of the client's perspective first, helping them to feel heard and understood, as well as accepted and validated, prior to offering the CFT model.

One approach to developing a shared understanding of compassion between the CFT therapist and client is to explore the client's memories of compassion across the three flows. In the current study, we endeavoured to examine participants' experiences of compassion for others, receiving compassion from others and self-compassion. We found that participants most often recalled experience of offering compassion to a friend (31.5%) and stranger (21.3%), with many of these experiences relating to compassion for friends with personal problems (21.3%). In terms of receiving compassion from others, the vast majority of participants reported receiving compassion from friends (44.1%), and again in relation to personal problems. Finally, experiences of self-compassion were largely in response to facing academic (23.5%) or personal (21.6%) problems, although a majority of the sample were university students, and so concerns regarding their studies would naturally be a prominent.

Nevertheless, there is significant common ground regarding memories of personal experiences of compassion across the three flows, including a recognition that compassion is a response to pain, distress and suffering.

Of particular note in our findings was that a significant proportion of people described an experience that could not be categorised as compassion across the three flows. In particular, a number of participants stated that they were not able to remember examples of compassion, or expressed certain FBRs to compassion. In fact, this inability to recall compassion may itself be a block. Future research should explore the link between how people perceive compassion (in terms of semantic associations and meanings) and how they recall personal experiences of compassion. For example, if a person does not view compassion (across any of the three flows) as important, they may not be able to remember experiencing it. Alternatively, if a person views compassion as important but they lack confidence in their ability to enact it, they may also not be able to remember experiencing it.

Another possible explanation for this inability of people to recall compassion experiences might lie in their levels of FBRs to compassion. Fears of compassion have been found to be linked to one's attachment history and affiliative experiences (Gilbert el al. 2011; Matos et al., 2017), to increase vulnerability to mental health difficulties (Kirby et al., 2019), and may vary between different cultures (Steindl et al., 2019). Individual differences in self-criticism might also help explain these findings, since self-criticism is known to be associated to fears of compassion (Gilbert el al. 2011) and to how people respond to compassion focused interventions (Duarte et al., 2015; Longe et al., 2010; Matos et al., 2022). Future research might thus seek to examine the role of FBRs to compassion, and self-criticism, on how people perceive compassion/self-compassion and their ability to recall compassion experiences. Finally, current psychopathological symptoms (e.g., depression) may influence people's recollections of compassion, and hence future studies should take current mood symptoms into account. Furthermore, exploring what variables help explain why some people recall compassion, especially certain individual differences in age, gender, culture, as well as clinical versus non-clinical sample, will be important future research.

In addition, our findings should be interpreted considering some methodological limitations that future research may seek to address. Despite their adequacy given the qualitative nature of our study, the three samples used were not representative of the entire population of each country which impairs the generalizability of the findings. Furthermore, because the meaning of compassion can be embedded by cultural, societal and linguistic influences, the generalization of the findings to other populations from different cultural backgrounds should be made with caution and warrants replication in other languages/cultures. The

developmental range of the whole sample was large (17 to 73 years old), and two of the samples had an unequal gender distribution, with more female respondents. Thus, in the future research should attempt to explore whether age and developmental stage play a role in the meaning and subjective experiences of compassion, and examine these aspects in more gender balanced samples. More research should be done on people's semantic associations and meanings of the words compassion and self-compassion, as well as the way this may influence subjective experiences of compassion across the three flows and how these might be interpreted or remembered. Nevertheless, we draw from the findings of this study a number of clinical considerations for CFT practice, especially in the early stages of CFT when the CFT therapist and client are developing a shared understanding of 'what is compassion?'.

Our findings suggest that there is considerable diversity of semantic understanding of what compassion is, and thus the CFT therapist should not assume that the words compassion and self-compassion are understood in the same way by any given client.

Taking a guided discovery approach is important when developing a shared understanding of 'what is compassion' between CFT therapist and client. Rushing too quickly to a didactic approach, telling the client what compassion is, may illicit resistance, discord in the therapeutic relationship, or even therapeutic rupture. Asking the client first 'What is compassion?' and then validating their perspective, especially those aspects of their perspective that aligns with the model, is vital in the first instance.

One way to use guided discovery regarding the question 'what is compassion?' is to explore memories of personal experiences of compassion across the three flows. Our findings suggest that this is a helpful way to identify compassion and explore the qualities clients may have brought to personal experiences of it.

However, a significant number of people will find it difficult to remember examples of compassion, or may express FBRs to compassion when asked for personal experiences, and so the CFT therapist should be prepared to work with this when it arises.

In preparation for such blocks, the CFT therapist may also have examples in mind. One such example is to ask the client to imagine that they have a friend who is experiencing a significant health concern and needs a particular medical investigation, but is also fearful of doctors or hospitals and so has been avoiding this investigation. Once the client confirms they can imagine such a situation, the CFT therapists asks them how they might approach their friend, and what they might do, to be helpful and to alleviate their friend's suffering. When thoroughly explored, the client will often arrive at the various competencies of compassionate

engagement and action, giving the CFT therapist an opportunity to validate and affirm the client and arrive at a definition of compassion.

There remains a need to provide psychoeducation regarding the question of 'what is compassion'. The CFT therapist should present the CFT model of compassion, the broad definition, the various competencies and qualities associated with this definition, and the differences between compassion and other concepts, such as kindness. However, this process of providing information is often helped by first asking permission to do so. In other words, the CFT therapist might say, "Would you mind if I talk about the approach we take to compassion, what it is and so on, from a compassion focused therapy perspective?" The client will almost certainly give permission, however, by asking for it, the CFT therapist is demonstrating collaboration and respect for the client, and this often decreases the risk of further resistance or discord arising when the education offered differs somehow from the client's perspective.

The CFT therapist should always return to the client and their perspective, inviting them to comment or question the definition and its components, and facilitating a thorough exploration and discovery of compassion across the three flows from the CFT perspective. Creating a shared understanding of compassion at the start is particularly helpful as therapy progresses and reduces the risk of FBRs arising in later therapy sessions.

While a range of approaches are invaluable when developing a shared understanding of 'what is compassion', one commonly used strategy for collaboratively exchanging information in a health setting, drawn from motivational interviewing (MI; Steindl et al., 2018) is the elicit-provide-elicit (EPE) technique (Rollnick et al, 2008). In the context of CFT, EPE would involve the CFT therapist *eliciting* from the client what they already know about compassion, *providing* (with permission) information regarding compassion that is tailored so that it complements the client's response, and then *eliciting* the client's feelings, thoughts, perspectives and questions about the information that was provided. Rather than simply providing information in a non-collaborative, didactic way, EPE can help with reducing discord, increasing information retention and increasing the likelihood of behaviour change. Given the findings of the current study, the various semantic associations with the words 'compassion' and 'self-compassion', and diversity of memories of subjective experiences of compassion across the three flows, including both being unable to remember examples of compassion or expressing FBRs to compassion, we recommend EPE, or conversations like this that take into careful consideration the therapeutic process, be a part of the early CFT sessions when the CFT therapist and client are developing a shared understanding of 'What is compassion?'.

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What stands between self-disgust and borderline features? The need to cultivate self-compassion in adolescents from Portugal

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Abstract

Borderline personality disorder (BPD) is characterized by emotional instability, unstable relationships, feelings of abandonment and emptiness, impulsivity, and self-harm. An unstable self-image is also a common borderline feature, often marked by self-criticism, self-hate and feeling of disgust towards aspects of the self. Considering the developmental path of BPD, it is essential to act at early ages with adolescents that show growing and persistent borderline features. The present study aimed to test the mediation role of self--compassion in the relationship between self-disgust and borderline features in Portuguese adolescents. Participants were 655 adolescents (381 girls and 274 boys) with an average of 15.58 years old (*SD* = 1.51), who completed self-report questionnaires at school. Data were analyzed through SPSS and PROCESS Macro to perform descriptive statistics, comparisons, correlations and regressions. Results showed that self-compassion mediated the relationship between self-disgust and borderline features. The mediation model explained 51% of borderline features and gender was used as a covariate, considering that girls exhibited higher self-disgust and borderline features, and lower self-compassion than boys.

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These findings indicate that cultivating self-compassion skills in adolescents could be a potential positive regulation mechanism for self-disgust's effect on borderline features.

Keywords: adolescence, borderline features, self-compassion, self-disgust, mediation.

O que se entrepõe entre a auto-aversão e os traços borderline? A necessidade de cultivar autocompaixão em adolescentes de Portugal

Resumo

A Pertubação Borderline da Personalidade (PBP) é caracterizada por instabilidade emocional, relacionamentos intáveis, sentimentos de abandono e vazio, impulsividade e auto-dano. Uma auto-imagem instável é também uma característica borderline comum, muitas vezes marcada por auto-criticismo, auto-ódio e sentido de aversão direcionados a aspetos do eu. Considerando o percurso desenvolvimental da PBP, é essencial agir em idades precoces com adolescentes que denotam traços borderline crescentes e persistentes. Este estudo procurou testar o papel mediador da auto-compaixão na relação entre a auto-aversão e traços borderline em adolescentes portugueses. Os participantes foram 655 adolescentes (381 raparigas e 274 rapazes) com uma média de idade de 15.58 anos (*DP* = 1.51), que completaram questionários de autorresposta na escola. Os dados foram analizados através do SPSS e PROCESS Macro para realizar estatísticas descritivas, comparações, correlações e regressões. Os resultados mostraram que a autocompaixão mediou a relação entre a auto-aversão e os traços borderline. O modelo de mediação explicou 51% dos traços borderline e o género foi incluído como covariável, uma vez que as raparigas apresentaram maior auto-aversão e traços borderline e menor autocompaixão do que os rapazes. Estes resultados indicam que cultivar competências auto-compassivas em adolescentes pode ser um potencial mecanismo de regulação positivo para o efeito da auto-aversão nos traços borderline.

Palavras-chave: adolescência, traços borderline, auco-compaixão, auto-aversão, mediação.

INTRODUCTION

Borderline personality disorder (BPD) is characterized by an unstable self-image or identity disturbance, emotional instability, unstable relationships, feelings of

abandonment and emptiness, impulsivity, and self-harm (American Psychiatric Association [APA], 2013). This severe personality disorder is associated with functional impairment, overuse of health services (Skodol et al., 2002) and patients with BPD present a suicide rate between 3% and 10% (Paris, 2004). Although BPD is usually diagnosed in adulthood, evidence has shown that borderline features can be manifested at early ages, particularly in adolescents (Crick et al., 2005; Sharp & Tackett, 2014). Acting preventively, for example promoting more effective and healthy regulation strategies to adolescents with marked borderline features, might attenuate the evolution of these symptoms (Bozzatello et al., 2019; Chanen & Kaess, 2012; Sharp et al., 2015), and possibly other indicators such as quality of life, well-being and social pleasure.

People diagnosed with BPD often describe inconsistency or disorganization about their sense of self (Fuchs, 2007). A qualitative study with five BPD patients provided evidence of multiple self conceptualizations rather than a singular identity (Agnew et al., 2016). Additionally, hand in hand with the fragmented concept of the self, BPD patients also struggle with a negative and insecure self-to-self relationship (Dammann et al., 2011). Winter et al. (2015) showed that BPD female patients avoid seeing themselves in the mirror compared to healthy controls. The authors clarified that this might be explained by the intention to avoid self-awareness due to a negative self-concept, expected rejection, shame, and negative body image perception. These processes are common in people with low self-esteem. In fact, BPD patients seem to exhibit self-esteem instability, which is associated with a poorer self-concept, decreased self-concept clarity, and diminished self-acceptance (Paradise & Kernis, 2002; Santangelo et al., 2020; Zeigler-Hill & Abraham, 2006). Accordingly, other studies have shown that borderline symptoms are related to marked self-criticism, harshness, low compassion and feelings of disgust towards the self (Carreiras, Castilho, et al., 2020; Donald et al., 2019; Guiomar, 2015).

Self-disgust occurs when a person experiences disgust, revulsion or aversion towards aspects of the self, including physical appearance and behaviors or even internal aspects such as personality or attitudes (Carreiras, 2014; Overton et al., 2008). Several studies have pointed to the relationship between self-disgust and depression (Overton et al., 2008; Powell et al., 2013; Ypsilanti et al., 2019), eating psychopathology (Ille et al., 2014; Palmeira et al., 2019), and borderline symptoms in adults (Guiomar, 2015; Ille et al., 2014) and adolescents (Carreiras, Castilho, et al., 2020).

Certain research works (Gilbert, 2010; LeDoux, 1998; Morrone-Strupinsky & Depue, 2005; Panksepp, 1998) showed that our brains contain three interacting types of emotion regulation systems: the threat and self-protection system (to

detect and respond to threats), the drive-excitement system (to promote positive feelings that motivate, encourage and energize) and the soothing and safeness system (to restore balance through soothing, safeness and peace). Self-disgust might be included in the threat and self-protection system to alert us to take action against aspects of the self that are perceived as threats and toxic. This response encompasses physiological activation (e.g., nausea, increased heart rate), cognitions (e.g., self-hate, self-criticism) and behaviors to avoid or exclude the perceived threats within the self (Carreiras, 2014). Gilbert (2010) suggested that stimulating the soothing and safeness system and the respective neurohormones will influence the activation of the threat and self-protection system. Feeling safe, secure and soothed would work as an antidote to decrease negative affect (e.g., depressive symptoms, anxiety, stress), deactivating the threat and self-protection system.

Self-compassion means being sensitive to own suffering and feeling motivation to relieve it (Gilbert, 2005; Neff, 2003) and it is a way to stimulate the soothing and safeness system. A compassionate mind can be essential to facilitate dealing with unpleasant, difficult and harmful situations and emotions (Gilbert, 2010). Being self-compassionate reflects staying mindful of the present moment instead of being overidentified with thoughts and feelings, perceiving suffering as part of the human condition and not feeling isolated, and being gentle and kind when talking with the self rather than harsh and critical (Neff, 2003). Although several studies identified a positive effect of self-compassion in people with BPD, for example on recovery, acceptance, and decreasing of borderline symptom themselves (Donald et al., 2019; Feliu-Soler et al., 2017; Keng & Wong, 2017; Loess, 2015), studies replicating such results in adolescent samples are scarce.

Considering the need to intervene preventively, studying borderline features at early ages has recently gained support. Nonetheless, not so many studies have focused on internal psychological processes and how they work in developing borderline features. For example, experiential avoidance predicted borderline features' levels at one-year follow-up. In this study, the effects of depression and anxiety on borderline features were washed out by the experiential avoidance, suggesting that experiential avoidance might be an important process in the relation between negative affect and borderline symptoms in youth (Sharp et al., 2015). However, few is known about the positive effects of self-compassion to counteract the negative self-to-self relationship, self-hate and self-disgust usually associated with borderline symptoms. In this line, this study aimed to test the mediation role of self-compassion between self-disgust and borderline features in a representative adolescent sample.

METHOD

Participants

The sample of the current study was composed of 655 Portuguese adolescents from the general population, of which 381 were girls (58%) and 274 boys (42%). They presented an average of 15.58 years old (*SD* = 1.51) and a mean of 10.26 years of schooling (*SD* = 1.43). Non-significant gender differences were found for age ($t_{(653)}$ = -.35, p = .72) and years of schooling ($t_{(653)}$ = 1.76, p = .08).

Procedures

This study is part of the first author's PhD project. All procedures consider the ethical standards of the Ministry of Education and the National Commission for Data Protection of Portugal (number: 6713/2018), the Ethics and Deontology Commission of the Faculty of Psychology and Educational Sciences of University of Coimbra, and the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Participants were students from four schools in the north and centre regions of Portugal. The adolescents and their parents gave written consent after being informed about the aims of this study, confidentiality, and voluntary participation. In the classroom, the adolescents completed the self-report questionnaires in the presence of the researchers and teachers to provide any clarification when needed.

Measures

The Borderline Personality Features Scale for Children (BPFS-C; Sharp et al., 2014; Portuguese version by Carreiras, Loureiro, et al., 2020) is a unidimensional self-report questionnaire composed of 11 items to assess adolescents' borderline features. Items are rated on a 5-point Likert scale (1 = *Never true*; 5 = *Always true*) and the total score is a sum of all items. The higher the scores, the higher the level of borderline features. The 11-item version presented good internal consistency (α = .85; Sharp et al., 2014) as well as the ten-item Portuguese version (α = .77; Carreiras, Loureiro, et al., 2020). In the current study, Cronbach's alpha was .88.

The Self-Compassion Scale (SCS; Neff, 2003; Portuguese version for adolescents by Cunha et al., 2015) is a self-report questionnaire composed of 26 items (e.g., "I'm kind to myself when I'm experiencing suffering"; "When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am") to assess the ability to be kind and understanding with oneself when experiencing suffering. The items are divided into six subscales (Self-kindness, Isolation, Common Humanity, Self-judgement, Mindfulness and Over-identification) and are rated on a 5-point Likert scale (1 = *Almost never*; 5 = *Almost always*). The total score is a mean of all subscales (after reversing Isolation, Self-judgment and Over-identification), and higher scores reflect higher self-compassion. The SCS revealed good internal consistency in the original version (α = .92) and in the Portuguese version (α = .85). In our data, Cronbach's coefficient for the total scale was α = .87.

The Multidimensional Self-Disgust Scale (MSDS; Carreiras, 2014; Version for adolescents by Carreiras et al., 2022) is a self-report questionnaire to assess the emotion disgust directed to aspects of the self. This instrument comprises 32 items divided into four subscales: Defensive activation ("When I feel self-disgust, my heart beats fast"), Cognitive-emotional subscale ("When I feel self-disgust, I feel diminished, inferior and small"), Avoidance ("When I feel self-disgust, I avert my gaze from the body"), and Exclusion ("When I feel self-disgust, I want to cut, burn or eliminate those parts of myself"). Items are rated on a 5-point Likert scale (1 = *Never*; 5 = *Always*), and the total and subscales scores are a sum of the items. Higher scores indicate higher levels of self-disgust. The adolescent version is composed of 30 items and presented good internal consistency (Cronbach's alphas ranging from .75 to .97; Carreiras et al., 2022). In the current study, the total score presented a Cronbach's alpha of .96.

Data Analyses

Data were analyzed through IBM SPSS Statistics version 23 and PROCESS Macro (Hayes, 2013). Normality of data was tested with the Kolmogorov-Smirnov test and examining the skewness (*sk*) and kurtosis (*ku*) values (normality assumed for $Sk < 3$ and $Ku < 8$; Kline, 2011). Outliers were examined considering the boxplot diagram.

Descriptive statistics were conducted to characterize the sample. Student's t-tests for independent samples were conducted to test differences between groups. Effect sizes were analyzed according to Cohen (1988), considering *d* values between .20 and .49 small, between .50 and .79 medium, and above .80 large. Pearson corre-

lation coefficients were used to examine the relationship between variables. The reference values of Dancey and Reidy (2017) were used to interpret the correlation coefficients: from .10 to .39 were considered weak, from .40 to .69 moderate, and above .70 strong.

A simple mediation model (model 4) was conducted using PROCESS Macro (Hayes, 2013) with a five thousand bootstrap procedure. Significance was considered when the 95% confidence interval did not include zero. The simple mediation model is a statistical method to explain how an independent variable (self-disgust) impacts a dependent variable (borderline features), going through a mediator variable (self-compassion). We analyzed the influence of the independent variable on the dependent variable examining two paths: the direct effect (by which self-disgust influences borderline features without going through self-compassion) and the indirect effect (by which self-disgust influences borderline features through self-compassion). Gender was included in the model as a covariate to control its potential confounding effect.

RESULTS

Preliminary Analyses

Preliminary data analyses were conducted to guarantee the assumption of data normality. No severe violations were found ($Sk < 3$ and $Ku < 8$; Kline, 2011). Outliers were maintained to keep the natural variance and consider that no significant differences occurred in our results (Osborne, 2008).

Descriptive Statistics

Means and standard deviations for all variables are presented in Table 1. Girls exhibited higher borderline features, self-disgust and lower self-compassion than boys, with small to medium effect sizes.

Table 1.
Means (M) and standard deviations (SD) of variables in the study for the total sample, males and females. Student's t-test (t) were conducted to test differences between groups and Cohen's d for effect sizes.

	Total sample (N = 655)	Males (n = 274)	Females (n = 381)	t(df)	p	d
	M (SD)	M (SD)	M (SD)			
Borderline features (BPFS-C)	24.43 (8.23)	21.77 (8.05)	26.34 (7.84)	-7.27 (653)	<.001	0.56
Self-disgust (MSDS-A)	19.08 (21.05)	12.87 (16.83)	23.55 (22.62)	-6.93 (653)	<.001	0.54
Self-compassion (SCS-A)	3.10 (0.63)	3.24 (0.54)	3.01 (0.66)	4.92 (653)	<.001	0.38

Note. BPFS-C = Borderline Personality Features Scale for Children; MDSD-A = Multidimensional Self-Disgust Scale for Adolescents; SCS-A = Self-Compassion Scale for Adolescents.

Correlations

Self-compassion was negative and moderately correlated with self-disgust (r = -.60, p< .001) and borderline features (r = -.57, p <.001), meaning that higher self-compassion was associated with higher self-disgust and higher borderline features. Borderline features and self-disgust presented a positive and moderate correlation (r = .69, p< .001; Table 2).

Table 2.
Pearson correlations between borderline features, self-disgust and self-compassion (N = 655).

	1	2	3
1. Borderline features (BPFS-C)	1		
2. Self-disgust (MSDS-A)	.69**	1	
3. Self-compassion (SCS-A)	-.57**	-.60**	1

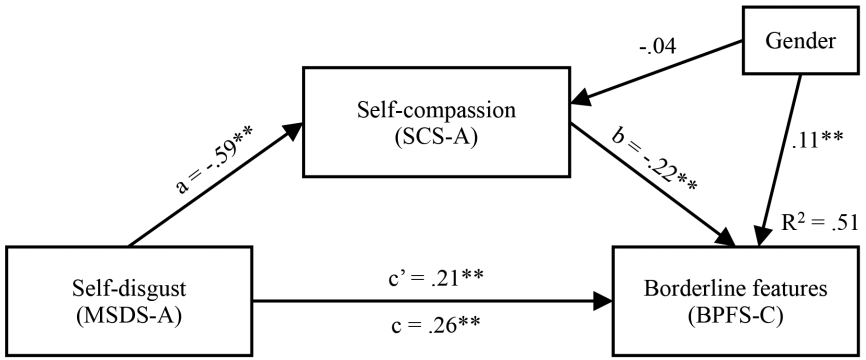
Note. ** p < .001. BPFS-C = Borderline Personality Features Scale for Children; MDSD-A = Multidimensional Self-Disgust Scale for Adolescents; SCS = Self-Compassion Scale for Adolescents.

Mediation Effect of Self-compassion Between Self-disgust and Borderline Features in Adolescents

To test if self-compassion played a role between self-disgust and borderline features, a mediation model was performed controlling gender (Figure 1). Results showed that these variables accounted for 51% of borderline features ($F_{(3, 651)}$ = 228.78, p< .001). Self-disgust presented a significant effect on self-compassion (a = -.59, 95% CI [-.02, -.02], $t_{(650)}$ = -18.33, p< .001) and self-compassion on borderline features (b = -.22, 95% CI [-3.76, -1.99], $t_{(650)}$ = -6.38, p< .001). The direct effect of self-disgust

on borderline features was significant (c' = .21, 95% CI [.18, .23], $t_{(650)}$ = 15.25, p< .001), as well as the total effect (c = .26, 95% CI [.23, .28], $t_{(650)}$ = 22.67, p< .001).

Figure 1.
The mediation effect of self-compassion in the relationship between self-disgust and borderline features.



Note. **p < .001; All presented effects are standardized. MSDS-A = Multidimensional Self-Disgust Scale for Adolescents; SCS-A = Self-Compassion Scale for Adolescents; BPFS-C = Borderline Personality Features Scale for Children.

DISCUSSÃO

Identifying core psychological mechanisms with the potential to counteract borderline features at early ages might result in decreasing these symptoms with important lifetime implications (Bozzatello et al., 2019; Chanen & Kaess, 2012; Sharp et al., 2015). Accordingly, this study aimed to examine the potential positive effect of self-compassion between feeling disgust towards the self and borderline features in adolescents. The relationship between a negative and insecure self-to-self relationship (Dammann et al., 2011), as well as self-criticism, self-hate and self-disgust and borderline features has been established (Carreiras, Castilho, et al., 2020; Donald et al., 2019; Guiomar, 2015) but the influence of self-compassion in this relationship is still underexplored.

Our results corroborated the idea that self-disgust is closely linked to borderline symptomatology, considering a moderate association between both variables. Perceiving the self as generally undesirable, insecure and aversive (including internal aspects related to personality and sense of self, and physical and external aspects related to personal appearance, body and behaviors) activates the threat and self-protection system, and consequently outputs of avoidance and rejection of what is perceived as toxic. As previously proposed, activating the soothing system might function as an antidote to ease the activation of the threat and self-protection system (Gilbert,

2005, 2010). Self-compassion emerges as a way to feel soothed and safe within the self, recognizing suffering and being actively motivated to alleviate it (Gilbert, 2010; Neff, 2003). Self-compassion skills training encourages people to embrace their flaws, failures and mistakes, with a compassionate and wise inner voice, accepting who they are (Neff, 2011). For this reason, the negative and moderate association between self-compassion and self-disgust was expected, as it has been reported in previous research works (Carreiras, Castilho, et al., 2020; Guilherme, 2019; Palmeira et al., 2017).

In the present data, gender differences were found for all variables. Girls exhibited higher borderline features and higher self-disgust than boys with medium effect sizes. These findings corroborate previous literature suggesting that females tend to report higher BPD symptoms (Carreiras, Castilho, et al., 2020; Swartz et al., 1990; Trull et al., 2010) and feelings of disgust towards the self (Carreiras, 2014; Guilherme, 2019; Guiomar, 2015). Also, our results align with previous works showing that males tend to be more self-compassionate than females (Cunha et al., 2015; Yarnell et al., 2015). In general, females tend to exibit higher internalized difficulties (e.g., depression, axiety) (Hayward & Sanborn, 2002; Mendle, 2014), a more self-criticial internal talk (Yarnell et al., 2015) and poorer self-esteem than males (Gentile et al., 2009), which might explain the gender differences in our interest variables. Considering these differences, we controlled the effect of gender in the mediation model.

The mediation model showed that self-disgust had an effect on borderline features indirectly through self-compassion, corroborating our initial hypothesis. The negative statistics associated with self-compassion indicate that it worked in the opposite direction of self-disgust and borderline features. Considering all variables, the model explained 51% of borderline features, demonstrating that a negative self-to-self relationship with aversion and disgust towards personal aspects had a direct effect on borderline features. It seems that adolescents who experience more self-disgust-related thoughts and feelings tend to exhibit higher borderline symptoms. Moreover, the mediation results seemed to indicate that being self-judging, harsh with the self, not accepting the current experience and feeling isolated in suffering have an important contribution to explain how self-disgust influences borderline features in adolescents, whether for boys or girls. Cultivating self-compassion at early ages has been indicated by several authors as an essential tool to promote psychological well-being and resilience and counteract emotional distress (Bluth et al., 2018; Marsh et al., 2017). Nonetheless, the role that self-compassion can play between self-disgust and borderline features have not been tested so far. Our results support the positive effect of self-compassion in adolescents, indicating that being more self-kind, mindful and feeling part of a shared human experience could be beneficial to oppose the effect of self-disgust on borderline symptomatology.

Evidenced-based interventions focused on developing self-compassion seems to be particularly important for adolescents with a negative self-to-self relationship, especially

if they have marked feelings of self-disgust. Compassion Focused Therapy (CFT; Gilbert, 2010) is an example of an intervention to foster and cultivate self-compassion that clinicians could implement in therapeutic settings. There are also group interventions for adolescents designed to develop self-compassion, for example Making Friends with Yourself (MFY; Bluth et al., 2016), which are a relevant option to employ in schools or community settings. Results showed that adolescents who attended the MFY program presented significantly higher self-compassion and life satisfaction, as well as significantly lower depression, comparing to the waitlist control. Compassion-based interventions are encouraged to adolescents with marked self-disgust, as a possible measure to decrease the likelihood to develop borderline features.

Some limitations of the current study are important to acknowledge. The cross-sectional design precludes causal inference, which stresses the need to be cautious when interpreting the mediation analysis. Although our results suggested that part of the effect of self-disgust on borderline features goes through self-compassion, longitudinal studies are essential to verify these findings. Additionally, we only used self-report questionnaires to assess the variables, which entails biases related to the person's feeling at the time they responded. Future studies are encouraged to use clinical interviews to assess borderline features. Notwithstanding these shortcomings, the current study was the first one exploring the relationship between these variables, identifying self-compassion as competence and attitude to cultivate in youth, possibly having a positive impact on borderline features. Adolescents with lower borderline symptoms would reflect greater mental health, emotional balance and well-being.

Compliance with Ethical Standards

This study was supported by the PhD Grant of the first author, sponsored by the Portuguese Foundation for Science and Technology (FCT). All procedures performed were in accordance with the ethical standards of the Ministry of Education and the National Commission for Data Protection of Portugal (number: 6713/2018) and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. All parents and participants gave their written informed consent.

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PLAYwithHEART: Study protocol to test the efficacy of a mindfulness, acceptance and compassion-based programme for adolescent athletes

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Abstract

Some studies have documented that athletes experience mental health challenges associated with the practice of sports. There is evidence of the benefits of mindfulness, acceptance, and compassion skills in athletes. The contribution of these processes has never been tested in an integrated and structured way. In this protocol, we aim to describe a controlled non-randomized trial to test a new integrative intervention based on contextual-behavioral therapies for adolescent athletes: the PLAYwithHEART programme. This trial is registered at ClinicalTrials.gov (Identifier: NCT04850872). The PLAYwithHEART programme will comprise eight weekly sessions (of about 45 minutes each) directed towards adolescent athletes. The PLAYwithHEART programme's structure and contents are presented in this protocol. Athletes will be recruited through contact with sport clubs in Portugal. A total of 189 participants will be selected and assigned to one of two conditions: experimental group (who will participate in the programme) or control group (in the waitlist control condition). Outcome measure-

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ment will be conducted at baseline, post-intervention, and at six-month follow-up. This programme aims to decrease the levels of anxiety in sport and increase the quality of life of athletes, by promoting skills such as mindfulness, acceptance, and self-compassion, and decreasing levels of shame and self-criticism, to deal with the challenges and demands of sport contexts. Results will contribute to reaching an optimized intervention for athletes.

Keywords: PLAYwithHEART; adolescent athletes; acceptance, mindfulness and compassion--based group intervention; sports anxiety; quality of life.

PLAYwithHEART: Estudo de protocolo para testar a eficácia de um programa baseado no mindfulness, aceitação e compaixão para atletas adolescentes

Resumo

Estudos recentes documentaram um aumento em diferentes indicadores de psicopatologia associado à prática desportiva. A literatura tem mostrado os benefícios das competências de mindfulness, aceitação e compaixão na prática desportiva. No entanto, o contributo destes processos nunca foi testado de forma integradora e estruturada. Neste protocolo, pretende-se descrever um estudo quase-experimental que tem como objetivo o desenvolvimento e teste de eficácia do programa PLAYwithHEART, baseado nas terapias contextuais em atletas adolescentes. Este programa é constituído por oito sessões semanais de 45 minutos cada. De forma a analisar a eficácia do programa de intervenção, será conduzido um estudo não randomizado controlado com lista de espera (grupo controlo vs. grupo experimental). Um total de 189 participantes serão recrutados através do contacto com clubes desportivos portugueses e responderão a três momentos de avaliação. O presente estudo está registado na plataforma ClinicalTrials.gov (NCT04850872). O programa PLAYwithHEART visa diminuir os níveis de ansiedade desportiva e aumentar a qualidade de vida dos atletas, através da promoção de competências como o mindfulness, a aceitação e a auto-compaixão, e da diminuição dos níveis de vergonha e autocriticismo, para lidar com os desafios do contexto desportivo. Este estudo poderá ter implicações práticas que poderão contribuir para o reconhecimento do desporto como contexto de oportunidade para a promoção da saúde e bem-estar.

Palavras-chave: PLAYwithHEART; atletas adolescentes; programa baseado no mindfulness, aceitação e compaixão; ansiedade desportiva; qualidade de vida.

INTRODUCTION

From the perspective of public health and preventive medicine, the regular practice of physical exercise during childhood and adolescence is considered essential for the promotion of health throughout life (Biddle, 2016; Pate et al., 2000; Snyder et al., 2010; Tammelin et al., 2003; Valois et al., 2004). The World Health Organization (WHO, 2003) and the European Union (European Commission, 2007) have emphasized the need for greater investment in strategies to encourage the practice of physical exercise at an early age. Taking into account that physical exercise is increasingly conducted in an organized manner, the role of sport in society has become increasingly relevant over the years, not only for individual but also for public health (e.g., Malm et al., 2019). However, some studies have documented an increase in different indicators of psychopathology (e.g., depressive and/or anxiety symptoms, feelings of inferiority/shame) associated with the practice of sports (Cruz, 1996; Fontana, 2015; Patel & Luckstead, 2000; Teques et al., 2019), regardless of gender, age, type of sport, or competitive level (Cruz, 1986).

The pressure exerted to obtain high performances may explain an increase in stress and anxiety in sports performance (e.g., Correia & Rosado, 2018), an experience that may contribute to the abandonment of sports (Scanlan et al., 2005). Indeed, sports can be experienced as a pleasant and challenging activity or as a threatening and even aversive situation (Araújo & Gomes, 2005).

Concerns about failure in sports (e.g., making mistakes, losing, being criticized) are considered the most prevalent sources of worry for athletes, since success in sports is perceived as central to their recognition (Martens et al., 1990; Smith, 1989). The search for social approval/recognition and the need to achieve certain performances/goals can trigger behaviours of social comparison, and self-criticism in athletes, associated with the experience of shame and inferiority and, consequently, the impoverishment of well-being (Walton et al., 2020). Although many athletes believe that self-criticism is essential to their sporting success (Sutherland et al., 2014), empirical evidence has shown that self-criticism is associated with negative outcomes. Recent studies have demonstrated significant associations between higher levels of shame and self-criticism with lower levels of psychological quality of life (Oliveira et al., 2021a, 2021c) and with higher levels of anxiety and depression in athletes (Oliveira et al., 2021b). Given that sport is essentially an arena for competition, it is likely that conditions relating to social rank (how one sees themselves in comparison to others) may assume a key role in contributing to mental health and well-being (Walton et al., 2020).

Certain competitive contexts, guided by the requirement of high performances, seem to promote the development of a social ranking mentality (Gilbert, 2000).

From this perspective, self-criticism (attitude of self-condemnation or negative judgment activated in situations of failure/mistakes), and shame (feelings of devaluation/inferiority) may be triggered by the perceived failures of athletes who may assume that failures/errors reveal lack of aptitude/capacity and/or personal value to others (e.g., parents, peers, and coaches; Brown et al., 2017; Gilbert, 2000; Vilela & Gomes, 2015). These environments may lead to increased levels of stress and anxiety in sport, associated with emotional/physical exhaustion, devaluation of the practice of sports, and decreased quality of life (Correia & Rosado, 2018; Vilela & Gomes, 2015).

Most of the psychological interventions designed for athletes have been based on traditional psychological skills training (PST), which has been applied to develop increased self-control over internal processes aimed at performance enhancement (Gustafsson et al. 2017). However, literature has indicated that these traditional PST interventions have not received sufficient efficacy standing despite 30 years of research. Also, studies evaluating the mechanisms by which optimal performance actually occurs suggest a very different finding than would be predicted by the theoretical model from which PST interventions have been devised (Gardner & Moore, 2004, 2006). Therefore, several researchers have discussed the effectiveness of these control strategies by pointing out that athletes still seem to experience difficulties in employing traditional psychological skills training-related techniques (Birrer et al. 2012; Gardner & Moore, 2007; Moore, 2009). In order to answer these issues, during the last decade, different programmes based on contextual-behavioral therapies have been developed. Programmes such as Mindfulness-Acceptance-Commitment (MAC); Mindfulness Sport Performance Enhancement (MSPE); Mindfulness Meditation Training for Sport (MMTS) have been developed for application in the sports context to promote attention to the present moment, and the acceptance of internal states in a non-judgmental way (Baltzell & Akhtar, 2014; Josefsson et al., 2019; Kaufman et al., 2009). These interventions have a different perspective to PST, since they propose that optimal performance does not require the reduction or control of internal states but, rather, requires a nonjudging moment-to-moment awareness and acceptance of one's internal state, whatever that may be, and an attentional focus on task-relevant external stimuli and behavioral choices that support one's athletic endeavor (Moore, 2009). These interventions are conceptually based on the definition of mindfulness, which refers to a quality of awareness that objectifies the contents of internal and external experiences, promoting greater interest, clarity, and tolerance towards that content (Baltzell & Summers, 2016; Kabat-Zinn, 1994). In parallel, there is empirical support for mindful-acceptance approaches as well as for those based on Acceptance and Commitment Therapy (Noetel et al., 2019). These programmes based on Mindfulness and Acceptance and Commitment

Therapy (ACT) have shown promising results, essentially in increasing the pleasure of the sporting experience, in the improvement of the practice/training, in the optimization of performance, as well as in the improvement of the well-being of the athletes (Baltzell & Akhtar, 2014; Josefsson et al., 2019; Kaufman et al., 2009; Moore, 2009; Scott-Hamilton et al., 2016; Vilela & Gomes, 2015).

Furthermore, there has been a growing interest in the study of compassion in the sport context. Compassion can be understood as the capacity to be attuned and emotionally moved by one's own or someone else's suffering, as well as the capacity of taking actions which give support. Compassion refers to a complex process that is innate, determined in part by individual traits, and moderated by different unconscious and conscious factors, context, social structures and expectations, and culture (Lown, 2015). Therefore, despite the fact that human beings are born with the capacity for compassion, this capacity may be suppressed depending on these factors (Lown, 2015). However, compassion can be learned. In fact, everyone can learn to deepen this capacity and train to regulate negative affect (Gilbert, 2015). Therefore, these capacities could be beneficial in the context of sport. A number of studies have explored the role of self-compassion within recreational and elite athletes. Self-compassion has been linked with different beneficial factors in sport, including increased well-being and reduced body image concerns, fear of failure, and fear of negative evaluation (Eke et al., 2019; Ferguson et al., 2014, 2015; Mosewich et al., 2011; Reis et al., 2019). Also, athletes who revealed higher levels of self-compassion have presented more positive and facilitative responses, and less negative responses to hypothetical, imagined or real negative sporting scenarios (Barczak & Eklund, 2018; Ferguson et al., 2015; Reis et al., 2015, 2019). Ceccarelli et al. (2019) demonstrated that athletes with lower self-compassion revealed a high heart rate variability reactivity when recalling a stressful sporting situation, in comparison to athletes with greater self-compassion who showed a more regulated autonomic profile (greater parasympathetic nervous system activity). Mosewich et al. (2013) developed an intervention focused on promoting self-compassion as an adaptive emotional regulation strategy in the face of negative events in the context of sport. Preliminary data suggest that the promotion of compassion contributed to an increase in performance, as well as to a well-being in sports (Carraça et al., 2019; Killham et al., 2018; Mosewich et al., 2013).

In summary, literature has suggested that several skills (eg., acceptance, mindfulness, and self-compassion) associated with contextual-behavioral therapies can play a relevant role in the quality of life and well-being of athletes, who can experience sport as a threatening and stressful activity. The integration of self-compassion components in ACT and mindfulness-based interventions has been an emerging research topic during the past decade, since these approaches are considered to be

compatible and complementary (Neff & Dahm, 2015; Neff & Tirch, 2013; Yadavaia et al., 2014). In fact, ACT, mindfulness, and compassion-based interventions, despite different approaches, share common components, all ultimately aiming to promote a more conscious, clear, kind, non-evaluative relationship with our own experience and that of others (Neff & Dahm, 2015).

Therefore, previous studies have shown the benefits of mindfulness, acceptance, and compassion skills in sports. However, the contribution of these processes has never been tested in an integrated and structured way, and research in adolescents is still scarce. The relevance of these interventions for the valorization of sports practice and the well-being of athletes is recognized, however, there is a lack of such programmes in Portugal, especially in adolescents (Carraça et al., 2018).

Aims

The purpose of this study is to describe a two-arm controlled non-randomized trial to test the efficacy of a new integrative intervention based on contextual-behavioural therapies (Mindfulness, Acceptance and Compassion-based therapy): the PLAYwithHEART (PLAY with Happiness, Engagement, Acceptance, and Respect with your Team) Programme.

PLAYwithHEART is an innovative manualized programme for the promotion of acceptance, cooperation, and pro-social skills for adolescent athletes. PLAYwithHEART aims to decrease the levels of sports anxiety and increase athletes' quality of life, by promoting skills inherent to an affiliative mentality (social safeness, mindfulness, acceptance, and compassion), as an alternative to a ranking social mentality (based on maladaptive processes, such as shame, and self-criticism), to deal with the challenges and demands of the sports context. The contents of the PLAYwithHEART and the design of the trial are presented in this study.

METHOD

This study is funded by the Portuguese Foundation for Science and Technology and is registered at ClinicalTrials.gov (Identifier: NCT04850872). The planning and implementation were carried out per ethical recommendations outlined by the American Psychological Association (2010) and the World Medical Association's Declaration of Helsinki (WMA, 2013). Ethical approval has been obtained from the Ethics Committee of the Faculty of Psychology and Education Sciences of the University of Coimbra.

Participants' recruitment and selection

Participants will be recruited between July 2021 and September 2022. The participants will be recruited from contacts that will be made through different sports clubs in Portugal. If sport managers of the clubs are interested in this study, the research/psychologist will provide detailed information about the aims, procedures, and voluntary and confidential nature of the study to athletes and their parents/legal tutors. Subsequently, all the parents/legal tutors and young athletes who agree to participate in this study will give written informed consent.

Participants will be screened by a psychologist/researcher through a brief interview, that ensures they meet the inclusion criteria in the programme. Participants are eligible to integrate this study if they meet the following inclusion criteria: a) are aged between 12 and 18; b) practice a competitive sport; c) give their informed consent and have the consent of their legal tutors; d) can read and write Portuguese; e) are available to participate in the eight sessions of the PLAYwithHEART Programme. Also, participants are not eligible to integrate this study if they have the following exclusion criteria: a) existence of cognitive difficulties that interfere in completing the self-answer measures; and b) being under psychological/psychiatric accompaniment.

Sample Size

Results from G*Power calculations for repeated measures analysis, assuming a p-value = .05, an effect size of f = .25, with a statistical power of .85, two groups, and three measurements, recommend a sample size of 178. Giving the 20% drop-out rate, the total sample size to be collected will be 189 (each group will be composed of 95 participants).

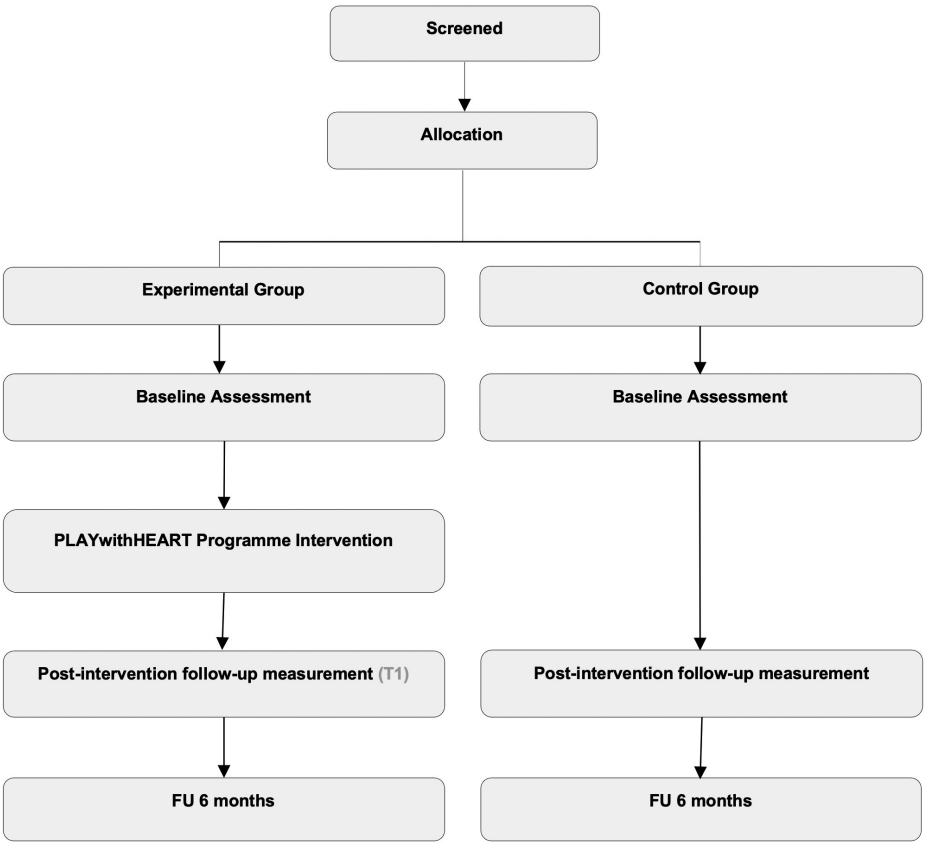
Allocation of participants

Participants will be allocated to one of two conditions: experimental condition (participants will receive the PLAYwithHEART intervention programme), and control condition (participants will not receive other intervention and will be on the waiting list to receive the PLAYwithHEART Programme). Groups will be composed, on average, by ten participants. As a result of restrictions due to training schedules and sports venues, participants cannot be randomly assigned to the groups. Instead, athletes will be distributed among groups according to the

sport practiced and the respective training schedules. Regarding the allocation of the participants, athletes interested in the PLAYwithHEART Programme will be allocated to the experimental vs. control group depending on the availability of the program facilitators and the availability of athletes' schedules to participate in the programme. Participants in the experimental condition will then receive the PLAYwithHEART intervention programme, and they will be asked to complete pre-intervention questionnaires (M0). The control group will only fill in the questionnaires and will receive the intervention after the experimental group. Figure 1 shows the expected flow of participants through the study.

Figure 1.

Flow diagram of the study designed to assess the efficacy of the PLAYwithHEART.



Intervention Development

The PLAYwithHEART Programme

The PLAYwithHEART intervention programme will be developed by the psychologist members of the current research team, taking into consideration the literature related to mindfulness-based interventions, ACT, and self-compassion interventions directed to athletes.

The PLAYwithHEART is a manualized, group-based intervention comprising eight weekly sessions, of about 45 minutes each, to be delivered to adolescent competitive athletes by certified psychologists with clinical experience in contextual-behavioral therapies. The duration of the sessions was stipulated by taking into account the relevant recommendations in literature (Visek et al., 2013) and evidence-based interventions previously conducted with athletes (Baltzell & Akhtar, 2014; Bernier et al., 2014; Lundgren et al., 2021; Terzioğlu et al., 2020). In this intervention programme, participants will be invited to perform tasks between sessions (usually, these tasks involve meditative practices with audio guides specifically recorded for this intervention). These tasks should be individually performed by participants ideally daily.

Overall, the PLAYwithHEART Programme focuses on ACT topics such as acceptance of internal experiences, values, and committed action (Hayes et al., 2012); on mindfulness practices (e.g., Kabat-Zinn, 1994), as well as on compassion-based approaches (Gilbert, 2009; Neff & Germer, 2013). In each session, participants are invited to engage in experiential exercises, mindfulness, and compassion meditation practices, and discuss their experiences and difficulties in the group. The first session aims to present the intervention's objectives and structure, allow participants to introduce themselves, have a sense of common difficulties (promoting group cohesion). In this session, the programme facilitators discuss the preconceived idea of the meaning of a mentally strong athlete with the participants (an athlete who does not feel anxiety, fear of failure, or who does not feel insecure before competitions vs. an athlete who feels these unpleasant emotions and thoughts but faces them instead of trying to control or avoid them), foster creative hopelessness, and offer mindfulness as a different way of facing difficulties. Furthermore, in this session, each participant is given the Participants' Manual encompassing information to complement the sessions and exercises. The following sessions present a similar structure: each session begins with a guided meditation, a review of participants' between-session assignments (whether they encountered obstacles with the practices/exercises, what was their experience), an introduction to the session's topics, and

in-session experiential exercises (real-life examples and metaphors are designed to facilitate the participants' practice and reinforcement of engaging in the skill addressed in the session), and ends with a meditation practice. The tasks between sessions are in line with the topics explored in each session and include informal practices aiming to integrate mindful awareness into everyday activities. Each session has a tittle that corresponds to a sports slogan so participants can quickly identify the theme addressed in the session. An overview of the intervention is presented in Table 1.

Table 1.
Overview of the PLAYwithHEART intervention.

Session	Topics/Aims	In-session exercises/metaphors	Between-session assignments
1. Yesterday you said tomorrow	- Introduction of the participants to the PLAYwithHEART Programme; - Identification of common difficulties and promotion of creative hopelessness; - Mindfulness as an alternative strategy to deal with difficulties.	The skittles game Redirecting the focus of attention Mindful eating (gums)	Informal mindfulness
2. If you have a body, you are an athlete	- Promote awareness about autopilot and recognize an alternative: Mindfulness; - Recognize that there are common patterns of expression of emotions; - Promote attention to body cues in order to recognize emotions; - Understand the bidirectional mind-body relationship.	Diaphragmatic breathing Exercise "Keeping the body in the mind" Body scan practice	Diaphragmatic breathing and/or Body scan practice Liberator of habits
3. Life is a sport make it count	- Understand the evolutionary perspective of the functioning of the mind; - Understand the protective function of emotions; - Understand the functioning of affect regulation systems and the importance of their balance.	Mindfulness of music Exercise "Activate the System" Diaphragmatic breathing	Mindfulness of sounds Exercise "Pay attention to emotions"

Table 1. (continued)
Overview of the PLAYwithHEART intervention.

4. Just do it!	- Understand and identify life values; - Identify actions committed to life values and barriers towards them; - Understand that although living a valued life is not easy, obstacles do not have to prevent living our values.	Meditation: Here and now ball The party exercise The Bull's Eye exercise Metaphor "Wade Through the Swamp" Diaphragmatic breathing	Diaphragmatic breathing
5. Run the day - Don't let it run you	- Explore and understand key concepts of cognitive fusion and defusion; - Recognize that although the thought has enormous power in our behaviour, it does not control it.	Meditation observation of thoughts "I can't walk across the room" exercise Exercise "Our chatty mind" Three-minute breathing space	Three-minute breathing space Exercice "Stay with your emotions"
6. Rewrite history. Redefine the position	- Understand the paradoxical effect of experiential avoidance; - Promote acceptance rather than control.	Meditation: The Sky and the Weather Armed man metaphor Chinese finger traps Mindfulness of acceptance	Meditation: The Sky and the Weather Reflection of the Harry Potter metaphor
7. Failure's not an option, it's a step	- Understand the concept of compassion and its importance in life in general and in the sport context; - Recognize self-critical discourse and rephrase for a more compassionate discourse.	Mindfulness practice "Everything we share" exercise Exercise "Paddles" Loving-Kindness practice	Loving-Kindness Practice Reflection on the phrase and video by Mickael Jordan
8. PLAYwithHEART	- Promote self-compassion; - Promote compassion for others and understand its importance; - Summary of the intervention.	Meditation "A compassionate friend" Exercise of dyads Exercise "Let's go"	

Note. Task meditations for the week should be performed at least once a day.

The PLAYwithHEART implementation

Primary and secondary outcomes

Before (T0) and after (T1) the intervention, and in the six-month (T2) follow-up, participants in the experimental condition and in the waiting-list control condition will be evaluated through self-report questionnaires. Only the research team will have access to the collected data. Each participant will have a code, in order to match the results in the various evaluation moments. Participants will provide sociodemographic and sport information and complete self-report measures to assess different outcomes (see Table 2).

Primary Outcomes

Sports Anxiety

The multidimensional assessment of the competitive anxiety trait will be assessed through the Sport Anxiety Scale (SAS-2; Cruz & Gomes, 2007; Smith et al., 2006), consisting of 15 items that are divided into three subscales: somatic anxiety, worry, and concentration disturbance. Items are assessed using a scale of Likert ranging from 1 (*Never*) to 4 (*Almost always*). Lower scores in this scale mean a better outcome. The Cronbach's alpha values were satisfactory across all dimensions in the original and Portuguese versions (alpha values above .70).

Quality of Life

The quality of life will be assessed by the KIDSCREEN-10 (The KIDSCREEN Group Europe, 2006; Matos et al., 2012). KIDSCREEN-10 is a self-reported instrument that evaluates the quality of life-related to health in children and adolescents. This scale comprises ten items and higher scores indicate better quality of life. Participants are asked to answer all items on a 5-point scale (1 = *Never/not at all* to 5 = *Always*), with respect to the last week. The Cronbach's alpha value was satisfactory (α = .78).

Key mediators

Mindfulness

Mindfulness skills will be assessed by the Child and Adolescent Mindfulness Measure (CAMM; Cunha et al., 2013; Greco et al., 2011). CAMM comprises ten items that allow the assessment of mindfulness skills in children and adolescents. The items are answered according to a 5-point scale (0 = *Never* to 4 = *Always*). After the items are inverted, the higher the score, the more mindfulness skills the adolescents present. In the original and Portuguese versions, the total scores demonstrated a good internal consistency (α = .80, in both versions).

Psychological Flexibility

This outcome will be measured by the Avoidance and Fusion Questionnaire for Youth (AFQ-Y8; Cunha et al., 2021; Greco et al., 2008). AFQ-Y is a self-response instrument consisting of 8 items that assess psychological inflexibility engendered by cognitive fusion and experiential avoidance. According to the conceptual model that underlies it, psychological inflexibility results from the overlapping of cognitive fusion and experiential avoidance processes. Participants are asked to evaluate the veracity of each statement, on a 5-point scale (0 = *Not at all True* to 4 = *Very True*). Lower scores reveal greater psychological flexibility. This scale demonstrated good psychometric properties in the original version (α = .83) and in the Portuguese version (α = .70).

Self-compassion

Self-compassion skills will be assessed by the Self-Compassion Scale (SCS; Cunha et al., 2016; Neff, 2003). SCS comprises 26 items and six subscales: Self-Kindness; Self-Judgement; Common Humanity; Isolation; Mindfulness; Over-Identification. Participants are instructed with the sentence "how I typically act towards myself in difficult times" and are asked to answer each item according to a 5-point scale (1 = *Almost Never* to 5 = *Almost Always*). Higher scores indicate greater self-compassion skills. This measure presented good psychometric properties in the original version (α = .92) and in the Portuguese version (α = .80).

Social Safeness

This outcome will be assessed by the Social Safeness and Pleasure Scale-Athletes Version (SSPS; Gilbert et al., 2009; Pinto-Gouveia et al., 2008). An adapted athlete version of the Social Safeness and Pleasure Scale (SSPS-AV) will be used to measure participants' social safeness in the context of sport - athlete-related social safeness (sense of belonging, acceptance, and connectedness in their teammates' relationships). Regarding this version, only the instructions of the original scale will be changed. The SSPS is a self-report measure composed of 11 items designed to measure social safeness, i.e., the extent to which individuals feel a sense of acceptance and connectedness in their relationships. The response options are rated on a 5-point scale (1 = *Almost never* to 5 = *Almost all the time*). SSPS has shown good internal consistency in the original and Portuguese versions (α = .92, α = .91, respectively).

Shame

This outcome will be measured by the External and Internal Shame Scale for Adolescents (EISS-A; Cunha et al., 2020). This measure consists of eight items that assess external and internal shame, as well as a global sense of shame. The items are answered according to a 5-point scale (0 = *Never* to 4 = *Always*). The higher the score, the greater the global sense of shame. This measure revealed a good internal consistency, with a Cronbach alpha of .85 for the total scale, of .75 for the external shame subscale, and .79 for the internal shame subscale.

Self-criticism

This outcome will be assessed by the Forms of Self-Criticizing & Self-Reassuring Scale-Athletes version (FSCRS; Gilbert et al., 2004; Silva & Salvador, 2010). An adapted version of the FSCRS will be used to assess participants' critical and self-reassuring responses when confronted with failures or setbacks in the context of sport. Regarding the original version, only initial instructions will be changed. FSCRS is a 22-item scale that comprises three subscales which measure: (1) inadequate-self; (2) hated-self; and (3) self-reassurance. Participants will be asked to answer all items following the statement "When things go wrong for me…" on a 5-point scale (0 = *Not at all like me* to 4 = *Extremely like me*). All subscales presented good psychometric properties in the original version (Cronbach's alphas ranged between .86 and .90) and in the Portuguese version (Cronbach's alphas ranged between .75 and .90). For the purpose of this study, only the self-criticism dimension (calculated from the sum of inadequate-self and hated-self subscales) will be used.

Table 2.
Schedule of Enrollment, Intervention, and Assessments.

	StudyPeriod				
	Enrollment	**Allocation**	**Post-allocation**		
Timepoint	-t2	-t1	t0	t1	t2
Enrollment					
Informed consent of the athlete	x				
Informed consent of the legal guardian	x				
Eligibility screen	x				
Allocation		x			
Intervention					
PLAYwithHEART			x	x	x
Waiting list			x	x	x
Primary outcomes					
Quality of Life			x	x	x
Sports anxiety			x	x	x
Secondary outcomes					
Shame			x	x	x
Self-criticism			x	x	x
Mindfulness			x	x	x
Acceptance			x	x	x
Self-compassion			x	x	x
Social Safeness			x	x	x

Treatment

Integrity

Several aspects of treatment integrity guidelines will be followed during the development of the PLAYwithHEART intervention: (a) integrity was thought as an important part of the study, in which facilitators' competence was ensured by previous training in ACT and compassion-based approaches, as well as supervision throughout the intervention; (b) the intervention was developed having in mind issues of integrity, by including exercises and consistent informative texts, and facilitators' lines and tips in texts; and (c) at the end of the sessions, facilitators should complete a self-assessment table related to their performance in sessions.

Acceptability assessment

Athletes in the experimental group will answer a questionnaire regarding the quality of the PLAYwithHEART intervention, the provided resources (audio files, participants manual), and participants' perceived change (e.g., sports anxiety, quality of life, ability to self-regulate emotions). The intervention's attrition will also be considered a measure of acceptability.

Feasibility assessment

Feasibility of this study will be assessed by collecting data on the following: rate of completion of the intervention; carrying out the proposed activities for home; adherence rates; feasibility of testing procedures and data collection methods, including completion rates.

Statistical Analysis

Data will be analyzed with the IBM SPSS Statistics v22.0 and the AMOS v22.0 softwares. The IBM SPSS will be used for preliminary analyses that compares groups on demographic and sports data, using independent samples t-tests or chi-square tests depending on the nature of the data. Groups will also be compared on the dependent variables at baseline using independent samples t-tests. In order to assess the association between the outcome measures, SPSS will also be used to perform Pearson correlations. AMOS will be used to assess individual variation in the growth of the dependent variables and examine if the intervention condition might predict changes in social safeness, mindfulness, psychological flexibility, and self-compassion over time, through Latent Variable Growth Curve Modeling.

DISCUSSION

While there is growing interest in integrating different components of ACT and approaches based on mindfulness and compassion (Neff & Dahm, 2015; Neff & Tirch, 2013), even more research is needed on how these different, but related approaches can be integrated into comprehensive interventions.

The PLAYwithHEART Programme will be the first intervention for adolescent athletes, to our current knowledge, that incorporates mindfulness, acceptance, and compassion approaches in an integrated and structured way. The controlled non-randomized trial presented in this study protocol will provide data on the efficacy of this program. It is expected that the Experimental Group will present: lower levels of sports anxiety, and an improvement of quality of life; higher levels of mindfulness, acceptance, self-compassion, and social safeness; and lower levels of shame, self-criticism, compared to the Control Group. These results are expected to remain stable six months after the implementation of the programme.

The study's main strength is the feasability and effectiveness analyses of an integrative and innovative programme for adolescent athletes. Also, the results of this study could allow to explore if PLAYwithHEART predicts changes in social safeness, mindfulness, psychological flexibility, and self-compassion over time. These processes could be crucial in decreasing sport anxiety and increasing quality of life in young athletes. However, one of the most significant challenges of this study will be the prevention of drop-outs. A strategic way of decreasing this risk will be to email participants with sticky notes between sessions. Also, due to the inactive nature of the control group, future studies should compare the intervention's efficacy to other psychological interventions tested in athletes, such as Cognitive and Behavioral Therapy and Model of Psychological Skills Training. Nevertheless, taking into account that this is the first time the PLAYwithHEART intervention will be tested, this programme may provide useful preliminary results on the effects of the intervention.

In conclusion, this programme meets the needs pointed out by WHO (2003), by contributing to the promotion of health and well-being in adolescence, a stage of development marked by multiple changes/challenges. Also, by focusing on the context of sport, it represents a contribution to the advancement of science, clarifying the role of emotional processes in the context of sport. The relevance of the PlaywithHEART is the valorization of sports practice and well-being of athletes. Also, although not a direct target of this project, it is expected that the promotion of skills of mindfulness, acceptance, and compassion and the reduction of anxiety is associated with better results in motivation, training practice, and performance of athletes. If effective, these results may contribute in reaching an optimized intervention for athletes, especially for adolescents.

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Online compassion focused therapy for social anxiety disorder in adolescence (CFT@TeenSAD): Preliminary data on efficacy throughout treatment

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Abstract

This work investigated the efficacy of Compassion Focused Therapy (CFT) on symptoms of social anxiety disorder (SAD) in adolescence, based on data collected throughout treatment. CFT has contributed to the psychological well-being of various populations, but limited evidence exists on its therapeutic gains for SAD in adolescence. Twenty-one adolescents (57.1% girls; 15-18 years old) presenting with SAD received online treatment. The CFT@TeenSAD intervention was organized into four modules: Our mind according to

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CFT, Developing the compassionate self and the skills of a compassionate mind, Practicing compassionate behavior, and Last remarks and continuing a compassionate journey. Before each session, adolescents reported on perceived change in symptom severity. At the end of each session, clinicians rated overtime change in that severity. Self-reports ($F(1,540) = 32.271$, $p < .0005$, $\eta p^2 = .63$) and clinician's reports ($F(1,528) = 24.783$, $p < .0005$, $\eta p^2 = .57$) showed that improvement was significantly heightened during treatment, with significant changes across all four intervention modules. Trajectories of change were similar across gender. Though preliminary, findings point to online CFT being a promising approach to treat SAD in adolescent boys and girls, given that it contributes to continuous decrease in severity of social anxiety symptoms.

Keywords: Compassion Focused Therapy, social anxiety disorder, adolescence, therapeutic change.

Terapia focada na compaixão online para a perturbação de ansiedade social na adolescência (CFT@TeenSAD): Dados preliminares de eficácia ao longo do tratamento

Resumo

Este trabalho investigou a eficácia da Terapia Focada na Compaixão (TFC) nos sintomas da perturbação de ansiedade social (PAS) na adolescência, com base em dados recolhidos ao longo da intervenção. A TFC contribuiu para o bem-estar psicológico em várias populações, mas é escassa a evidência sobre a sua eficácia no tratamento da PAS em adolescentes. Vinte e um adolescentes (57.1% raparigas; 15-18 anos) com PAS receberam tratamento online. A intervenção CFT@TeenSAD foi organizada em quatro módulos sequenciais: A mente de acordo com a TFC, Promoção do eu-compassivo e de competências para uma mente compassiva, Prática de comportamento compassivo, Últimas notas e continuar numa viagem compassiva. Antes de cada sessão, os adolescentes reportaram mudança percebida na gravidade dos sintomas e os clínicos fizeram essa avaliação no final de cada sessão. Tanto os adolescentes (F (1.540) = 32.271, p<0.0005, $\eta p2$ = 0.63) como os clínicos (F (1.528) = 24.783, p< 0.0005, $\eta p2$ = 0.57) relataram melhoria continuada ao longo do tratamento, com mudança significativa ao longo dos quatro módulos. As trajetórias de mudança foram semelhantes para rapazes e raparigas. A TFC surge como uma abordagem promissora na PAS em adolescentes, contribuindo para a diminuição contínua da gravidade dos sintomas.

Palavras-chave: Terapia focada na Compaixão, perturbação de ansiedade social, adolescência, mudança terapêutica.

INTRODUCTION

Social anxiety disorder (SAD) is characterized by a marked and persistent fear of social and/or performance situations in which one may be exposed to the scrutiny of others. Individuals with SAD fear acting in ways that might embarrass themselves and that such action may result in criticism by others, humiliation, or social rejection (American Psychological Association [APA], 2013).

Research shows that SAD typically emerges in adolescence (Stein et al., 2017), with estimated prevalence rates during that life stage varying greatly [e.g., from 1.29% in Norway (Jystad et al., 2021) to 9.1% in the USA (Merikangas et al., 2010); a recent exploratory study in Portugal using a school-based sample of adolescents aged 15 to 18 years old places that prevalence at 8.04% (Vagos, et al., 2021)]. SAD has been consistently found to be more prevalent in adolescent girls than boys (e.g., Jystad et al., 2021; Merikangas et al., 2010; for a review on gender difference including studies pertaining to adolescent samples see Asher et al., 2017). Difficulties in interpersonal interactions during adolescence often result in severe functional impairments across multiple domains of life (Rao et al., 2007), such as school (Burstein et al., 2011), romantic relationships (Hebert et al., 2013), and friendships (Erath et al., 2007). Moreover, SAD is associated with an increased vulnerability to other anxiety and mood disorders (Jystad et al., 2021; Mohammadi et al., 2020), behavioral disorders (Mohammadi et al., 2020), and substance abuse (Burstein et al., 2011; Jystad et al., 2021). If left untreated, SAD tends to persist throughout adulthood (Keller, 2006), with a chronic, unremitting course (Stein et al., 2017); if treated with traditional Cognitive Behavioral Therapy, its recovery rate is substantially lower in comparison with other anxiety disorders (Evans et al., 2021). Therefore, it seems paramount to continue to explore psychotherapeutic ways of effectively changing the course of SAD in adolescence.

Research has been highlighting the potential benefits of compassion-based interventions on a range of mental health problems (Kirby et al., 2017) and these interventions have also been proposed to be suitable for adolescents (Carona et al., 2017). Compassion Focused Therapy (CFT) considers that the human mind has evolved to help individuals adapt to their environments, by regulating their emotions and motivating their behaviors based on the joint action of three basic systems: the threat and protection system that focuses on early detection of threats (including social threats) and elicits negative emotions (e.g., anxiety and anger) in an attempt to keep the individual safe from harm; the drive system that prompts the individual to act to obtain relevant rewards and resources for survival (e.g., food, sexual partner, social status), through positive activating emotions (e.g., excitement and pleasure); and the soothing system that is activated when individuals do not

have to deal with threats or look for resources, triggering feelings of contentment, safeness, calmness, connection and affiliation with others (Gilbert, 2010, 2017a). Each system plays an evolved function and is linked to specific emotions and physiological correlates (Depue & Morrone-Strupinsky, 2005). However, when the threat or drive systems get overactivated, mental health issues may arise. Specifically, when the threat system is overly sensitive, maladaptive self-to-self relating (e.g.., self-criticism and shame) and self-to-other strategies (e.g., subordination) may arise. The soothing system has an important regulation function, allowing for a deactivation of alertness to threats or to imperatives to achieve (Gilbert, 2009).

Shame and self-criticism are core constructs to understand psychopathology according to CFT and have also been associated with social anxiety. Findings on adult non-clinical samples point to social anxiety being associated with higher levels of internal shame (Matos et al., 2013), self-criticism (Iancu et al., 2015) and self-blame specifically (Gilbert & Miles, 2000); moreover, it seems that shame and self-criticism are significant predictors of social anxiety symptoms (Shahar et al., 2015). Social anxiety also seems to be associated with lower levels of compassion one gives oneself, in non-clinical samples of both adults (Makadi & Koszycki, 2020; Werner et al., 2012) and adolescents (Gill et al., 2018; Ștefan, 2019). Shame has likewise been shown to predict social anxiety symptoms in a clinical sample of adolescents diagnosed with SAD, directly and indirectly via self-judgment and safety-seeking behaviors (Vagos et al., 2020).

As a therapeutic approach, CFT aims to help people switch from a shame-based self-critical attitude towards the self (and others) to a more compassionate and caring attitude (Gilbert, 2017b). It intends to stimulate the soothing system and to cultivate compassion, by promoting engagement with suffering and developing the skills to practice wise actions (Gilbert, 2017a). To do so, CFT relies on Compassionate Mind Training (CMT). CMT intends to develop and sustain a sensitive, caring, and tolerant way of relating to ones' suffering and engage with it in a courageous, wise, committed, and non-judgmental way. Along with these attributes, CMT aims to develop compassion skills to prevent and alleviate suffering (i.e., compassionate attention, imagery, reasoning, feelings, sensations, and behavior; Gilbert, 2010).

CFT has proven effective in reducing mental health symptomatology among various populations (Craig et al., 2020; Kirby et al., 2017), but particularly for those who present psychological difficulties associated with high levels of shame and self-criticism (Leaviss & Uttley, 2015). Concerning SAD in particular, preliminary evidence on individual CFT delivered to adults pose it as a promising approach, which led to less shame and self-criticism and to individuals giving more compassion to themselves (Boersma et al., 2015). Also, a randomized controlled trial conducted with adults diagnosed with SAD has shown CFT to be effective in

reducing social anxiety symptoms and self-criticism, in increasing quality of life, and in promoting a more flexible and compassionate perspective towards the self (Gharraee et al., 2018). Still, to our knowledge, no study to date has investigated the efficacy of CFT on adolescent with SAD. Given that SAD has its most probable onset during adolescence (Lijster et al., 2017) and is highly impairing (Mesa et al., 2014), and considering that CFT seems to be an understandable and feasible intervention with adolescents (Carona et al., 2017), we propose that research on the effectiveness of CFT with adolescents with SAD is highly needed. Additionally, investigating change of symptoms over the course of psychotherapy has not yet been applied to SAD in adolescents, nor to CFT.

The present work sought to explore preliminary efficacy data concerning the course of social anxiety symptoms throughout an online 10-session manualized CFT program (CFT@TeenSAD) applied to adolescents diagnosed with SAD, considering self and clinician's reports as outcomes. As a secondary goal, this work intended to investigate if change over the course of treatment would be similar for girls and boys. We expected both self-reported and clinician ratings of severity of social anxiety symptoms to decrease over the course of treatment. This expectation is sustained in previous research showing the efficacy of CFT in adults with several mental health difficulties (Craig et al., 2020), particularly, its efficacy on SAD symptoms (Boersma et al., 2015; Gharraee et al., 2018), and on theoretical considerations that change in CFT is sequential, with subsequent stages of change being nested in previous ones (Gilbert, 2010). Moreover, because the presentation of SAD and its associated impairment does not differ by gender (Dahl & Dahl, 2010), even if SAD is more prevalent in girls (Burstein et al., 2011; Merikangas et al., 2010), we expected boys and girls to present similar trajectories of change over the course of CFT.

METHOD

Participant recruitment

This work refers to data collected within the procedures defined for the research project *TeenSAD: Changing the Course of Social Anxiety in Adolescence* (ClinicalTrials.gov Identifier: NCT04979676). This project refers to a superiority randomized clinical trial comparing diverse intervention conditions with a waiting-list control group and

was approved by the Ethics Committee of the host institution prior to any participant recruitment procedure being implemented.

Schools were selected across the country based on direct contacts with schools known to the research team and indirect contacts within online groups of school psychologists. Each school was contacted by the research team to present the study and inquire about their interest/availability to collaborate with the current research throughout its three-year duration. Schools were contacted if they taught students attending the 10th and 11th grade, regardless of geographic location, type of funding (i.e., public or private) or type of teaching (secondary or professional). Schools were provided with a detailed methodological note upon which to decide on their participation and the research team was available to answer any questions. Schools that agreed to decide on their participation then sent out informed consent forms to parents/legal guardians of students attending the 10th and 11th grades. The informed consent form detailed all phases of the research and provided with a direct contact to the lead investigator who was available to answer any questions that parents/legal guardians could have. Adolescents presenting with parental consent were additionally asked for their assent via an online form, before answering the Portuguese version of the Social Anxiety Scale for Adolescents (Cunha et al., 2004). The ones scoring one standard deviation above the mean found for a large normative sample (i.e., n = 522 adolescents aged between 12 to 18 years of age of which 57.3% were female) on that instruments' total scale were invited for further assessment using a structured clinical interview. Interviews were conducted by an experienced clinical psychologist using the Portuguese version of the Mini International Neuropsychiatric Interview for Children and Adolescents – MINI-KID (Sheehan et al., 2010; Portuguese authorized version by Rijo et al., 2016 - see instruments section). Interviews served to assess for inclusion and exclusion criteria for the intervention phase of participant selection. Inclusion criteria were being aged between 15 and 18 years at the moment of the interview and receiving a primary diagnosis of SAD (DSM-5; APA, 2013). Exclusion criteria were the indication of educational specific needs, psychotic symptoms, or suicidal risk. Again, informed consent was obtained from parents/legal guardians and verbal assent was obtained from adolescents themselves to take part of the intervention. Adolescents who were authorized and willing to participate were then allocated by the principal investigator to a control group or one of three intervention conditions. Only the CFT@TeenSAD intervention will be considered in this work.

The CFT@TeenSAD Intervention

The CFT@TeenSAD (Salvador et al., 2020) intervention manual was developed within the research project *TeenSAD: Changing the Course of Social Anxiety in*

Adolescence (ClinicalTrials.gov Identifier: NCT04979676). The intervention consisted of ten individual sessions lasting 75 minutes each, delivered online following a CFT-based manualized intervention and intending to foster compassionate feelings towards oneself. Two booster sessions, the data of which were not included in this work, occurred at one and two-months after treatment completion. The intervention followed a progressive strategy of change, in as much as it was expected that throughout the intervention the adolescent would learn and start to apply actions with a more compassionate stance. The progress was made throughout four interdependent modules, each one with a specific primary focus: (a) Our mind according to CFT, (b) Developing the compassionate self and the skills of a compassionate mind, (c) Practicing compassionate behavior, and (d) Last remarks and continuing a compassionate journey. See Table A in the Supplementary Material for a detailed information on the structure of the intervention.

The first module included sessions 1 and 2 and was mainly focused on helping adolescents to understand the evolutionary roots of human's basic needs, emotions, and motives, including those referring to social events, and to grasp the nature and function of the three-basic emotional systems and how they interact with each other. The second module included sessions 3, 4 and 5 and mostly intended to help adolescents understand what compassion is, and how to deal with potential idiosyncratic fears and resistances to compassion. Still within this module, the adolescent was guided in developing compassion specific skills (i.e., compassionate attention, imagery, reasoning, thinking, sensory focusing, and feelings) that would sustain compassionate behavior. The third module included session 6 through 9 and consisted of prompting the practice of compassionate behavior. Adolescents were encouraged to act compassionately, to take responsibility, and to tolerate and cope in healthy compassionate ways with their own distress, while exposing themselves to feared social and performance situations relevant to SAD, inside and outside therapy. The fourth and last module was comprised of session 10 when key learnings were revisited, and adolescents were invited to develop an intention on how to continue to nurture and nourish their compassionate mind, even if setbacks would occur.

All sessions followed the same structure. They began with adolescents engaging in a soothing rhythm breathing and focusing on their own compassionate intention, followed by revisiting and discussing how contents of the previous sessions were integrated into the adolescents' daily life. Then, the core theme of the session was addressed through experiential exercises, and a compassionate practice was also offered. The session ended with a summary of key-messages of the session and the assignment of an activity that the adolescent was encouraged to undertake between sessions as practice of the key-learning points covered in each session.

Across all sessions, the therapists' role was focused on developing a warm and secure therapeutic relationship through which adolescents would be helped to continuously develop the motivation to pursue compassion towards the self and care for well-being. Therapists were two clinical psychologists who had extensive knowledge, practice, and training in CFT, and received at least biweekly supervision by a senior psychologist with proficiency and expertise in CFT.

Instruments

Eligibility assessment

Mini International Neuropsychiatric Interview for Children and Adolescents – Mini-KID (Sheehan et al., 2010; Portuguese version by Rijo et al., 2016). The Mini-KID is a structure diagnostic interview that assesses a broad range of Axis I diagnoses in children and adolescents as described in the DSM-5 (APA, 2013). It offers the clinician with yes/no questions to assess for the presence of specific diagnostic criteria for each clinical diagnosis, and helps the clinician decide on a primary diagnosis, considering the symptoms identified, their level of impairment, and time of onset. Interrater reliability was excellent across diagnoses except for dysthymia for its original version (Sheehan et al., 2010); its Portuguese version resulted from a careful translation and backtranslation process and has been previously used as a method for diagnoses (Rijo et al., 2016). To apply this interview autonomously, the evaluator receives specific training, including role-play exercises, and undergoes an initial observation phase of experienced evaluators using the interview. The Mini-KID was used in the recruitment phase of the current work, specifically to assess for the presence of inclusion criteria and absence of exclusion criteria (see Participant recruitment procedures).

Outcome measures

Social Anxiety Session Change Index (Hayes et al., 2008). The Social Anxiety Session Change Index (SASCI) includes four items designed to evaluate how individuals attending therapy for SAD perceive to have changed since the beginning of treatment in level of anxiety in social/performance situations, in avoidance of those situations, in concerns about being embarrassed or humili-

ated, and in social anxiety-related daily interference. Items are scored using a 7-point scale ranging from 1 (i.e., *much less than at the start of treatment*) to 7 (i.e., *much more than at the start of treatment*). Considering the four items as a single measure, it has shown adequate internal consistency (i.e., $\alpha \geq .84$), validity in relation to perceived change in fear of negative evaluation, and validity in relation to social anxiety, severity of symptoms and improvement as reported by the clinician. It has also shown to be sensitive to treatment changes expressed qualitatively by the individual (Hayes et al., 2008). Items were translated to the European Portuguese language and were presented to participants at the beginning of sessions 2 through 10. Cronbach alpha values within the current sample ranged from .21 for the first intervention module (i.e., four items[9]; see Intervention Approach below and Supplementary Material) and .95 for the third intervention module (i.e., 16 items).

Clinical Global Impression Scale – Social Anxiety (Zaider et al., 2003). The Clinical Global Impression Scale – Social Anxiety (CGI-SA) was designed to be answered by clinicians/therapists in relation to patients presenting with SAD. It considers two measures: one intends to assess overall severity of symptoms within the past week and the other reflects how symptoms may have changed in relation to a baseline moment. The current work considered solely the latter. The CGI-SA considers seven response categories that refer specifically to symptoms and impairment caused by social anxiety (i.e., 1 = *No social anxiety in excess of normal (…)* to 7 = *(…) disabled in social and work functions*). It has shown construct validity in as much as its scores associated with and were predicted by self-reported and other clinician administered measures of social anxiety and impairment (Zaider et al., 2003). Items were translated to the European Portuguese language by experts in SAD assessment and treatment and the clinician filled them at the end of each intervention session.

Statistical methods em minúsculas e itálico

To understand clinical improvement over the course of treatment, we used adolescents' weekly self-reported perception of change assessed by SASCI (adapted from Hayes et al., 2008) total score and the weekly impression of improvement in the adolescent's symptoms provided by the therapists (adapted from Zaider et al.,

9 For adolescents, data for the first intervention module considered only session 2, given that the instrument asks adolescents to report on their symptoms in comparison to before starting treatment.

2003). Data from both sources were merged considering the focus of intervention modules, as described above. So, sessions 1 through 2 centered on familiarizing the adolescent with how the human mind works according to CFT; sessions 3 through 5 focused on developing compassionate skills; sessions 6 through 9 revolved around compassionate behavior, and the last session intended to highlight the continuous use of compassion.

To assess the perception of clinical improvement by adolescents and therapists across modules and to observe the effect of gender on that perception across modules, we conducted two repeated measures mixed ANOVAs with intervention modules as within-subject factor with four levels (module 1, module 2, module 3 and module 4) and gender as between subject factor (boys and girls). Greenhouse-Geisser correction was applied when the sphericity assumption was not fulfilled according to Mauchly's Test. To identify statistically significant differences between improvement means across modules, we conducted post hoc comparisons (Bonferroni corrected with the statistical significance level accepted at $p < .05$). We conducted the analysis using SPSS Statistics for Mac, v.25 (IBM Corp., Armonk, N. Y., USA).

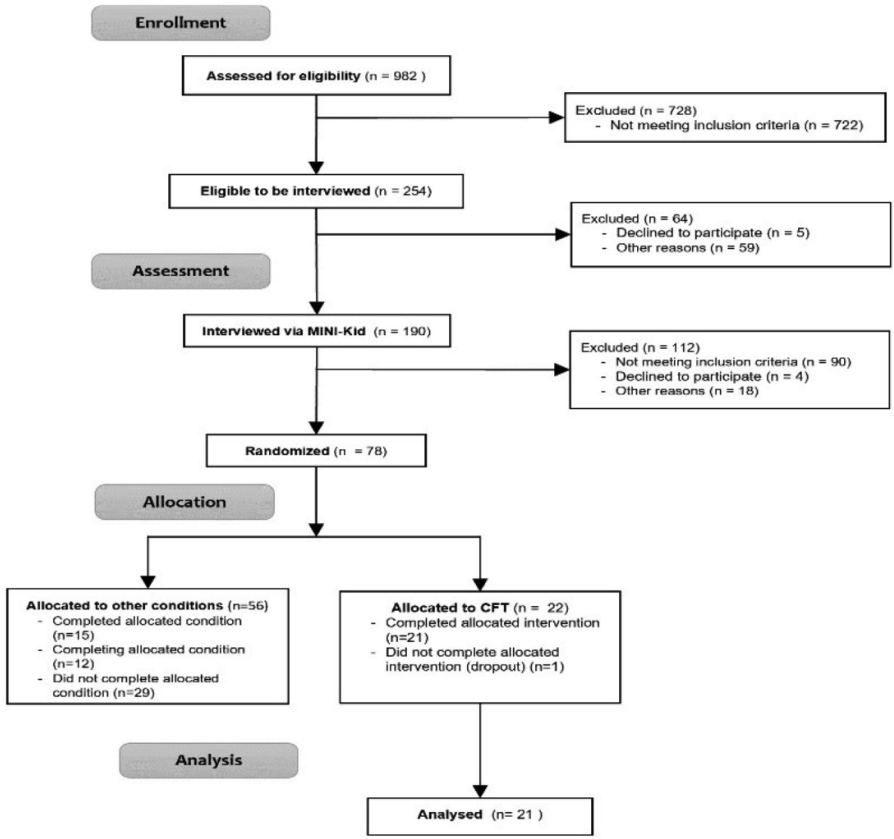
RESULTS

Participant flow and characterization

Eighteen schools were selected across the country and twelve agreed to collaborate with this research. Of the students attending the 10th and 11th school year at those schools, 982 adolescents had parental consent and assented to take part of the screening phase of this research. Of those, 255 adolescents scored one standard deviation above the mean on the Social Anxiety Scale for Adolescents (Cunha et al., 2004) and were contacted to take part of the clinical interview; five declined to participate further in this research and 59 were unreachable through the contacts they had provided. Thus, 190 participants were interviewed, of which 79 fulfilled criteria to be offered intervention for SAD. Twenty-two adolescents accepted and took part of the CFT@TeenSAD intervention; one adolescent dropped out at session 2. The remaining 56 participants were allocated to other conditions not considered in the current work (see Figure 1).

Figure 1

Participant flow



The sample analyzed in this work consisted of 21 adolescents aged between 15 and 18 years of age, whose sociodemographic characteristics are displayed in Table 1. Most participants were girls (i.e., 57.1%), attended the 11th grade (52.4%), came from families with a medium socioeconomic status[10] (47.6%) and had not previously received psychological support (47.6%). Boys and girls had similar mean ages [$t_{(19)}$ = -1.52, p = .15], and were similarly distributed by school year [$x^2_{(2)}$ = 3.51, p = .17] and by socioeconomic level [$x^2_{(2)}$ = 1.72, p = .42]. Boys and girls also had received,

10 Socioeconomic status was defined based on the profession of the parents, based on the Portuguese profession classification (Instituto Nacional de Estatística, 2011). Examples of professions in the high socioeconomic status groups are judges, higher education professors, or M.D.s; in the medium socioeconomic status group are included nurses, psychologists, or school teachers; in the low socioeconomic group are included farmers, cleaning staff, or undifferentiated workers.

on average, a similar number of diagnosis [$t_{(19)}$ = 1.31, p = .21], though boys had significantly more experience of previous psychological support [$x^2_{(2)}$ = 8.76, p = .03], particularly for anxiety symptoms, including social anxiety (n = 3).

Table 1
Participants' socio-demographic characteristics

	Complete sample	Girls	Boys
Age in years (M (SD))	16.10 (0.94)	15.83 (0.84)	16.44 (1.01)
School Year			
10th grade (%)	42.9	58.3	22.2
11th grade (%)	52.4	41.7	66.7
12th grade (%)	4.8	0	11.1
Self-reported socioeconomic status			
Low (%)	42.9	41.7	44.4
Medium (%)	47.6	41.7	55.6
High (%)	9.5	16.7	0
Number of diagnosis (M (SD))	1.48 (1.12)	1.75 (1.42)	1.11(80.33)
Previous psychological intervention			
No (%)	47.6	75.00	11.11
Yes, for anxiety symptoms (%)	33.3	16.7	55.55
Yes, for depressive symptoms (%)	4.8	0	11.11
Yes, for unspecified symptom (%)	14.3	8.3	22.23

All participants had a primary diagnosis of SAD, which was found using the Mini International Neuropsychiatric Interview for Children and Adolescents – MINI-KID (Sheehan et al., 2010; Portuguese authorized version by Rijo et al., 2016). Concerning comorbidities at the time participants enrolled in the study, 13 (61.9%) adolescents presented no other clinical diagnosis, two presented current panic disorder (9.6%), one presented specific phobia (4.8%), one presented agoraphobia (4.8%), one presented attention deficit and hyperactivity disorder (4.8%), and one presented five comorbid diagnoses besides SAD (4.8%; i.e., posttraumatic stress disorder, obsessive compulsive disorder, current panic disorder, agoraphobia and current major depressive episode).

Change in outcome measures throughout the CFT@TeenSAD intervention

Repeated measures mixed ANOVA for self-reported improvement showed no interaction between gender and intervention modules (F (1.541) = 1.297, p = .284,

$\eta p^2 = .064$) and no main effect of gender (F (1) = .184, p = .672, $\eta p^2 = .01$), suggesting that the patterns of change for boys and girls were equivalent. As for the main effect of time, change was significantly different across the program with a large effect size (F (1.540) = 32.271, $p < .0005$, $\eta p^2 = .63$). Posthoc pairwise comparisons showed that mean scores were significantly different across all pairs of modules, with progressive improvement towards the end of the program; see Table 2[11] for mean scores per gender and for the total sample across modules, and Figure 2 for differences between distinctive modules.

Table 2
Means and standard deviations for clinical improvement across modules, per gender and for the complete sample

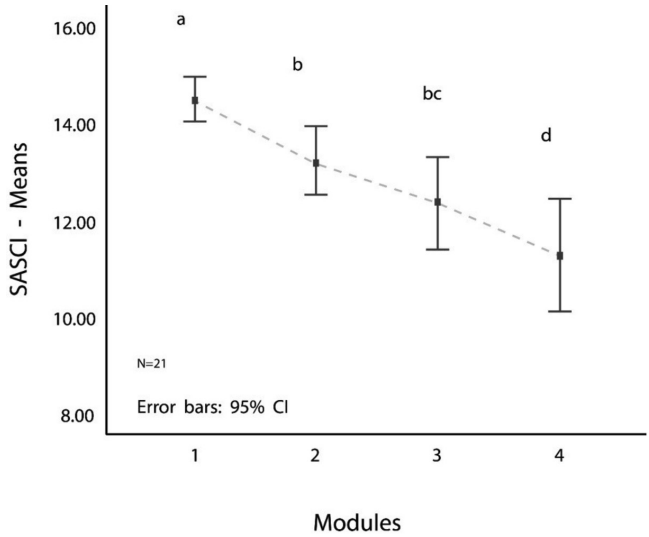
	SASCI	CGI-SA
	Mean (SD)	Mean (SD)
1: Our mind according to CFT		
Boys (n = 9)	15.44 (.73)	3.89 (.17)
Girls (n = 12)	15.00 (.95)	3.94 (.13)
Total (n = 21)	15.19 (.87)	3.92 (.15)
2: Developing the compassionate self and the skills of a compassionate mind		
Boys (n = 9)	13.67 (1.59)	3.39 (.42)
Girls (n = 12)	13.47 (1.27)	3.45 (.50)
Total (n = 21)	13.56 (1.38)	3.43 (.46)
3: Practicing compassionate behavior		
Boys (n = 9)	12.00 (2.48)	2.83 (.35)
Girls (n = 12)	12.75 (1.86)	2.79 (.57)
Total (n = 21)	12.43 (2.12)	2.80 (.48)
4: Last remarks and continuing a compassionate journey		
Boys (n = 9)	10.78 (3.07)	2.88 (1.27)
Girls (n = 12)	11.75 (2.26)	2.25 (.62)
Total (n = 21)	11.33 (2.61)	2.52 (.98)

Note: SASCI: Social Anxiety Session Change Index; CGI - Clinical Global Impression.

11 See Table B in the Supplementary Material for further detail results on mean differences across intervention modules.

Figure 2

Mean clinical improvement across according to SASCI.



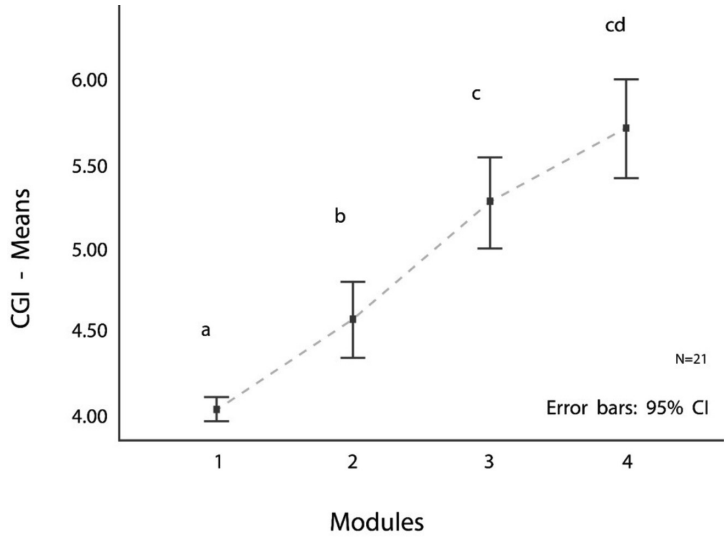
Note: On the left panel mean values are depicted by gender and on the right panel for the total sample. Means identified by distinctive letters are statistically significantly different (Bonferroni corrected; p< .05).

Similarly, the repeated measures mixed ANOVA for the clinician's perception of improvement showed no interaction between gender and intervention modules ($F(1.528) = 1.902$, $p = .174$, $\eta p^2 = .09$) and no main effect of gender ($F(1) = .860$, $p = .365$, $\eta p^2 = .04$), again suggesting that boys and girls progressed equally. Moreover, the main effect of time suggests that change was significantly different across the program with a large effect size (F (1.528) = 24.783, $p < .001$, $\eta p^2 = .57$). Again, post hoc pairwise comparisons showed significantly different mean scores per module with change progressing positively across the program; see Table 2[12] for mean scores per gender and for the total sample across modules and Figure 3 for differences between distinctive modules.

12 See Table C in the Supplementary Material for further detail results on mean differences across intervention modules

Figure 3

Mean clinical improvement across according to CGI.



Note: On the left panel mean values are depicted by gender and on the right panel for the total sample. Means identified by distinctive letters are statistically significantly different (Bonferroni corrected; p< .05).

DISCUSSION

The current work set out to explore preliminary evidence on the efficacy of change over the course of a CFT individual, online, and manualized approach to SAD in adolescents, considering self-reported and clinician-reported improvement in symptoms. As such, this work tried to address several limitations of previous ones on the efficacy of CFT, namely intervention fidelity across participants by following a manualized treatment approach, application to individuals (and not groups; Craig et al., 2020), and considering change as it unfolds in therapy.

Current results based on self-reports and clinician-reports consistently point to the therapeutic efficacy of this CFT approach to treating adolescent SAD: there was a continuous improvement, reflected in decrease in symptoms severity over the course of treatment. Current findings add to previous ones that indicated the pre- to post-intervention efficacy of CFT applied to adult SAD (Boersma et al., 2015; Gharraee et al., 2018). Specifically, current findings indicate that CFT may also be

successfully applied to adolescents and contribute to a continuous improvement in symptoms. Moreover, these findings concur to the efficacy of online interventions for social anxiety, not only concerning cognitive-behavioral interventions (Boettcher et al., 2013), but also for interventions aimed at promoting compassion (Stevenson et al., 2019). In our study, despite the small number of participants, the large effect sizes found in both measures (the self-reported improvement and the clinician's reports), which are not affected by the sample size (Cohen, 1988), support the practical relevance of this intervention in adolescent SAD and its replication in future studies.

As for the course of change across sex, it was similar for boys and girls, as expected. Men and women have been shown to present similar levels of self-compassion (Yarnell et al., 2015), and internalizing symptoms seem to be similarly predicted by shame and shame-coping strategies (Paulo et al., 2020). So, the similar expression of SAD impairment by gender (Dahl & Dahl, 2010) may generalize to the expression of compassion and how its correlates associate with social anxiety symptoms, so that SAD may be tackled by the development and practice of the same skills for boys and girls within a CFT approach.

Descriptive data from the current sample further aligns with the same data presented previously for the SASCI (Hayes et al., 2008) and for the CGI (Zaider et al., 2003) concerning adult samples and assessing change during individual cognitive-behavioral therapy and change during cognitive-behavioral group therapy alone or in combination with phenelzine, respectively. Considering self-reported improvement of symptoms, our data was very close to that obtained by session 10 in Hayes et al. (2008), both indicating improvement according to Hayes et al. (2008) definition. As for the clinician's report, our findings indicate a similar improvement at session 10 as that found by Zaider et al. (2003) by session 12: both refer to participants presenting meaningful change in functioning, though still symptomatic and/or impaired (i.e., 'definitely improved'; Zaider et al., 2003). These findings offer support for the relevance of a CFT approach in the treatment of adolescent SAD.

Current results also add further evidence to the holistic, progressive, and developmental perspective of change according to CFT, given that change was continuous throughout the intervention. Specifically, CFT proposes that individuals go through several nested stages of change concerning their motivation and psychological competencies in becoming a compassionate self and living a compassionate life (Gilbert, 2010). Initially, people recognize difficulties in their emotions and slowly begin to associate these difficulties with the way their minds work, though still feeling ruled by their emotions (i.e., module 1). Then, individuals begin to develop qualities and skills that help them understand the different parts of themselves and the feelings elicited by those parts, and that those feelings do not necessarily

need to be acted out (i.e., module 2). In the current work, alike previous works focusing on SAD (i.e., Boersma et al., 2015; Gharraee et al., 2018), individuals were then encouraged to take responsibility for acting compassionately, anchored on the previously developed qualities and skills (i.e., module 3). Although acting with a compassionate stance may not appear as fundamental to other CFT manualized approaches directed at other conditions (e.g., Ribeiro da Silva et al., 2021), its key role to therapeutic change in relation to SAD in particular should be addressed in the future. Current findings indicate that practicing compassionate behavior may be an appropriate and necessary way to fit CFT intervention to the specific needs of individuals with SAD, given that the intervention module focused on practicing compassionate behavior contributed to continuous improvement until the end of therapy.

The current work holds for some noteworthy limitations, one of them being the sample size, which did not allow comparisons to be made on session-by-session progress. Though organizing the intervention in progressive modules is a theoretically sound and a previously used approach (Ribeiro da Silva et al., 2021), considering specific sessions might be more informative on specific trajectories of change. Another limitation has to do with having no comparison group, either a psychological placebo that would point to therapeutic change trajectories being specific to active ingredients in psychotherapy (e.g., attentional placebo; Ingul et al., 2014), or another therapeutic approach that would point to change being specific to active ingredients of change for CFT. Previous evidence on therapeutic change over the course of treatment for Cognitive-Behavioral Therapy delivered to adult SAD showed a progressive reduction in social anxiety symptoms (and other related variables) over the course of treatment (Goldin et al., 2014), mirroring current findings with the CFT@TeenSAD approach to adolescent SAD. Finally, the current work considered a smaller number of sessions than was previous practiced in treating adolescent SAD (e.g., Leigh & Clark, 2016) and when applying CFT for adult SAD (Boersma et al., 2015; Gharraee et al., 2018). As such, though self-reported improvement in the current work was continuous until the last session, comparison with the descriptive data presented in the work by Hayes et al. (2008) show that further progress might have been self-reported as far as session 16. The question of how many sessions are needed to achieve clinically reliable change and recovery after treatment (Wise, 2004) should be addressed in future research.

Our work is innovative in exploring the change over the course of treatment of CFT applied to adolescent SAD. It also presents promising results on the relevance and preliminary efficacy of CTF in remitting social anxiety symptoms, thus modifying the usually chronic course of SAD in adolescence (Bruce et al., 2005). Further works on CFT therapeutic efficacy (e.g., in comparison with a control

and/or experimental group, about stability of change after treatment completion) may come to establish CFT as an evidence-based approach to adolescents SAD, by promoting a compassionate way of helping human beings live in conditions of safeness, support, connectedness and kindness, as they should (Gilbert, 2010), and as socially anxious adolescents so much need.

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Background, introduction, and research update • pág. 109-130
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A Compassion-Focused Therapy approach for hoarding disorder: Background, introduction, and research update

Chia-Ying Chou[1] and Troy DuFrene[2]

Abstract

Hoarding Disorder (HD) was formally recognized as a mental health diagnosis in 2013. A number of therapeutic methods have been developed and tailored for HD, including Cognitive Behavioral Therapy (CBT) and Compassion Focused Therapy (CFT). The aims of this article are threefold: First, to provide a description of the rationale of developing a group CFT protocol for HD (CFT-HD); Second, to introduce the theoretical framework, treatment targets, and techniques of CFT-HD; Third and finally, to share existing empirical evidence of CFT-HD, and an ongoing study on CFT-HD conducted in a private practice setting. Implications of the development of and research findings on CFT-HD, as well as future directions, are discussed.

Keywords: hoarding, compassion-focused therapy, group therapy, therapy protocol.

Uma abordagem da terapia focada na compaixão para a perturbação de acumulação: Contexto, introdução e atualização da investigação

Resumo

A perturbação de acumulação (PA, no original em inglês, *Hoarding Disorder* [HD]) foi formalmente reconhecida como um diagnóstico de saúde mental em 2013. Vários métodos terapêuticos foram desenvolvidos e adaptados à PA, incluindo a Terapia Cognitiva Com-

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portamental (CBT) e a Terapia Centrada na Compaixão (CFT). Os objetivos deste artigo são três: primeiro, fornecer uma descrição dos fundamentos do desenvolvimento de um protocolo de CFT de grupo para a PA (CFT-HD); Segundo, introduzir o quadro teórico, objetivos de tratamento, e técnicas de CFT-HD; Em terceiro e último lugar, partilhar as provas empíricas existentes de CFT-HD, e um estudo contínuo sobre CFT-HD conduzido num ambiente de prática privada. São discutidas as implicações do desenvolvimento e dos resultados da investigação sobre a CFT-HD, bem como as orientações futuras.

Palavras-chave: acumulação, terapia centrada na compaixão, terapia de grupo, protocolo terapêutico.

INTRODUCTION

Hoarding Disorder (HD) is characterized by persistent difficulty in discarding possessions due to perceived need to save them or distress in letting them go; presence of clutter; impairments in self-care and social functioning; and significant increases in safety hazards due to cluttered homes (American Psychiatric Association, 2013). It is a chronic mental health challenge with a lifetime prevalence of 2% - 4% in the United States and Europe, and a significant concentration of first diagnoses among adults 65 years of age or older (Best-Lavigniac, 2006; Grisham et al., 2009; Kessler et al., 2005; Kim et al., 2001). Research about HD and its effective treatment remains relatively limited, although it is building quickly. This vulnerable population will benefit greatly from any findings that identify underlying processes leading to HD symptoms and/or effective interventions for managing and reducing them. Hereafter we introduce Compassion-Focused Therapy (CFT) as a treatment option for HD. First, we provide an overview of the current standard of treatment and the rationale for developing CFT as an alternative treatment option. Second, we offer a detailed introduction to the CFT approach for HD, in particular, a group therapy protocol we have developed for this purpose. Finally, we review existing evidence for CFT for HD, ongoing, and future studies, proposing both their hypotheses and implications.

RATIONALE FOR DEVELOPING COMPASSION-FOCUSED THERAPY FOR HOARDING

The first researchers to identify HD as a distinct diagnosis were cognitive-behavioral in orientation, and CBT remains the current standard of treatment for

the disorder. Descriptions of a CBT framework for HD intervention, its treatment effects and limitations are needful orientation prior to presenting a rationale for developing a CFT approach to treating HD.

The cognitive-behavioral model for HD

The Cognitive-Behavioral model for HD (Frost & Hartl, 1996) has identified four domains of HD-related dysfunctions: (a) Avoidance, characterized by postponing sorting and decision making about discarding; (b) information-processing difficulties, including decision-making, memory, organization, and categorization problems; (c) emotional attachment to possessions associated with seeing them as an extension of self, a source of safety or comfort; (d) hoarding-related beliefs, such as beliefs about one's responsibility for, need to control, and expected catastrophic consequences of losing their possessions. Based on this model, individual and group Cognitive Behavioral Therapy (I-CBT and G-CBT) have been developed (Gilliam et al., 2011; Meyer et al., 2010; Muroff et al., 2012; Pollock et al., 2014; Steketee et al., 2010). While specific protocols and packages differ, CBT interventions tend to make use of common CBT technologies, including exposure, cognitive restructuring, thought recording, and behavioral experimentation (Steketee & Frost, 2013). As the current standard of care for HD, CBT has been shown to be effective (Rodgers et al., 2021), however, with significant room for improvement: A meta-analysis including both I-CBT and G-CBT found a large effect size (Hedge's $g = 0.82$) on HD symptom severity, and that the rate of a clinically significant change in HD symptoms after CBT is between 25% and 42% (Tolin et al., 2015; N = 232). Similarly, a meta-analysis focusing on only G-CBT reported a large effect size (Hedge's $g = 0.96$) on HD symptom severity, and the rate of a clinically reliable change as between 21% and 68% (Bodryzlova et al., 2019; N = 178). These findings show that, on average, less than half of the individuals who have gone through CBT for HD have obtained clinically significant changes in their symptoms. A closer look into which mechanisms related to HD have been successfully addressed and which may have not is warranted.

To that end, a study examined the changes CBT had made to hoarding-related cognition, and whether they mediated the degree of HD symptom reduction (Levy et al., 2017). Supporting the authors' hypotheses, the study found that changes in hoarding cognition as measured by beliefs about emotional attachment to possessions, concerns of losing memory without possessions, perceived responsibility toward, and need to control possessions mediated HD symptom reduction (Steketee et al., 2003). However, the degree of change on these four types of beliefs was limited to 0.5 to 0.9 standard deviations from the average of the pre-treatment scores.

These findings suggest that, firstly, addressing hoarding-related cognition is key to treatment for HD, and, secondly, alternative ways are needed to more effectively address the problems of HD than the current form of CBT does.

The missing pieces in CBT

Taking a step back to consider what may have been missed in current CBT-based treatments for HD, we identified several areas outside the scope of the hoarding-related cognition and HD-related dysfunctions included in the CBT model proposed by Frost and Hartl (1996). These include: (a) emotion regulation challenges; (b) attachment and relationship difficulties; and (c) self-related issues, which in many cases stem from adverse or traumatic life experiences.

First, regarding emotion regulation challenges, associations between HD and different forms of emotion regulation challenges have been reported in many studies (see review by Barton et al., 2021). In a study (Tolin et al., 2018) examining emotion regulation skills and tendencies based on the model of emotion regulation by Gratz and Roemer (2004), individuals experiencing HD were found to have significantly greater difficulties in emotional clarity, impulsivity, goal-directed actions, accepting emotions, and accessing strategies for feeling better, than the control group. These difficulties were all found to significantly correlate with HD symptom severity. Similarly, several studies have examined other mechanisms related to emotion regulation, such as anxiety sensitivity and distress intolerance, defined respectively as beliefs that anxiety-related sensations are dangerous, and inability to tolerate psychological distress. These studies have shown significant contribution of anxiety sensitivity and distress intolerance to avoidance, one of the HD-related dysfunctions identified in the CBT model (Frost & Hartl, 1996), and, in turn, to HD symptom severity (Ayers et al., 2014; Shaw et al., 2015; Timpano et al., 2009; Timpano et al., 2014; Williams, 2012). The CBT approaches to address challenging emotions are primarily cognitive and behavioral skills, such as cognitive restructuring and imaginary and in vivo exposure. For example, CBT identifies hoarding-related beliefs, attempts to challenge and change them in order to help individuals address challenging emotions and avoidant behaviors, which are believed as a result of difficulty facing certain emotions. However, limited effects of CBT on HD-related cognitions and avoidance found in previous studies suggest room for improvement in CBT's approach to address emotion regulation (Chou et al., 2019; Levy et al., 2017).

Second, related to the difficulties in emotion regulation, problematic interpersonal relationships have been found among individuals experiencing HD (Grisham

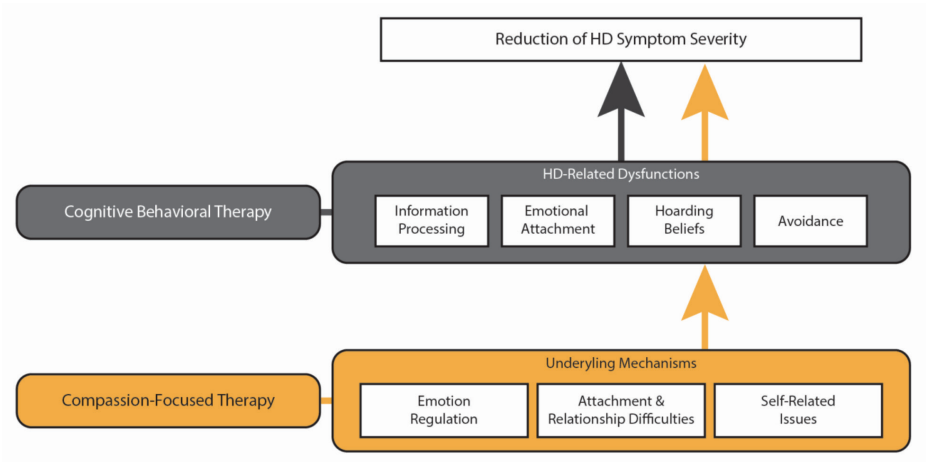
et al., 2018). Greater attachment-related anxiety and avoidance, which are suggested to be stemming from early life adversity, are associated with increased emotional attachment to material possessions (David et al., 2021; Grisham et al., 2018; Kehoe & Egan, 2019; Yap et al., 2020). Evidence supports the hypothesis that emotional attachment to possessions is a way to compensate for unmet interpersonal needs among individuals experiencing HD (David et al., 2021; Yap & Grisham, 2021). This explains, at least partially, how and why emotional attachment to possessions are distorted to a clinically significant degree among those suffering with HD, since feeling attached to possessions is not unique to HD (Grisham et al., 2009). Accordingly, in a recent review integrating attachment theory and existing findings in the HD literature, dysfunctional interpersonal attachment was identified as a missing piece in the CBT-based framework and interventions for HD (Mathes et al., 2020).

Third and finally, regarding self-related issues, a growing body of research has been focusing on examining the reliance of possessions to define oneself and seeing possessions as an extension of the self among individuals experiencing HD and how such self-concept issue may have contributed to increased attachment to objects in HD (Moulding et al., 2021; Kings et al., 2017). Echoing this line of work, studies have shown significant associations between one's ambivalence about self-worth, shame, and self-criticism on one hand and emotional attachment and sense of responsibility to possessions on the other (Chou et al., 2018; Frost et al., 2007). These self-related issues, too, are an area that is not included in the CBT-based treatments for HD.

An expanded framework for HD

Following the review above, research updates have suggested areas of study that were not included in the model (Frost & Hartl, 1996) that has informed the development of the CBT approach for HD. To facilitate future research and treatment development in the field of HD, we propose an expanded framework for HD based on the model proposed by Frost and Hartl (1996), and with additions informed by latest research findings summarized above. Specifically, as illustrated in Figure 1, we hypothesize emotion regulation challenges, attachment and relationship difficulties, and self-related issues to be underlying mechanisms that affect HD symptoms through the HD-related dysfunctions identified in Frost and Hartl's model (1996). Accordingly, we developed a CFT group therapy protocol for HD targeting these underlying psychological mechanisms with the intention to address HD symptoms from the bottom up. This protocol and how it is designed to address the underlying mechanisms illustrated in Figure 1 are introduced in detail in the following section of the article.

Figure 1
An expanded model for hoarding and treatment targets of CBT and CFT



THE CFT APPROACH FOR HD

As a therapy approach, CFT differs from CBT in its understanding of the reasons why psychological issues arise, and its focus of intervention. The first part of this section provides a general introduction to CFT. This orientation will support the following introduction of the group CFT protocol for HD (CFT-HD).

General introduction of CFT

CFT is a model of psychotherapy originally developed by Paul Gilbert and colleagues (Gilbert, 2010). Some of the impetus for the model came from Gilbert's observations while using traditional CBT techniques: He found that, while cognitive reappraisal techniques may have introduced the client to effective coping content, the emotional texture of these reappraisals can often include blame, shame, and self-criticism. Thus, while resulting in more accurate and presumably less dysfunctional thinking, these interventions may contribute to increased psychological distress (Gilbert, 2010). In formulating an alternative to these approaches, Gilbert and his colleagues have drawn from a wide range of sources, including evolutionary psychology, attachment theories, neuropsychological research, and Buddhist philosophy. According to CFT, humans, like most other mammals, rely on close

social connection for emotional support and regulation. In order to maintain and strengthen these social connections, humans have developed physiological systems that respond strongly to stimuli associated with caring, altruism, and affiliation (e.g., Klimecki et al., 2013). One of the core themes of CFT is that if, in psychotherapy, we are unable to access these basic physiological systems that evolved to help regulate threat-based processing, the effect of applying purely behavioral or cognitive interventions may be limited. By engaging in psychological and somatic practices that activate these neurophysiological systems, e.g., imagery exercises, soothing rhythm breathing, the parasympathetic nervous system may be engaged, resulting in decreases in depression, shame, and feelings of social marginalization (among other common psychological difficulties) and increases in overall wellbeing (Kirby, 2017).

Evidence has suggested significant benefits of adding CFT-based approaches to CBT for a range of psychiatric problems (Beaumont et al., 2012; Gale et al., 2014). Several studies have also shown that CFT interventions increase the ability to self-soothe, distress tolerance, reduce shame and self-criticism, enhance self-perception, and positively affect cognitive patterns associated with particular psychiatric disorders, such as eating disorders and personality disorders (Ashworth et al., 2011; Beaumont et al., 2012; Gale et al., 2014; Gilbert & Procter, 2006; Judge et al., 2012; Laithwaite et al., 2009; Lucre & Corten, 2013). Compassion training techniques applied in CFT have also demonstrated impacts in biological measures such as changes in activity in brain regions associated with emotional regulation (Begley, 2007; Davidson et al., 2003; Longe et al., 2010), heart rate variability, and cortisol levels in directions suggesting improved emotion regulation (Rockliffe et al., 2008).

Group CFT protocol for HD (CFT-HD): Overall introduction

CFT-HD weaves psychoeducation unique to the CFT model, and interventions developed to facilitate treatment goals, which includes but not limited to reducing shame, improving self-compassion and the abilities to self-soothe.

CFT psychoeducation includes: (a) the nature of the human brain as an evolutionary product; (b) the three emotion regulation systems: the drive-, threat-, and soothing-and-connection-based systems; and (c) the definition and attributes of compassion and how it can help. First, learning how the human brain works – its natural capacities and flaws – and that it is not our fault that we have a tricky brain, which we did not choose or design, serves to de-shame emotional and behavioral challenges (Gilbert, 2010). This piece of CFT psychoeducation is particularly crucial for the work with hoarding, given the stigma and shame associated with the diagnosis, as well as the role of intra-personal and self-related difficulties in

HD (see Figure 1 and summary in the above section). CFT applies evolutionary psychology to explain how our evolved brain contributes to difficult feelings and behaviors that are not of our choice. This builds a foundation to help individuals experiencing hoarding to distinguish taking responsibility vs. blame, and more compassionately address the challenges.

Next, psychoeducation on the three emotion regulation systems provides a framework for individuals to understand how emotions and their related bodily sensations and behaviors work, and how they can regulate these systems. For example, in CFT-HD, individuals are encouraged to learn to reflect and observe their emotional and physical responses when they consider the option of discarding certain possessions. They are guided to identify emotional, sensational, and cognitive responses associated with each of the emotion regulation systems: threat, drive, and soothing systems, and are introduced to the importance of balancing them. In the skills training part of the treatment, they will then be guided in different exercises and skills training that help to develop self-soothing capacities. These are the methods in CFT-HD to address emotion regulation challenges described in the previous section and in Figure 1.

Finally, defining compassion as the sensitivity to suffering and commitment to relieve and prevent it, and identifying the attributes of compassion including wisdom, strength and courage, commitment, and warmth set up the understanding that to address hoarding and its related challenges requires turning toward difficulties and cultivating specific skills to face and resolve them (Gilbert, 2010). This part of the psychoeducation distinguishes compassion from "enabling", and highlights one of the cores of CFT-HD, which is about confronting hoarding and its associated behaviors, feelings and emotions, personal history, and practical difficulties, with compassion, and not turning away (i.e., avoid) from them.

Besides, a range of experiential exercises are introduced and practiced to help participants absorb contents of the psychoeducation described above and achieve several treatment goals. These include guided meditation to develop somatic awareness, breathing practices, imagery exercises to develop internal supportive resources such as an imagined compassionate-being, and exposure-based interventions incorporating some of the soothing techniques exemplified above. More detailed description of the specific practices included in the CFT-HD protocol are described in the paragraphs below and in Table 1. In CFT-HD, time and space are allocated for the review of emotional responses to these exercises and to relate those responses to the experience of HD. Cognitions (i.e., HD-related beliefs) are not directly targeted in CFT-HD. Instead, the philosophy of the approach is that beliefs change as one moves from one state of mind to another, and as the balance of their three systems (i.e., threat, drive, soothing and connection) changes.

CFT-HD: Treatment structure and content of modules

CFT-HD treatment groups are scheduled for 20 weekly sessions that meet for two hours each. In our work to date with this protocol, groups have been facilitated by a single clinician, a licensed psychologist with specialized training and expertise in CFT and HD. Sessions have often been observed by a clinician in training for evaluation and technical or administrative support purposes, but the observers did not help direct the group. While participants commit to attending all the sessions, they are allowed to miss two of the sessions without being charged or facing drop-out. The participants and therapists may agree to break on some weeks due to holidays and schedule conflicts, although these skipped sessions are not included in the session total. Groups are expected to have six to ten, and no more than 12 participants.

Table 1 provides a general overview of the eight modules that make up the CFT-HD intervention. The first session is outside the module structure. It includes a general introduction of the therapy, facilitator and members introduction, a review of the previously signed informed consent materials, and a discussion of confidentiality expectations for group members. Sessions 2 – 19 follow the module outline presented in Table 1. Module content is progressive, with later modules building on concepts and skills from earlier modules, so the order of the modules should likely not be changed. In general, two to three sessions are spent on each of the eight modules, although this schedule need not be followed too rigidly and can be slowed or sped up to accommodate the needs of the group. Each session begins with a two-to-three-minute check-in about the week from each participant, followed by learning of the modules through reading as well as experiential exercises. These contents are best introduced in interactive styles and in a pace that facilitates reflection.

Modules 1 and 2 introduce the participants to the important concepts of CFT, such as the working definitions of "compassion", and the evolved human brain. These concepts are particularly important in the context of hoarding, for the former sets the tone of the treatment about learning skills to face discomfort and suffering rather than running away from it; and the latter helps to address shame and self-blame that often occur among those who experience HD. Awareness of physical and emotional states, as well as the nature of human emotions and emotional learning are the focuses of Module 3. Group participants get opportunities to practice becoming aware of the internal experiences that will be the focus of the treatment going forward and cultivate a compassionate understanding of their emotions. Module 4 introduces the three-circle model and guides participants to looking at emotions and their related bodily and behavioral responses in terms

of their drive-, threat-, and soothing-and-connection-based systems. Participants are encouraged to practice framing their own behavior in three-circle terms and use this framework as a roadmap to help them understand their state of being and ways to become more balanced.

The proportion of experiential exercises and deeper processes increase starting Module 5. About ten to 12 sessions into the treatment, participants have been taught several somatic and imagery exercises and given a chance to practice these with feedback in session. These skills are now applied to help them in imaginary or in vivo exposure to hoarding-related topics, such as confronting a pile of personal possessions and considering the option of discarding. For example, in Module 5, the group is guided to develop an imaginary compassionate figure, which will serve to activate their soothing system and support them in exposure-based interventions. Besides, self-compassion is contrasted with self-criticism, and participants are guided through role-plays to highlight the different effects of the two.

Building the compassionate-self is the focus of Module 6, while Module 7 extends on it to cultivate the three flows of compassion: compassion flowing out, compassion flowing in from others, and compassion from one part of the self to another. These flows of compassion set up the foundation for the compassionate-buddy system and chair work. As described in the previous section and Figure 1, both interpersonal and intrapersonal difficulties are roots of hoarding challenges. Interpersonal difficulties are given opportunities to reveal themselves and be addressed within the safe container of the group through the compassionate-buddy system. In this system, the therapist pairs up group members into duals or trios. They are given a structured protocol that instructs members to check-in with one another by audio or video calls between sessions on how they are doing in their effort to create more physical space at home. They are given example questions and scripts to remind one another to draw support and wisdom from their compassionate figure or compassionate-self. This system is designed not only to facilitate peer support, but also to create a safe and structured container for the group to learn several interpersonal skills, including boundary communication, equal give and take, the ability to interact with others while experiencing fears of connection and abandonment. On the other hand, intrapersonal difficulties are addressed in chair work, where members are guided to recognize and take turns to embody each different part of themselves in the context of a hoarding-related situation (e.g., fear of letting go, sadness, and the compassionate-self). The goals of this technique include improving emotional awareness, clarity, and acceptance, and accessing the compassionate wisdom and strength in the process of emotion regulation and problem resolution.

Finally, in Module 8, the process of facing the ending of the group is facilitated in ways that support the 'saying goodbye' processes in other contexts of life.

Members are encouraged to stay open and express their feelings about the ending, and appreciations for one another. They are also guided to review their gains and consider further supportive resources. Of note, although grief processing or identification of blocked grieving processes is not made an explicit component of the protocol, it runs through and is emphasized in almost all the modules. For example, when introducing what the soothing system is, grief may arise when participants connect with a lack of soothing experiences in their lives to date. Similarly, grieving processes may arise while addressing fear of compassion, and building a compassionate-being or self. Grief can also arise in chair work, for example, when processing different feelings around making the decision to let a possession to. When grief occurs in the process of the treatment, it is of significance and is important to address because, in our experience, unresolved grief often emerges as a factor associated with HD presentations (Chou, 2021).

Table 1
Compassion-Focused Therapy for Hoarding Disorder (CFT-HD) protocol: modules, topics, goals and descriptions

Module	***Topics***	***Descriptions and goals***
1. What is compassion? (Session 2)	Definition of "compassion"	Establish working definitions of compassion and clarify common misunderstanding about it.
	Leaning towards suffering	Discuss behavioral and emotional avoidance, and its consequences; Emphasize facing discomfort and suffering is key of CFT-HD.
	Experiential exercise: How was my morning?	Practice noticing bodily and emotional discomfort.
2. It is not your fault (Sessions 3 and 4)	The evolved human brain	Introduce the old brain and new brain, their focuses, functions, and characteristics.
		Explain how this evolved human brain can be tricky and related to our suffering.
	Life circumstances are not of our choosing	Identify other factors in life that are beyond one's control or choice.
		Facilitate the understanding that hoarding, and many other psychological challenges are not one's fault but one's responsibility to make better.
	Experiential exercise: Soothing rhythms breathing	Introduce soothing rhythms breathing as a somatic emotion regulation tool and encourage the group to practice regularly throughout the course of the treatment.

Table 1 (continued)
Compassion-Focused Therapy for Hoarding Disorder (CFT-HD) protocol: modules, topics, goals and descriptions

3. Nature of our emotions (Sessions 5 and 6)	Emotional awareness and vocabulary	Cultivate emotional awareness by practicing noticing somatic responses associated with different emotions, and expanding emotional vocabulary.
	Acceptance of emotions	Practice emotion regulation skills to hold space for or contain challenging emotions, and extend the "not your fault" lens to facilitate acceptance of emotions.
	Emotional learning and body memories	Introduce the concepts of emotional learning and body memories, and explain the ways in which bodily states can elicit emotional memory.
	Safety strategies and their consequences	Provide guidance to reflect on certain behavioral patterns acquired at some point in one's life for important functions, and whether these patterns still serve the individual well.
4. The three-circle model (Sessions 7, 8, and 9)	The three emotion regulation systems: threat system, drive system, and soothing system	Introduce each of the three emotion regulation systems: the evolutionary functions, characteristics, feelings and emotions, bodily responses, and behaviors associated with each one of them.
		Discuss personal emotional, somatic, and behavioral indicators of the activation of each system.
		Introduce the importance of balancing the three systems and help group members to develop a map of emotion regulation based on the three-circle model.
5. Orienting toward compassion (Sessions 10, 11, and 12)	Main attributes of compassion	Introduce main attributes of compassion: wisdom, strength, commitment, and warmth.
		Discussion guided to facilitate a felt-sense understanding of the compassionate attributes.
	Experiential exercise: a compassionate figure	An imagery exercise to guide the envisioning of a compassionate figure, and receiving compassion from him/her/them/it.
	Experiential exercise: home tour with the compassionate figure	An exercise aiming to utilize the compassionate figure as an emotion regulation resource in the imaginary exposure of walking through and looking at different parts of the cluttered home.
	Fears of compassion	Address and normalize the difficulties in relating to the concept or experience of compassion.

Table 1 (continued)
Compassion-Focused Therapy for Hoarding Disorder (CFT-HD) protocol: modules, topics, goals and descriptions

	Self-compassion vs. self-criticism	Describe the contrast between self-compassion vs. self-criticism, and facilitate a discussion on the fear of the former, and unwanted consequences of the latter.
6. Compassion and the self (Sessions 13 and 14)	Multiple selves	Help group members reflect on the idea that there are different parts of oneself, and facilitate the loosening of a fixed self-identity and fixed state of being.
	Building the compassionate-self	Guide members to recognize and strengthen their existing compassionate-self, or to develop one by cultivating and embodying the attributes of compassion.
	Experiential exercise: Compassionate-self acting out	An experiential exercise to integrate the somatic and psychological states associated with the compassionate-self.
7. Compassion and others (Sessions 15, 16, 17, and 18)	Three flows of compassion	Introduce the three flows of compassion: compassion flowing out, compassion flowing in from others, compassion flowing from one part to another part of the self - as exercises to strengthen the "muscles of compassion".
	Experiential exercise: Giving and receiving compassion	An experiential exercise followed by a discussion about the experiences and difficulties doing it.
	Compassionate-buddy system	Therapist assigns buddies (duals or trios) within group
		A concrete and structured buddy homework protocol is introduced for group members to learn to support each other in a 30-minute weekly phone call.
		Discuss challenges occurred in the buddy work (e.g., boundary communication, commitment, fear of rejection) and frame them as opportunities for personal and relationship growth.
	Experiential exercise: Chair work	Facilitate an exercise integrating different skills learned thus far: identifying and holding space for emotions, understanding of the multiple-selves, giving and receiving compassion from one part of the self to the other.
		Help group members learn to work with conflicting emotions compassionately and skillfully.

Table 1 (continued)
Compassion-Focused Therapy for Hoarding Disorder (CFT-HD) protocol: modules, topics, goals and descriptions

8. Preparation for ending (Sessions 19 and 20)	Preparing to say goodbye	This part should gradually begin toward the last third of the treatment. This may look like acknowledging, e.g., there are six more sessions left, including feelings about group ending as a prompt for topics to check-in, and allowing sufficient time in multiple sessions for the group to talk about ending.
	Reflection and feedback	Help group members identify and describe changes that have taken place during the group, and concrete ways for maintaining them moving forward.
		Make it an opportunity for group members to practice giving and receiving compassion by providing each other feedback on their progress and change.
	Future resources	Encourage members to consider their next steps and help connect them with resources if needed

EXISTING EMPIRICAL EVIDENCE AND ONGOING RESEARCH

As a newly developed intervention for HD, the CFT for Hoarding approach has been adopted in a slightly shorter format (16 two-hour sessions as opposed to 20) and examined as a follow-up treatment for individuals who had completed CBT but still significantly symptomatic (Chou et al., 2019). This study showed satisfactory feasibility and satisfaction of CFT as a treatment method for HD. Positive effects of the treatment was also supported by the findings that: 1) 77% of the CFT completers had post-treatment severity scores below the cut-off for clinically significant HD; 2) the mean post-treatment severity levels for all symptom domains dropped to near or just above the clinically significant cut-offs after completing CFT; and 3) 62% of the sample achieved a clinically significant reduction in HD symptom severity. Moreover, CFT was found to significantly improve hoarding-related dysfunctions identified in the CBT model (Frost & Hartl, 1996), such as information processing (especially decision making) and avoidance (i.e., self-distraction, behavioral disengagement, and denial). Additionally, evidence also supported the effects of CFT on distress tolerance, self-criticism and shame, and increased capacity to reassure oneself in difficult situations, and reduction of

self-ambivalence (uncertainty about self-worth). It was suggested that CFT may have relieved HD symptoms and achieved the aforementioned treatment efficacy in decision making and avoidance through addressing these emotion regulation and self-related mechanisms (Chou et al., 2019).

Study protocol of an ongoing pilot trial

Following the promising findings on CFT as a follow-up treatment for HD (Chou et al., 2019), one of the next logical steps to take is to examine CFT as a standalone treatment for HD. A pilot trial aiming to investigate the acceptability, feasibility, and effects of CFT-HD as a primary treatment in comparison to CBT is thus planned (see below).

Group treatments and recruitment

Based on the information in the preceding sections, treatment groups using CFT and CBT approaches have been running consecutively and alternately via a HIPAA-compliant online platform since April 2020 in a private practice in California. Participants and the therapists shared both audio and video signals, and attempts were made to ensure that participants' faces could be clearly seen by the therapist and other participants.

The CFT treatment group followed the protocol set forth in the earlier sections of this paper and was, as indicated, facilitated by a licensed psychologist. The CBT group followed a protocol set forth referencing the workbook and therapist guide of Treatment for Hoarding Disorder (Steketee & Frost, 2013). The CBT groups run so far were facilitated by a licensed marriage and family therapist with specialized training and experiences working with HD using CBT. Apart from the session content, the CFT and CBT groups followed similar schedules for an equal number and length of sessions.

Participants are assigned to either group based on the alternating sequence. In our work so far, assignment to treatment conditions has been of convenience, with participants' preferences taken into account: Most participants are open to either treatment option. If a participant prefers to be in one of the treatments, they are asked to wait until their treatment group of choice is ready to begin. Randomization to condition would, of course, be optimal, but it is likely that recruiting issues will make this difficult in private-practice settings.

Participants for the groups are recruited mainly by referral from local clinicians and networks, fliers and social media ads. Individuals who express interest and

provide verbal informed consent are screened by phone to confirm that they are 18 or older, based in the state of California, experiencing hoarding, and without imminent suicide risk. Those passing the screening procedure are scheduled for a formal intake assessment with a trained pre-licensed clinician to verify that the participant meets inclusion criteria for the group: (a) no high or imminent suicide risk within the past six months; (b) no other current severe mental or physical illness (e.g., active symptoms of Substance Use Disorders, severe brain injury or degenerative diseases) that would significantly impair group participation; and (c) a positive diagnosis for HD. Besides the intake, pre- and post-treatment assessment on HD symptom severity and other related measures were collected for program-evaluation purposes (details in the paragraphs below).

Written informed-consent was obtained prior to commencing the intake assessment. As part of the consent process, participants were informed of future intent to use their data for research and were asked separately if they were willing to give consent for us to use these data. They were informed that consent to use their de-identified data for research was totally voluntary and separate from consent for treatment. It would not affect their participation in treatment in any way, and could be revoked at any time before, during, or after the group treatment. To date, every participant has given such consent, and no participants have revoked consent after giving it. However, we have refrained from data analysis in anticipation of IRB guidance about doing so.

Intake, pre- and post-treatment assessment methods

Scheduled for two hours, the intake assessment includes an informed-consent procedure, a clinical interview, and a battery of questionnaire assessments. The clinical interview portion of the intake assessment includes administration of the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998) to assess for psychopathology other than HD and the Structured Interview for Hoarding Disorder (SIHD; Nordsletten et al., 2013) to assist in confirming the HD diagnosis. If the MINI suggests no current serious mental illness and the SIHD suggests a positive diagnosis for HD, the participant is directed to the pre-treatment assessment battery.

The pre-treatment assessment is conducted in a Qualtrics instance that includes nine questionnaires: Two of the instruments focus on hoard symptoms (i.e., saving and acquisition of possessions, clutter, difficulty discarding), and other behaviors and cognitions associated with HD, the Saving-Inventory - Revised (Frost et al., 2004) and the Saving Cognitions Inventory (Steketee et al., 2003). The Beck Depression Inventory – II (Beck & Steer, 1984) and Beck Anxiety Inventory (Fydrich et al.,

1992) collect information about participants' state depression and anxiety. Following the framework illustrated in Figure 1, participants complete the assessments on emotion regulation and related measures: Difficulties in Emotion Regulation Scale - 18 (Victor & Klonsky, 2016) and Distress Tolerance Scale (Simons & Gaher, 2005). They also complete the Relationship Quality Scale (Fraley et al., 2011) to estimate the extent of and problems with maintaining close, supportive relationships. Another series of assessments looks at factors associated with self-identity and intra-personal relationship: the Experience of Shame Scale (Andrews et al., 2002); the Forms of Self-Criticizing/Attacking & Self-Reassuring Scale (Baião et al., 2015); and the Self-Ambivalence Scale (Bhar, 2005). Finally, participants complete three subscales related to avoidance (i.e., Behavioral Disengagement, Denial, Self-distraction) of the Brief COPE (Carver, 1997), and Frost Indecisiveness Scale (Frost & Shows, 1993) to assess these two difficulties, not included in symptom measures, but commonly found among people experiencing hoarding.

Concurrent with the last week of the group, participants were redirected to the assessment battery. All measures referenced above were readministered to help the participants and the clinical team evaluate effects of the treatments. Additionally, a questionnaire about treatment acceptability was also included. This questionnaire asks questions, such as how helpful the treatments were, how applicable the knowledge and skills trained are, and so on, rated using a Likert scale, as well as an open-ended question for free-form feedback about the treatments. To explore whether the treatments help participants become open to support, participants were also asked if they have engaged in other HD treatment or peer-support activities during the course of the treatment.

Hypotheses, implications, and future research directions

As described above, the aim of this pilot trial is to examine the feasibility, acceptability, and effects of CFT-HD. Our primary hypotheses are that: 1) CFT-HD will be feasible and acceptable by (a) having at least 70% of the participants attending 18 sessions out of 20 sessions (feasibility), and (b) 80% of participants evaluating treatment as "extremely positive" or "positive" (4 or 3 on a 4-point scale; acceptability); 2) CFT will show promising treatment effects by (a) helping at least 45% (average in the meta-analysis by Bodryzlova et al., 2019) of the participants achieve clinically significant reduction in HD symptom severity. It is not the aim of this pilot trial to compare CFT-HD with CBT for HD. However it is our goal to collect pilot data of the treatment effects of CFT-HD, relative to CBT, on reducing HD symptom severity, as well as the HD-related dysfunctions and underlying mechanisms included in Figure 1.

If CFT-HD shows promising results by meeting the targets listed in the primary study hypotheses, a larger one-arm study examining the path through which CFT-HD affects HD symptomatology (i.e., testing the hypothesized model proposed in Figure 1) would further inform the development and refinement of the approach. Moreover, if CFT-HD is found to be acceptable, feasible, and effective as a standalone treatment for HD, a RCT comparing this approach with CBT would be warranted. Effect sizes estimated in this study will inform design of future studies. If CFT fails to meet the performance targets, the data, such as feedback and evaluation from participants, will inform a major revision of the CFT protocol.

To conclude, we dedicate our effort in developing the CFT-HD approach with the hope that it has been and will continue to help people to move closer to a life that is richer and freer from suffering than the one they are currently living. We propose this different approach to the current treatment-as-usual, open to the possibility that it may be more effective for some clients. As scientists, however, we necessarily remain open to corrigibility, to the possibility that the hypothesized underlying processes and the treatment approach presented above may, on more thorough empirical investigation, be found to duplicate or yield limited additional effects compared to the existing interventions. We encourage further studies as we hold the CFT-HD approach lightly. What we are very confident of now, though, is the impact that HD has on the lives of those who experience it as well as the people who love and care about them. It is ultimately for their sakes that work to improve treatment for HD like this should continue.

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VÁRIA

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Resumos da 4ª Mostra de Doutoramento em Psicologia – PsihDay

Universidade de Coimbra, Faculdade de Psicologia e de Ciências da Educação
Coimbra, junho de 2021

Realizou-se a 7 de junho de 2021 a **4ª Mostra de Doutoramento em Psicologia** da Faculdade de Psicologia e de Ciências da Educação da Universidade de Coimbra (FPCE-UC). Devido à pandemia de COVID-19, esta edição da Mostra de Doutoramento em Psicologia teve características diferentes das edições anteriores. Foi realizada exclusivamente *online* e não se inseriu num PsihDay com uma conferência e uma tertúlia. Todas/os as/os doutorandas/os em Psicologia na FPCE-UC foram convidadas/os a participar, independentemente da fase em que se encontrava o desenvolvimento das suas teses. Procurando alinhar a Mostra de Doutoramento em Psicologia com o formato dos 3MT ("3 Minute-Thesis" da Universidade de Coimbra), foi usado esse modelo: as/os participantes tiveram três minutos para fazerem uma apresentação oral do seu trabalho em tempo real, sem nenhum material de apoio ou suporte audiovisual. Uma outra diferença foi a criação de duas categorias nas apresentações dos trabalhos: *projeto de investigação* e *estudos empíricos*. Esta divisão resultou da avaliação que tem vindo a ser feita ao longo das edições anteriores e que, consistentemente, tem apontando as dificuldades e desvantagens de avaliar (e atribuir um só prémio) a todos os trabalhos, independentemente de ainda se encontrarem apenas na fase de desenvolvimento do projeto (geralmente estudantes no 1º ano) ou em fases já adiantadas (e, por vezes, já perto da conclusão da tese). Houve, assim, dois prémios atribuídos pela Direção da FPCE-UC: um na categoria *projetos de investigação* e outro na categoria *estudos empíricos*. Para além disso, as/os três primeiras/os classificadas/os em cada uma das categorias foram convidadas/os a fazerem uma apresentação mais longa inserida num Simpósio (com discussão), a ter lugar na semana de comemorações da FPCE-UC. Esses simpósios (um com três comunicações da categoria *projetos de investigação* e outro com três comunicações da categoria *estudos empíricos*) tiveram lugar no dia 3 de novembro de 2021.

Tal como nas edições anteriores, a Comissão Organizadora da Mostra de Doutoramento em Psicologia foi composta exclusivamente por estudantes de doutoramento em Psicologia e as/os doutorandas/os que fizeram apresentações na 4ª Mostra de Doutoramento em Psicologia foram convidadas/os a submeter os respetivos resumos para publicação na *Psychologica*. A todas/os as/os que participaram na 4ª Mostra de Doutoramento em Psicologia, deixamos aqui expressos os nossos sinceros agradecimentos.

Comissão Científica

Coordenador do Doutoramento em Psicologia, (Joaquim Pires Valentim) e Doutoras/es, membros da Comissão de Coordenação do Doutoramento em Psicologia (Maria Cristina Canavarro, Maria Paula Paixão, Teresa Rebelo e Bruno Cecílio de Sousa).

Comissão Organizadora

Ana Laura Mendes, Ana Rita Martins, Andreia Jesus, Bárbara Monteiro, Diogo Carreiras, Francisca Duarte, Joana Simões, Julieta Azevedo e Maria Inês Clara.

The impact of polyvictimization in the psychological functioning of adolescents in residential care

Alexandra M. Lino[1], Isabel Alberto[2] and Luiza Nobre-Lima[3]

Abstract

Polyvictimization refers to the experience of multiple forms of violence and is recognized as a severe threat to the child's health and development. While its prevalence and consequences for the developing child have been widely studied in several countries, research in this area is scarce in Portugal, particularly in residential care contexts. This study aims to fill this gap in knowledge by: i) adapting the Juvenile Victimization Questionnaire – 2nd revision (JVQ-R2; Hamby et al., 2005), an internationally used screening measure of polyvictimization, to be administered in the residential care context; ii) analyzing the prevalence and impact of polyvictimization in the psychological functioning (cognitive development, behavior, self-concept, interpersonal relationships, and trauma) of 200 adolescents between 12 and 17 years old living in residential care. Data analysis will be performed in comparison with an equivalent sample from the general population. This research is expected to contribute to a greater understanding of polyvictimization, both nationally and internationally. In line with goal 16 of *2030 Agenda for Sustainable Development* (United Nations, 2015), the adaptation of a tool like JVQ-R2 will allow for an early and accurate identification of severe patterns of child victimization, as well as the assessment of youth's vulnerability to other forms of victimization, thus enhancing the ability to respond preventively. Additionally, identifying polyvictimization's consequences on critical aspects of youth's adaptability to life circumstances will favor the development of increasingly effective practices in the elimination or mitigation of the developmental compromises caused by exposure to violence in childhood and adolescence, both in the residential care and child protective services contexts as in the broader environments of human development.

Keywords: adolescents, polyvictimization, psychological functioning, residential care.

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HEPPI: Protocol of a cognitive-emotional intervention program for homebound older adults with mild cognitive impairment

Andreia G. Jesus[4], Margarida Pedroso de Lima[5], Manuela Vilar[6] and Nancy Ann Pachana[7]

Abstract

The number of people aged 65 years or older is rapidly growing worldwide. This growth can lead to an increase in homebound older adults, who are unable or require a considerable effort to leave their homes due to multiple medical and mental health problems. Homebound elderly people are more likely to have amnestic Mild Cognitive Impairment (aMCI) and psychological distress (e.g., depressive and anxious symptomatology) than community-dwelling older adults who are not confined to their homes. aMCI older adults are at a stage of high risk of developing dementia, especially Alzheimer's disease. Thereby, the provision of evidence-based home-delivered interventions, addressing both cognitive and psychological features of homebound elderly people, is crucial in this prodromal phase of dementia. Homebound Elderly People Psychotherapeutic Intervention (HEPPI) is a home-delivered structured and individualized cognitive-emotional intervention program for homebound older adults with aMCI and depressive and/or anxiety symptoms. This intervention takes place at the homebound older adults' homes, in 10 weekly sessions, and combines cognitive training, psychotherapeutic techniques, and compensatory strategy training. The HEPPI aims to maintain or improve memory function, reduce depressive and/or anxious symptomatology, and help homebound older adults to compensate the impaired general cognitive functioning, improving their quality of life, and subjective perception of memory and health. A randomized controlled trial is being conducted to assess its feasibility and efficacy, comparing an experimental group, which receives the

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HEPPI program, to a wait-list control group. Participants in both conditions complete baseline, one-week post-intervention, and three-month follow-up assessments. This study will provide an empirically validated home-delivered non-pharmacological person-centered intervention for homebound older adults in the Portuguese context while contributing to increase the accessibility to mental health care resources for this particular elderly population.

Keywords: cognitive-emotional intervention program, depressive and anxious symptomatology, homebound older adults, mild cognitive impairment, randomized controlled trial.

The influence of time-of-day and morningness-eveningness in cognitive performance of children and adolescents: Clarifying synchrony and asynchrony effects

Catarina Bettencourt[8], José Augusto Leitão[9], Manuela Vilar[10] and Ana Allen Gomes[11]

Abstract

Chronotype - a continuum ranging from extreme morning-types to extreme evening--types - is a genetically influenced preference for earlier or later schedules to engage in cognitively/physically demanding tasks. Although scarce, research shows that chronotype inter-individual differences are present in pre-pubertal children since kindergarten and that their performances can be influenced by both chronotype and time-of-day interactions. Synchrony effects are commonly found for cognitive performance, referring to enhanced performances at on-peak (i.e., preferred) times comparing to off-peak times. Asynchrony effects (superior off-peak performance) have also been reported in the literature. Synchrony/asynchrony effects are expected to be found depending on the cognitive underpinnings of different tasks. Some authors defend that synchrony effects occur in tasks involving controlled efforts to process and retrieve information, whereas for perceptually driven tasks, accurate automatic responses are more likely to be produced without being hampered by cognitive control processes at off-peak hours, resulting in asynchrony effects. This hypothesis has not been duly tested, nor has it been explored to any extent in children. Considering that executive control is known to develop from childhood to adolescence and that post-pubertal children exhibit a significant shift in

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their time-of-day preferences, we intend to systematically probe the associations between cognitive processes, time-of-day, and chronotype in non-pubertal (3rd grade) and pubertal (8th grade) children. We will conduct individual neuropsychological assessment sessions targeting memory, language, and attention/executive functions using selected tests from a battery validated from 5 to 15 years old following a 2x2 between-subjects design. We aim for a fine-grained probing of the controlled/automatic processes dichotomy and its cognitive underpinnings, while examining the changes in cognitive performance linked to puberty-related shifts in time-of-day preferences. The first author has been awarded a PhD scholarship (reference 2020.05326.BD), supported by the FCT – Fundação para a Ciência e a Tecnologia (Portuguese Foundation for Science and Technology).

Keywords: (a)synchrony effects, chronotype, cognitive performance, morningness--eveningness, time-of-day.

Mindful Moment: A web-based mindful and compassionate parenting training for mothers during the postpartum period

Daniela V. Fernandes[12], Maria C. Canavarro[13] and Helena Moreira[14]

Abstract

Mindful Moment (a web-based mindful and compassionate parenting training) is a self-guided program for postpartum mothers, based on the Mindful Parenting Training developed by Bögels and Restifo (2014) and the Mindful with Your Baby Training developed by Potharst et al. (2017, 2019). This program focuses on the decreasing of parenting stress, and the development and enhancement of psychological resources, such as mindful parenting and self-compassion. Mindful Moment is constituted by six modules: each module addressing one specific thematic content (1. Mindful parenting and parenting stress; 2. Beginner's mind; 3. Self-compassion and self-care; 4. Reactive vs. responsive parenting; 5. Relationship with others [social support and communication]; 6. Mindful parenting for life). In each module, participants will be provided with both psychoeducational content, therapeutic strategies, and exercises for daily home practice, in text format, combined with audio and video. The main goal of this research project is to assess the feasibility (e.g., user's adherence, dropout) and acceptability of Mindful Moment and to gather preliminary evidence of its efficacy. The pilot Randomized Controlled Trial will be a two-arm trial. Mothers with a child aged up to 18 months old will be enrolled in the study. The feasibility of Mindful Moment will be evaluated in terms of user's adherence and dropout. Participants in both conditions will be invited via email to complete baseline, post-intervention, and follow-up assessment (eight--weeks after post-intervention). Assessments will include self-report questionnaires to assess user's acceptability and satisfaction, several indicators (e.g., parenting stress, depressive and anxiety symptoms, infant's temperament), and mechanisms that may be involved in the treatment response (e.g., mindful parenting, self-compassion).

Keywords: mindful parenting, parenting stress, pilot randomized controlled trial, postpartum period, web-based interventions.

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Memory distortions in young individuals with an inpatient measure in educational centers: An investigation with the Social Contagion Paradigm

Daniela Ferreira[15] and Maria Salomé Pinho[16]

Abstract

The social contagion effect refers to false memory formation, after exposure to misinformation, through social interaction between individuals. Based on Asch's (1956) Conformity Paradigm and Loftus and Palmer's (1974) Classical Disinformation Paradigm, the Social Contagion Paradigm (SCP) dates back to 2001, having been proposed by Roediger Meade and Bergman (2001). This paradigm involves the presentation of photographs of typical room scenes in a house, and it is intended that the subjects incorporate, in the memory of these scenes, information implanted by social influence (a confederate), thus succumbing to social contagion. To our knowledge, this paradigm has not been studied in a forensic population yet. Our project comprehends an update/adaptation and standardization of the SCP's stimulus scenes (normative data for central and peripheral objects expected to belong to each stimulus scene, including familiarity, arousal, emotional valence, typicity and imaginability), exploration of the impact of a pre-test on the social contagion effect, and analysis of the influence of the presentation form of misinformation, through a real confederate or an hypothetical participant's protocols of contagion, on individuals with an inpatient measure in educational centres. The results of this PhD project will contribute to deepen the knowledge about the susceptibility conditions of the forensic population, between 12 and 21 years old, to false memories. The eventual decrease in the social contagion effect when a pre-test is administered would allow to outline a change in the approach to witnesses in legal contexts. Therefore, we aim to participate in the discussion concerning the elucidation of issues related to the veracity of testimonies in legal settings and to encourage Portuguese investigation on false memories, through the SCP.

Keywords: false memories, misinformation, protective effect of testing, social contagion effect, social contagion paradigm.

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Effects of type of education and gender in subjective temporality of students in secondary education

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Abstract

The increasing complexity of the labour market conveys new challengers for the students, specifically in the normative moments of transition such as from the secondary school to the higher school and/or the labour market. In this context, beliefs of subjective temporality appear as a construct that might facilitate or hinder the transition process of secondary education to other life contexts. In fact, the research carried out in recent decades has allowed us to confirm the importance that temporality has for psychology in terms of understanding human behaviors and cognitions. The study, which presents a short longitudinal design, had as its objective the evaluation of the differences in the subjective temporality of 490 students, taking simultaneously into account the type of education attended and their gender. Using the Multidimensional Model of Subjective Temporality for Secondary Education, previously developed by the authors of this study, the averages in the dimensions are compared using a mixed MANOVA 2×2×2. The results obtained suggest the existence of some interesting (and statistically significant) effects. In the case in between-subject effects, the type of education variable, and the sex×type of education interaction were both statistically significant. However, no evidence statistical significance was found for the gender main effect. With regard to the within-subject effects, only the time×type of education interaction showed statistical significance. No evidence of statistical significance was found for the time variable, for the time×sex interaction, or for the time×sex×type of education interaction. The limitations of the study were presented and their implications for career development interventions were discussed in the context of supporting normative transition processes at the end of secondary education.

Keywords: subjective temporality, secondary education, vocational education, longitudinal study.

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Staying mindful and compassionate during COVID-19 pandemic

Jéssica Duarte[20] and Ana Paula Matos[21]

Abstract

The COVID-19 pandemic and its rapid progression caused a persistent and negative impact on our society and one of the biggest mental health crises of the last decades. We intend to study which variables can, over time, increase or decrease the psychological suffering associated with the COVID-19 pandemic. The variables identified as potentially contributing to the development of psychopathology were gender, being a university student, previous severe mental illness, social resources (e.g., emotional ties), and variables related to COVID-19 (e.g., belonging to a risk group, the occurrence of infection). As a result of social distancing, internet traffic increased more than 50% in Portugal during COVID-19 pandemic. Internet usage can be an adaptive strategy that helps reduce stress, anxiety, and depressive symptoms. However, it can become a maladaptive coping strategy if used excessively and compulsively. Therefore, another aim is to study the (mis)use of the Internet and its characteristics (e.g., intensity, type of activities developed, functions). We also intend to study the predictive and moderating effect of compassion and mindfulness, as literature shows that these 3rd third generation variables seem to mitigate depressive symptoms and disorders related to stress and trauma, as well as the (mis)use of the Internet. Participants will be assessed five times: during the first quarantine, post-quarantine, 12, 18, and 24 months of follow-up. At 18 months of follow-up, we will test the relationship between symptoms related to stress and trauma and post-traumatic growth. The present study can contribute to the development of interventions that promote mental health in different phases of the pandemic. This research is unique and innovative, both at national and international level, namely in the study of the relationship between 3rd third generation variables and Internet use in this current context. The first-author received a PhD scholarship (reference: 2020.10145.BD) from the FCT – Fundação para a Ciência e a Tecnologia (Portuguese Foundation for Science and Technology).

Keywords: COVID-19 pandemic, mental health, longitudinal, (mis)use of the internet, 3rd generation variables.

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Lack of emotional clarity and impact of COVID-19 in people with bipolar disorder

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Abstract

Research reported that a group of people diagnosed with Bipolar Disorder (BD) had suffered a higher effect of the pandemic COVID-19 than a healthy control group, showing higher levels of stress and impact in their income (Yocum et al. 2021). Our study aimed to explore the influence of COVID-19 in people with and without BD and explore the role of the difficulties in regulating emotions. People were recruited online and in person and informed consent was granted. The study included 45 people diagnosed with BD (M_{age} = 41.38 ± 9.3, 62.2% ♀; 37.8% ♂) and 48 people of the general population (M_{age} = 42.11 ± 9.81, 47.9% ♀; 52.1% ♂). Between groups comparisons regarding gender, age and years of study showed no significant differences, neither when comparing for impact of COVID-19, QoL-total, or depression. However, there were significant differences regarding anxiety levels, with BD presenting lower levels then the general population, and lower physical well-being and impact of COVID-19 in work/studies dimension. When exploring difficulties regulating emotions, only *Lack of emotional clarity* (subscale – DERS) had a significant predictor effect and accounted for 22.2% of the variance of impact of COVID-19 in BD. When using anxiety and depression as predictors, only anxiety worked as a significant predictor in BD, accounting for 21% of the variance of the impact of COVID-19. The same analysis in the general population was not significant. Significantly higher levels of anxiety in the non-clinical population might be due to BD having a different way to deal with adversity, and even a protective role of being less in contact with other people. As expected, there was a higher impact

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in job/studies in BD though. Lack of emotion clarity contributes to a considerable part of the variance of the impact of COVID-19 in BD, suggesting a relevant therapeutic focus for future research.

Keywords: bipolar disorder, distress, COVID-19, emotion dysregulation, lack of emotional clarity.

Compassionate Mind Training for caregivers of adolescents living in residential youth care: Preliminary findings of a cluster randomized trial

Laura Santos[26], Maria do Rosário Pinheiro[27] and Daniel Rijo[28]

Abstract

Compassion plays a significant role in caregiving and its benefits have been largely reported in different settings. Nonetheless, compassion-based interventions have not yet been delivered to staff working in residential youth care (RYC). Thus, a Compassionate Mind Training program for caregivers (CMT-Care Homes) was developed, aiming to cultivate compassion and to promote an affiliative mentality in RYC. This study presents the preliminary findings of the CMT-Care Homes program. Following a cluster randomized trial design, six residential care homes (RCH) for at-risk adolescents were randomly allocated to the intervention (n = 3) or the control group (n = 3). Participants were 64 caregivers from both genders, aged between 25 to 62 years old, working on a regular basis with adolescents in RCH. Caregivers were evaluated at pre- and post-intervention (n = 32 intervention, n = 32 control) through self-reported questionnaires on compassion and emotional climate outcomes. To investigate CMT-Care Homes outcomes, a two-factor mixed MANOVA was performed. Multivariate tests showed a significant and strong Time×Group interaction effect (Pillais' trace = .414, F = 3.338, p = .002, = .414). Univariate tests indicated that, at the post-intervention, participants who attended the CMT-Care Homes experienced significant improvements on compassion, self-compassion and fears of compassion, when compared with the control group, that has deteriorated in most outcomes. After the intervention, while the emotional climate remained almost unchanged in the control group, caregivers who attended the CMT-Care Homes felt significantly fewer threatening emotions in their workplace and significantly more soothing-related

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emotions. Additionally, participants who attended the program experienced a significant improvement on social safeness, while controls decreased this kind of feelings in relation to others. These findings offer preliminary evidence of the effectiveness of the CMT-Care Homes program, suggesting that this training allows to cultivate an affiliative mentality in caregivers working within RYC settings.

Keywords: caregivers, compassion, compassionate mind training, cluster randomized trial, residential youth care.

Web-based cognitive-behavioral intervention to treat insomnia in Portuguese cancer survivors

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Abstract

Persistent insomnia is highly prevalent among cancer survivors long after the completion of active cancer treatment. Untreated insomnia has been associated with increased cancer-related fatigue, depression and anxiety, impaired quality of life and immune functioning, and poorer cancer outcomes. Despite its prevalence and adverse consequences, insomnia is poorly managed in the oncologic context. Cognitive-behavioral therapy is recommended as the first-line treatment for chronic insomnia in patients with and without medical comorbidities, with strong evidence of its short- and long-term efficacy. However, the high costs of face-to-face delivered cognitive-behavioral therapy paired with the limited number and poor geographical distribution of providers remain obstacles to its access. This project proposes to develop, implement, and evaluate the absolute efficacy of a six-week self-guided web-based cognitive-behavioral intervention for Portuguese cancer survivors with insomnia. A waitlist-randomized controlled trial will be performed to assess the impact of this e-mental health intervention on insomnia severity (primary outcome) immediately post-treatment (primary endpoint). Secondary outcomes include cancer-related fatigue, quality of life, sleep efficiency, anxiety, depression, and cognitive functioning post-intervention. Follow-up assessments to determine whether the treatment effects are sustained will be held at three-, six-, and 12-months. Main inclusion criteria include a subclinical or significant insomnia complaint and the completion of acute treatment at least one month prior to enrolment. Consent and screening processes will be undertaken entirely at distance. This intervention may prove to be an effective and accessible solution to disseminate cognitive behavioral therapy, the treatment of choice for

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insomnia management, among Portuguese cancer survivors. This work was supported by the FCT – Fundação para a Ciência e a Tecnologia (Portuguese Foundation for Science and Technology) (PhD grant reference: 2020.05728.BD).

Keywords: cancer survivors, cognitive behavioral therapy, e-mental health, insomnia, Internet intervention.

Be a Mom Coping with Depression: A randomized controlled trial to test the effectiveness of a cognitive-behavioral blended intervention for postpartum depression

Mariana Branquinho[32], Ana Fonseca[33] and Maria Cristina Canavarro[34]

Abstract

Postpartum depression affects about one in seven women and can have negative consequences for the mother and the baby's development. Despite that, few women with postpartum depression seek professional help, indicating the need of new and more accessible treatment formats. Blended psychological interventions combine face-to-face session with e-health interventions, benefiting from the advantages of both treatment modalities. The inclusion of e-health tools promotes flexibility, autonomy and allows to have access to contents between sessions. On the other hand, professional guidance increases treatment adherence and motivation, and allows the adjustment to patient's specific needs. This blended format can also reduce the treatment gap between face-to-face sessions, by replacing some with online session, contributing to time and costs savings for women and healthcare systems. Despite its advantages, there is no blended intervention for the treatment of postpartum depression. This project aims to develop and test the effectiveness of a blended cognitive-behavioral intervention for the treatment of postpartum depression in Portuguese women. This intervention (Be a Mom Coping with Depression) combines seven face-to-face sessions with a psychologist and six sessions through an online program, that are weekly alternated over a period of 13 weeks. A randomized controlled trial will be conducted, comparing the blended intervention to the routine care that women receive to treat postpartum depression in primary care units. Adult Portuguese women during the postpartum period (up to 12 months postpartum) with a clinical diagnosis of postpartum depression will be eligible to participate in the study. It is expected that the blended intervention will be as effective as the treatment

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as usual in decreasing depressive symptoms. With this project, we want to provide the Portuguese mothers access to a new and empirically-validated format of psychological intervention for postpartum depression, while contributing to a more effective management of resources in healthcare services.

Keywords: blended intervention, cognitive-behavioral therapy, postpartum depression, randomized controlled trial.

Switching between empathizing and systemizing modes through the use of mind-wandering and Task Focused Attention in individuals with Williams syndrome and with autism spectrum disorders

Patrícia S. Coelho[35], Paulo Boggio[36] and Óscar F. Gonçalves[37]

Abstract

Mind-wandering has been defined as the process of perceptual decoupling and mental improvisation in which the mind flows across spaces, time, and multiple perspectives. This wandering process has been hypothesized to facilitate the individual to switch from a systemizing (orientation to the physical domain) to an empathizing mode (orientation to the psychological domain). Research suggests that the brain's default mode network, activated during mind-wandering, prioritizes the processing of psychosocial domains (empathizing). Contrastingly, the frontal-parietal network, activated during focused attention, is responsible for the processing of physical reality (systemizing). However, the relationship between mind-wandering/empathizing and focused attention/systemizing modes remains to be completely understood. The present project aims to provide a better understanding of this relationship by looking at the impact of inducing mind-wandering and attention focus on empathizing and systemizing thinking, both in healthy and clinical samples, using behaviour and brain measures.

Keywords: default mode network, empathizing and systemizing modes, focused attention, frontal-parietal network, mind-wandering.

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Rural and urban arsonists: Investigating specific criminal profiles and the efficacy of the firesetting intervention program for prisoners

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Abstract

Every year, arson has significant impacts to the community, environment and economy, resulting in hundreds of criminal processes. Typologies characterizing offenders' behavior have been developed throughout years, even though statistical validation remains an issue. Few studies have attempted to validate these typologies resorting to statistically robust procedures. Concerning rural arsonists, so far there is one typology with three different profiles that has tested its convergent validity: Psychiatric/Alcohol Problems (difficulties in integrating the community and alcohol problems), Socially Adjusted (younger than 40 years old; mostly students and firefighters), and Socially Maladjusted (instrumental motivation, frequently without psychiatric history or alcohol abuse). Regarding rehabilitation, the Firesetting Intervention Program for Prisoners (FIPP) showed to be methodologically suitable for arson offenders. FIPP is a cognitive behavioral group treatment program developed specifically to arson behavior. This program consists of 28 weekly group and individual sessions aimed to increase the awareness of arsonists about arson behavior factors and provide support on the development of coping skills. FIPP has four components empirically related to arson behavior: 1) Fire-Related Factors: to prevent recidivism; 2) Offense-Supportive Cognition: cognitive restructuring of attitudes that support violence, entitlement and antisocial behaviors; 3) Emotional Regulation: effective strategies for anger regulation and perceived self-regulatory control; 4) Social Competence: psychoeducation and experiential exercises focused on assertiveness, relationships and self-esteem. FIPP is the main rehabilitation strategy for arsonists delivered in various countries that will be applied in Portuguese prisons. The current project aims to the develop and validate rural

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and urban arsonist typologies, resorting to a robust methodology in a sample of arsonists arrested cases. Secondly, FIPP's preliminary efficacy will be investigated in different rural arsonist profiles, within prison settings. This project aims to offer accurate methods to better identify rural and urban arsonists, while investigating the efficacy of a structured intervention program.

Keywords: arson, criminal typologies, intervention program, machine learning, validity.

Self-care for adolescents in residential care: A cluster randomized trial assessing the impact of a compassionate mind training intervention

Rita Ramos Miguel[41], Daniel Rijo[42], Maria do Céu Salvador[43] and Luiza Nobre-Lima[44]

Abstract

Residential care youth show extensive mental health intervention needs due to history of maltreatment and embedded characteristics of residential placement. It leads to harmful and cumulative effects throughout development, linked to internalizing and externalizing difficulties. However, existing interventions show limited suitability and poor randomized effectiveness evaluation. To overcome these shortcomings, a new compassion-based program for adolescents in residential care will be developed within this research project. Two main studies will assess its effectiveness: 1) a feasibility study testing the intervention acceptability, and 2) a cluster randomized trial (CRT). The cluster randomized trial will test the program effects over adolescents' psychological functioning, also investigating whether changes in compassion are associated with changes over time in mental health difficulties. The moderator effect of age, gender and maltreatment history will be also investigated. Findings intend to improve mental-health of youth in residential care, to provide an evidence-based intervention to be delivered in residential care settings, and to increase empirical support of compassion-based interventions, amplifying its scope of delivery.

Keywords: residential care, compassionate mind training, adolescence, cluster randomized trial.

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What makes practitioners "good cooks"? A research project about therapist factors in an evidence-based parenting program for children behavior problems

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Abstract

Evidence-based parenting programs have demonstrated to be highly effective for reducing behavior problems in children. Considering their consistent results, they can be compared to cooking recipes that have already demonstrated to originate successful and tasteful meals. Such as in cooking, in evidence-based interventions the way you do it matters as much or even more than what you do. Therefore, the American Psychological Association has recommended research on the characteristics and actions of the therapist contributing to the positive outcomes of evidence-based programs. In the field of parenting training programs, we still don't know much regarding the specific practitioner's characteristics and actions that promote better outcomes. Our study aims to fill this literature gap and explore the specific role of the practitioners in the effectiveness of parenting programs directed at children's behavior problems. We conducted a systematic review of 24 relevant studies; we developed and applied two surveys and run eight focus groups with 24 parents and 19 practitioners enrolled in the Portuguese implementation of one of the most thoroughly studied parenting programs: the Incredible Years Basic parenting program (IY). Our main findings are: a) the parent-practitioner alliance, the practitioner's fidelity to the intervention, and specific practitioner's actions and personal variables are consistently related to the outcomes of several parenting interventions for behavior problems, around the world; b) in Portugal, parents attribute their IY practitioners a prominent role in promoting positive change; c) there are specific personal characteristics, which are reflected in the practitioner's actions, that parents and professionals perceive to be determinant to

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assure the effectiveness of the IY, such as the practitioner's humbleness, self-reflexiveness or psychological flexibility; d) the program's impact is more positive when practitioners are more authentic in the way they engage with the program, respond to the parents and relate with themselves.

Keywords: therapist factors, person of the therapist, behaviour problems, parent training.

Teoria compreensiva dos projetos de vida: Evidências empíricas

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Abstract

O objetivo desta investigação é descrever as evidências empíricas da Teoria Compreensiva dos Projetos de Vida (PVs). Esta teoria intitula-se compreensiva pois abrange múltiplas dimensões dos PVs enquanto constructo psicológico. A teoria partiu de uma revisão de escopo que analisou as contribuições teóricas de 93 artigos. A partir de uma análise temáticas desses artigos, foram propostas seis grandes dimensões teóricas: (1) volitivo--estratégica, (2) dialético-contextual, (3) biográfico-identidária, (4) teleológico-existencial, (5) histórica e (6) desenvolvimental. As dimensões descrevem diferentes propriedades e correlatos dos PVs. Evidências empíricas da Teoria Compreensiva dos PVs foram extraídas de um estudo qualitativo com 26 brasileiros, entre 15 e 59 anos. A partir de uma análise temática, foi possível criar um modelo teórico que associa de maneira complexa as seis dimensões geradas na revisão de escopo. Ao identificar semelhanças entre o discurso dos participantes e as dimensões teóricas, o estudo trouxe evidências de que as dimensões teóricas são representativas da realidade. Outras evidências empíricas foram identificadas no estudo de construção da Escala de Projetos de Vida (EPV), uma escala embasada na Teoria Compreensiva dos PVs. A EPV parte da definição de PV enquanto processo em contínua evolução constituído da formação, execução e manutenção de estruturas e ações intencionais que, em conjunto, formam uma narrativa prospetiva, de longo prazo, capaz de incitar decisões e esforços na vida cotidiana. Assim, o instrumento avalia dois fatores: identificação (i.e., clareza a respeito do futuro intencionado); e envolvimento (i.e., mobilização de planos e ações no cotidiano). A EPV possui excelentes evidências de

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validade e fidedignidade, extraídas de estudos com mais de quatro mil participantes de cinco países. Um instrumento psicométrico é a operacionalização de uma teoria. Neste sentido, as boas evidências de validade e fidedignidade da EPV são também evidências empíricas da Teoria Compreensiva dos PVs.

Palavras-chave: motivação, personalidade, perspetiva temporal futura, projetos de vida.

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