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THE NATURE AND BASIS FOR COMPASSION FOCUSED THERAPY

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Abstract: People with complex emotional difficulties sometimes find it difficult to emotionally engage with psychological therapy. They may say things such as, "I understand the logic of the therapy, and it makes perfect sense but I just can't feel it". These kinds of difficulties are often underpinned by shame and self-criticism. Such individuals often come from harsh or neglectful backgrounds and have experienced low affection. Compassion focused therapy suggests that: (a) Shame and self-criticism are forms of safety strategies that can be resistant to change. (b) The ability to feel reassured by the therapist and therapeutic interventions depends upon activation of a specialised emotion system that gives rise to the *feelings* of safeness, soothing and reassurance. (c) For some people this system is inaccessible and/or frightening to work with. (d) Increased access and activation of the soothing, safeness and reassurance system can be a key focus of therapy.

Key words: Compassion, Self-criticism, Shame.

INTRODUCTION

Increasingly psychotherapies are looking to studies in child development and neuroscience to understand what happens in the brain, and people's subsequent psychological development, when they are subjected to various forms of early rearing difficulties (Cozolino, 2002, 2007; Schore, 1994). We now know that children who come from neglectful or abusive backgrounds and/or where there are high levels of stress are vulnerable to suffering various deficits in the maturation of affect regulation systems in the brain (Gerhardt, 2004). Understanding how people's psychological vulnerabilities are linked to gene-environment interactions (Caspi & Moffits, 2006) and subsequent brain development of specific systems and pathways are at

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the forefront of many trauma-focused therapies (Ogden, Minton, & Pain, 2006; van der Heart, Nijenhuis, & Steele, 2006). One of the hallmarks of individuals from these backgrounds is that they tend to be highly shame focused, self-critical and find it very difficult to be kind and forgiving, supportive or reassuring to themselves (Gilbert & Irons, 2005; Irons, Gilbert, Baldwin, Baccus, & Palmer, 2006).

Compassion Focused Therapy[1] (CFT) was developed for people with these difficulties and is rooted in an evolutionary neuroscience approach to mental health problems (Gilbert, 1984, 1989, 2005a, 2005b, in press-a, in press-b). Although evolutionary models can be traced back to the early psychoanalysts Freud and Jung (Ellenberger, 1970), modern evolutionary models focus on the evolution of various specialised systems that are sensitive to certain cues, processing domains and social role forming (Buss, 2003; Gilbert, 1989). One major co-constructed role, that has a major impact on physiological maturation, affect regulation and the development of skills such as empathy and mentalising [the ability to think about, and reflect on one's own and other people's mental states and motives (Fonagy & Target, 2006)], *is attachment* (Bowlby, 1969, 1973; Mikulincer & Shaver, 2004, 2007). The care providing relationships of early childhood have multiple functions which change with the developmental needs of the child. One of these functions is the way the caregiver acts to help the child regulate difficult emotions—something the child cannot do for themselves. In essence, the parent acts as a soothing agent who, via various signals of affection (warm voice tones, facial expressions, touching, holding, listening and talking to, and explaining) calms the child by stimulating specific affect regulation systems in the child. Neuroscience has revealed how "the soothing system" may have evolved in humans, its neurophysiological substrates and how it has come to regulate other affect systems.

The neuroscience of soothing

Depue and Morrone-Strupinsky (2005) reviewed a substantial affective neurosciences literature and showed that there is good evidence for two types of positive affect. The two types of positive affect give rise to different affective experiences, and have different functions and different neurophysiologies. One form of positive affect is orientated to drive and to seek out key resources conducive to survival (such as food and sex). Affect here is linked to achieving and acquiring and is experienced as activating and exciting. It is especially linked to dopaminergic systems. For example, achieving an important goal such as passing an exam, winning a major

[1] For more information on this approach visit www.compassionatemind.co.uk

game/ contest or winning a lottery will result in high activation. If individuals take cocaine or amphetamine, which are dopamine agonists, they can experience hyperactive states of drive and excitement. Anticipation of pleasure from success is an important source of motivation.

However, not all positive emotions are associated with activation. There are also positive emotion-states linked to feeling content and peaceful, with a sense of calm well-being. Indeed, once animals have acquired what they need and are not under any threat, it can be harmful to stay in activated states. So, a satisfied unthreatened animal can move to a state of quiescence or contentment. This quiescence or contentment system down-regulates the drive and threat systems. Depue and Morrone-Strupinsky (2005) offer considerable evidence that contentment is not just the absence of threat or drive but is regulated by a specialist system linked to endorphins and oxytocin.

Both drive/acquisition/excitement and contentment/soothing systems have been adapted by evolution for use in social relationships. Depue and Morrone-Strupinsky (2005) distinguish affiliation from agency and sociability. Agency and sociability are linked to control, achievement seeking, social dominance (drive systems) and the (threat focused) avoidance of rejection and isolation. Affectionate and affiliative interactions, however, have a calming effect on participants and can alter pain thresholds, the immune and the digestive systems. In essence, interpersonal soothing has evolved to stimulate the contentment/soothing system in new ways. Affection is conveyed via soothing communications and operates via an oxytocin-opiate system (Carter, 1998; Depue & Morrone-Strupinsky, 2005; Uväns-Morberg, 1998). Unlike the activating, excited feelings of the drive system, activation of the soothing system gives rise to feelings of safeness, calmness and social connectedness. In other words the soothing system is a *natural regulator* of drive and threat (Gilbert, 2005a, 2005b, 2007a, in press-a). So, for example, if a baby is distressed, anxious or angry, the mother is able to calm him/her down through their soothing behaviours: holding, stroking, gentle talking and rocking. These affectionate caring behaviours stimulate child's soothing system which calms down distressing feelings and lays down memories of being soothed by others (Carter, 1998; Depue & Morrone-Strupinsky, 2005; Uväns-Morberg, 1998). In fact, it is now understood that the evolution of attachment enabled a range of physiological processes and systems within the child and mother to be regulated through their relationship (Hofer, 1994; Porges, 2007).

Moreover, the ability to be calmed via the kindness and/or protection of others has also enabled humans to evolve various reflective and meta-cognitive abilities. Becoming stressed and over-aroused (and not able to calm down) typically interferes with these abilities (Fonagy & Target, 2006). Furthermore, affectionate behav-

iour helps stimulate the internal development (neuronal connections) of this system, provides emotional memories of being soothed by others, and the abilities to be able to soothe oneself. When individuals experience protection, affection, love and care they feel safe, content and at peace. So this contentment/soothing system underpins feelings of reassurance and *being able to feel reassured* – both by the kindness and support of others and via one's own thinking, attention and behaviour.

The interaction between the three systems of threat/self-protection, drive/acquisition, contentment/soothing is given in Figure 1. These systems are in constant interaction and give rise to a range of brain state patterns which form a basis for felt experience, thought and behaviour (Gilbert, 2005a, in press-a).

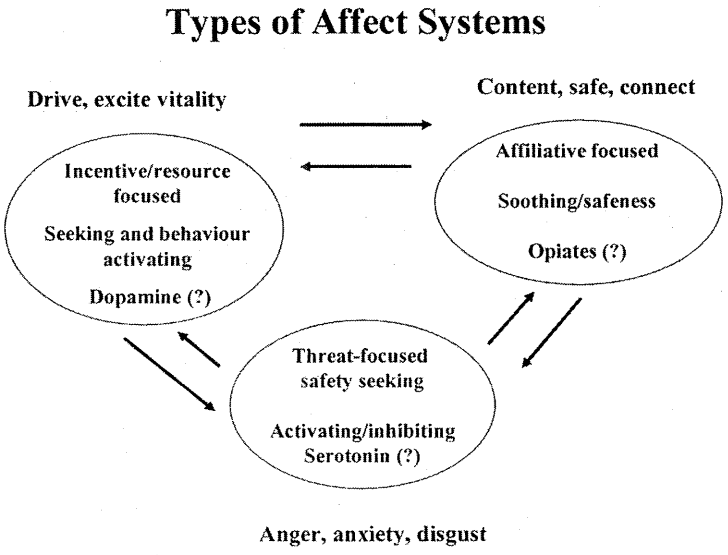

Figure 1. Types of affect system.

Note: Adapted from Gilbert (2005) with permission from Routledge.

Gilbert, McEwan, Mitra, Franks, Richter, and Rockliff (2008) developed a self-report scale to try to distinguish experiences of drive emotions and safeness-contentment emotions. In a student population they found a three-factor solution associated with an excitement emotion (feeling excited and activated) factor, a calm and relaxed emotion factor, with a separate factor for feeling safe, warm, and content. In multiple regression analysis it was the feeling safe, warm, and content factor that was the best predictor for depression and anxiety.

COMPASSION FOCUSED THERAPY

Compassion focused therapy (CFT) suggests that a key difficulty for some clients is that the soothing/contentment system is not easily accessible and/or well developed (Gilbert, 2000, 2007a, in press-a; Gilbert & Irons, 2005). There can be many reasons for this. For example, a state of depression itself can tone down positive affect systems. For people from harsh backgrounds, however, it is more common to find that the soothing system may have been relatively under-stimulated during development. There are a number of implications for psychological therapies if people cannot easily access their soothing system. For example, cognitive therapists will spend time helping clients understand the nature of their negative thoughts and look at their thoughts in a more helpful alternative-generating way. The problem is, however, that there is an affect system that lies behind the "experience" of reassurance and relief. What is it that allows an individual to explore an alternative thought and then have a sense of reassurance and relief? In other words, the thought becomes believable and they can trust it, and feel safe with it. In this respect, CFT argues that those individuals who often say "I understand the logic but I can't feel it" are those individuals for whom the soothing system is not accessible. They find it very difficult to experience feelings of warmth, reassurance and safeness at the best of times and certainly find it very hard to generate those feelings when exploring alternative thoughts or engaging in behavioural experiments. Given this, CFT focuses on developing the soothing system and balancing the systems of threat and drive with it.

Key to CFT is the psycho-education of the "three circles", explaining the innate nature of basic affects and affect regulation in their *formulation*. Formulation is a co-constructed process, which enables people to recognise how some of our basic defences (e.g., anger, anxiety, and submissive withdrawal) can arise automatically and are (or sources of) safety strategies. For example, some of the children, who grew up with an aggressive parent, may have learnt to be submissive and not to express their anger. In times of conflict, they may feel anxious inhibition and engage in submissive behaviour. This automatic safety strategy, however, can have unintended consequences of limiting a person's control in his/her social contexts. Individuals can then become self-critical from two sources; one from the internalised judgments of their critical parent, and second be self-critical of their own and submissive behaviour. This can happen in relationships of unequal power. For example, when people are criticised by their boss they may find themselves being submissive, unable to articulate a clear argument in defence. But later, may be lying in bed at night, they may ruminate as to why they didn't say this or that and can be critical of themselves for their automatic submissive defence. In the formulation,

therefore, CFT focuses on four basic domains. Background experiences that give rise to emotional memories and developed affect systems; key fears (e.g., that others will be abandoning or critical); developed safety strategies (e.g., submissive); unintended consequences (e.g., lack of control in social situations; difficulties in acting on genuine desires or choices; easily manipulated by others; unable to express true feelings). We can also look at the consequences, all the unintended consequences such as inhibited self-development, intensified self-criticism and so on.

The formulation allows individuals to link their early histories to the sensitisation of the fear and threat systems and from there to consider how their brains have both automatically and consciously developed a variety of safety protective behaviours and beliefs. An example of formulation is the following case. Jane had a very critical mother. As a result she had many experiences of her mother looking at her with criticism/anger in her face, which generated bodily experiences of fear and shame within Jane. In CFT some clarity on these memories and their impact on the body is important (Ogden, Minton, & Pain, 2006). So, Jane had many conditioned emotional memories of angry faces linked to verbal criticism (negative views in the mind of the other) and internal, overwhelming feelings of fear and shame. Thus, cues of angry faces/voices could reactivate these emotional memories and emotional conditioned responses, which involve a range of physiological systems resulting in unpleasant feeling states and defensive behaviours (Gilbert, 1992). So, Jane's "brain" will automatically have been putting in place strategies to cope/protect her from both the external threats (anger/rejection and put downs from important others) and internal threats (e.g., feelings of shame).

To try and stop her mother treating her that way, and also to prevent those horrible feelings reoccurring within her, she has to: (a) develop high sensitivities to the moods in her mother, with fast acting fear if a negative mood is detected; (b) seek reassurance, and (c) try to please her mother, and become an appeaser. Hence, her safety behaviours were orientated both towards preventing criticism in a powerful other and also toward trying to stop having certain kinds of experiences (shame) within the self. By outlining this linkage one can see that the shame based appeasements, submissive and self-blaming behaviours are all *natural* consequences of basic safety strategies.

There is another aspect to these kinds of experiences which are crucial in CFT. When children are threatened or harmed by a parent, or school bully, they often feel alone; there is no one to help them, rescue them, intercede or protect them. Jane, for example, could not recall anyone ever helping her to defend herself against her mother's attacks. So when people experience criticism, it is very common for them to also feel abandoned and alone; or to have a constant underlying sense of aloneness.

In CFT we validate that experience, helping clients recognise that *this really was* how it was for them; when under threat from a parent or school bully they were alone. So it is only natural they would feel that again because of their (conditioned) emotional memories. The therapeutic task is how to work with those "I am alone" memories. In CFT, one would not take feelings or beliefs of "I am alone" as evidence of "cognitive distortions" but as genuine emotional memories.

So, compassion begins in the formulation because we teach the client how to have compassion for their background and how to have compassion for their safety strategies. In this way, they develop insights into the sources and functions of their safety strategies in a compassionate way. So we don't pathologise safety strategies or even the symptoms and unintended consequences that can emerge out of them (e.g., depression). This allows one to proceed to explore the problems and symptoms, not so much as "psychopathology" but often as natural consequences of people's best efforts (safety strategies) to cope with very difficult situations. Thus we focus on identifying the brain's basic tasks of constructing protective shields and strategies. Hence, the first part of CFT focused therapy is beginning to have compassion for the way in which one has had to develop certain kinds of safety beliefs and safety strategies.

Along with the formulation, CFT also explains in detail the three circles model. Clients find this very helpful, intuitively appealing, relatively simple and gives them a framework for working. We then collaborate on how we can bring the three circles into balance by developing the contentment/soothing system. Clients will then begin to think about ways that this could be useful to them but also the fears and blocks.

Engaging compassion systems

There are many ways in which we can try to engage the soothing system via developing compassion. The idea that developing compassion for self and others is a way of helping ourselves with the suffering inherent in life has of course been fundamental to Buddhist psychologies for thousands of years. Indeed there is a large literature on these approaches (Davidson & Harrington, 2002; Leighton, 2003; Dalai Lama, 1995, 2001; Wang, 2005). There are now a range of different views of the precise components of compassion (Gilbert, 2005a, in press-a, in press-b). For example, Neff (2003a, 2003b), from a social psychology and Buddhist tradition, sees *self-focused* compassion as consisting of bipolar constructs related to kindness, common humanity and mindfulness. *Kindness* involves understanding one's difficulties and being kind and warm in the face of failure or setbacks, rather than being harshly

judgmental and self-critical. *Common humanity* involves seeing one's experiences as part of the human condition, rather than as personal, isolating and shaming. Mindful *acceptance* involves awareness and acceptance of painful thoughts and feelings, rather than over-identifying with them.

The focus of CFT, however, is from an evolutionary psychology (especially attachment research) and neuroscience perspective. From this approach, and informed by Buddhist psychology too, CFT focuses on what is called the compassion circle which outlines a set of interdependent motives, attributes, competencies and skills of compassion (Gilbert, 2007a, in press-a, in press-b). This is given in Figure 2.

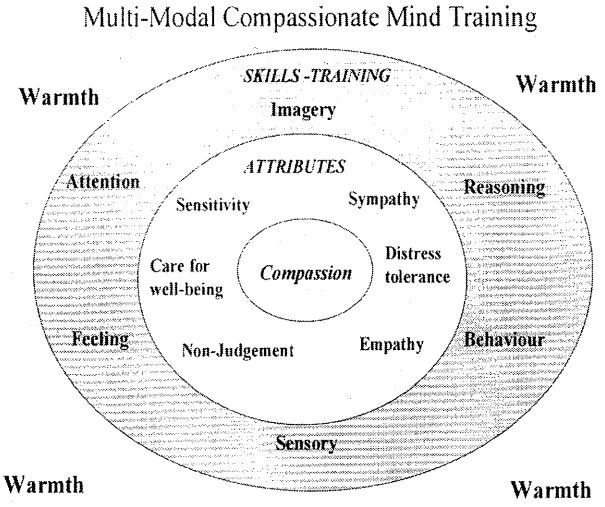

Figure 2. The compassion circle.

In Figure 2 you will see there is an inner and outer circle. In the inner circle are six attributes for self-compassion. (a) Developing a genuine motivation to care and nurture the self —a task that can cause quite a lot of difficulty in the early stages. (b) Development of sensitivity to one's distress, needs, and wants; this is linked to self-monitoring of emotions and thinking. (c) Developing sympathy for one's life experiences, including one's current state of mind and difficulties; this means we can be emotionally moved and in touch with our pain with a genuine desire to heal. (d) The ability to develop sympathy and be in touch with one's pain often depends

upon developing distress tolerance. As many therapies note, clients can engage in emotion avoidance (e.g., Linehan, 1992). Emotion avoidance blocks many of the attributes of the compassion circle. Hence developing genuine caring for self and the ability to be emotionally tolerant of distress are key for the other attributes of compassion. (e) Empathy is of course more than sympathy—it relates to a 'knowing and understanding' that links cognitive and emotional insight (Decety & Jackson, 2004). (f) Non-judgmental refers to giving up condemning and self-criticism. We make a distinction between compassionate self-correction versus shame-linked self-criticism. Self-criticism is usually focused on the (immediate or more remote) past, is linked to anxiety, frustration, contempt and sense of punishment and tends to have a deflating impact on self-feelings. Compassionate self-correction on the other hand is based on a genuine desire to correct error, improve for the future, and with a sense of encouragement and support (Gilbert, in press-a, in press-b). For example, if a child is learning a new task and is struggling and making mistakes we can imagine two teachers. One is quick to spot errors, point these out to the child, with a hinted irritation, shaming and threat. The other teacher, however, focuses on efforts, how easy it is for us to make errors unintentionally, sees what the child has done well and can build on, and uses positive facial expressions and encouragement for the future to try again. We suggest that the second teacher is more likely to build confidence and the ability to keep going if errors arise. So, giving up self-criticism and becoming non-judgmental, does not mean "anything goes, or low non-caring standards"; it is about shifting a self-correcting system from a punitive to a more positive motivating system.

In the outer circle are a number of skills with which we try to help people develop each of the compassion attributes of the inner circle. So, we can teach and explore compassionate *imagery,* compassionate *attention*, compassionate *thinking* (*reasoning*), compassionate *behaviour*, compassionate *feelings*, and compassionate *sensory refocusing*. Compassionate behaviour, involves doing things to help one deal with life difficulties and this often involves the development of *courage*. For example, an agoraphobic will have to confront their anxiety and go out outside. They are more likely to find the courage to do this if they develop a kind, supportive voice in their head, rather than a critical and panicking one. Indeed, in CFT we recognise that clients will have to face many difficult things—be these emotional memories, unpleasant emotions or engaging in frightening behaviours, and they will need courage. Validating their courage and teaching them how kindness and support aid courage is important.

Compassion focused imagery

A lot of behavioural experiments, guided practices, and exercises – called Compassionate Mind Training (Gilbert, 2007, in press-b; Gilbert & Irons, 2005) – are used in CFT. These are designed to work with the compassion circle, which in turn is specifically designed to activate the soothing/contentment system. Moreover, these are exercises that can be practiced every day. One of these exercises is the use of imagery. We know that imagery can be very physiologically powerful (Singer, 2006). If, for example, you are hungry and you see a meal this can activate your hypothalamus to secrete hormones that makes your stomach acids and saliva flow. Equally however, if you are very hungry and you just fantasise a wonderful meal, the same may occur. In other words, the image is capable of stimulating the same physiological systems as the actual event. The same, of course, is true of sexuality; our sexual fantasies can stimulate pituitary hormones and give a sense of arousal. We explain this to clients, that is, that the way in which we think and the things that we imagine can be physiologically potent. Clearly, therefore, individuals who are locked into ruminating on negatives or are very self-critical are likely to be constantly stimulating their stress system which will be pumping cortisol into their bodies. In contrast, if they can learn to switch their attention and focus onto compassionate thoughts and compassionate images, this may well have the effect of stimulating the soothing system. For this reason, we are going to work with images which are experienced as being compassionate. Now there are many exercises one can use here in which the following steps tend to operate. First, before undertaking any imagery exercise, we teach mindfulness, because people's minds will wander quite naturally; so, all exercises are done by just noticing when one's mind wanders and gently and kindly bringing it back on task. We also teach a style of breathing called soothing rhythm breathing, although some clients find it difficult to begin with. It is not essential, just helpful.

A useful beginning can be to explore people's memories of being kind to others and others being kind to them. One spends time quietly remembering specific events and exploring the feelings associated with them. This is explained as trying to understand and notice what compassion feelings feel like. One key exercise involves imagining oneself as a *compassionate person* with all of the qualities of that person. We assume a compassionate facial expression and body posture. We imagine what we look like, what we sound like or what our thoughts are like. We imagine what wisdom feels like and gentleness is like; we imagine that we have seen much in life and we understand it; we imagine a genuine desire to bring compassion into the world and to be compassionate. This exercise is called "becoming the compassionate self" and is practiced every day. It has overlaps with various Buddhist forms of

imagery practice that involve identifying with deities (Vessantara, 1993). However, some people will struggle with this at first. Once people can do this reasonably well, and have some sense of a compassionate self, they can then use this to deal with difficult emotions. For example, suppose somebody is struggling with anger. You would engage the person in becoming the compassionate self and let them feel that in the body and then imagine looking at the angry self; see their angry self a comfortable distance away, see the facial expressions and imagine the feelings in the angry self. Now just extend compassion to the angry self; send as much compassion and understanding as one can to the angry self. Sometimes this changes people's feelings and experience of their anger. We stand to the side of it and, rather than be fearful or ashamed of it, feel compassion for it. Another variant on this practice is to imagine filling one's mind with compassion for all living things. Research shows that if people practice this exercise they can change brain processes (Lutz, Brefczynski-Lewis, Johnstone, & Davidson, 2008).

Another imagery exercise is to imagine a *compassionate other*. In Buddhist practice it is usually the Buddha that is imagined and that the Buddha is sending compassion to the self (Leighton, 2003). Because of the religious and cultural associations we don't use that in CFT (although people are welcome to if they wish, of course; Gilbert & Irons, 2005). Rather we find there are various advantages if people start to think about *what they would* want from a compassionate other. So we brainstorm with the client many of the qualities *they would like a compassionate other to have*. We guide them to the extent that, these will include wisdom, strength, warmth and non-judgement. We include wisdom because it is important that this "imagined compassionate other" is imagined as having a sentient mind; they understand the human condition. Indeed they may have been through similar things to ourselves. The notion of strength is to focus on the concept of fortitude and the ability to bear/ tolerate/ stay with the client. The concept of warmth is to focus on the *affect* of the image and to really practice feelings of warmth for the self. The concept of non-judgement is to help clients learn to feel accepted in the presence of their image.

We then invite clients to fantasise and allow an image to come to mind that conveys those qualities for them. Sometimes it can be a human, but not always. Sometimes people see a bright or coloured light or a mountain or animals that they imbibe with a sentient, wise and caring mind. People who have been abused rarely use humans as compassionate images in the first instances. One client, for example, imagined a great tree in which she sat. This tree was very wise and very old and would speak to her very gently and with warmth. She had a feeling of protection in its branches.

We focus on the sensory cues of the image; what it feels like, what it sounds like, what it looks like and clients are directed to spend some time focusing on these sensory aspects of the image. However, visual imagery is often quite difficult for people and we advise that they are unlikely to have Polaroid-type pictures in their mind (Singer, 2006). They will have fleeting fragments of images, "a sense of' an *impression of...*" That is good enough. The key is the learning how to be able to switch attention to a compassionate imagery focus. We also discuss how they would like the image to relate to them, and how they would like to relate to their image. We stress that, just as sexual fantasies can stimulate the sexual arousal system, so practicing imagining compassion, imagining it flowing towards one, imagining how it feels to have full compassion for the self, can stimulate the soothing system.

Compassionate imagery is used as both a meditation and an activity that allows even brief practice (e.g., whilst sitting on the bus). We also use it for "here and now work" when one is distressed. So a typical exercise might be to help people work with their images and develop their images, thinking about the qualities of their images, getting to know their images and developing a "sense" of a compassionate other. Then, when they feel distressed they learn to spot the cues of rising distress and take a "compassion time out". To do this they engage in some short mindful breathing and refocus their attention on their compassionate image. They may just bring their image to mind, or imagine soothing helpful words (like alternative thoughts a therapist might work with) to reframe the problem (Lee, 2005). This seeks to break up the loops generated by self-criticism or negative rumination and switch attention and focus into a different physiological system, which is based on calming and soothing.

Another useful compassion focused intervention is compassionate reasoning and compassionate letter writing. In compassionate reasoning one engages in fairly standard cognitive interventions of generating alternatives to one's negative thoughts or beliefs. One can then engage in soothing rhythm breathing, focus on one of the compassionate images and practice reading the alternative thoughts with as much warmth, compassion and understanding as possible. We stress that it is not so much convincing yourself of the evidence of your alternative thoughts but the feelings in the alternative thoughts that is crucial; how you hear them in your mind. CFT finds that the more compassionate feelings people can put in their alternative thoughts the more believable these are felt to be.

Compassionate letter writing. There is increasing evidence that expressive writing can be helpful to some people (Smyth & Pennebaker, 2008). Compassionate letter writing is a way in which we help people shift perspective in their thinking about an issue. For example, if they are upset about something or are having to generate courage to engage with something, we invite them to write a letter from the com-

passionate "part of self". They might write a letter to someone whom they imagined going through the same as they are and focus on trying to be kind and supportive. They can also write to and about themselves. So, here again they spend some time on soothing breathing rhythm, engage with the compassionate imagery and so they can orientate themselves to a compassion focus with feeling (even just slightly) and write a letter to themselves from a compassionate point of view. In CFT, we find letter writing can be useful for a number of reasons. Firstly, it is diagnostic because it illuminates very quickly the way people may be using cognitive techniques unhelpfully or are unable to generate compassionate dialogues with themselves. For example, it illuminates if people are using cognitive alternatives as a way of minimising or invalidating their primary experience, by simply telling themselves "You are thinking in black-and-white terms"—with the inference of "stop it". It also gives an opportunity to train the client and re-direct their efforts to more gentle ways of change. Sometimes, one can leave the client for five minutes in the session while they spend time with themselves writing a compassionate letter. Sometimes, it can be helpful to read that letter back to them and this can be very moving in therapy.

Practice carried out between sessions often involves imagery practice, compassionate writing and having a compassionate behaviour to engage in each day. If it is a behaviour which engages a need for courage and "facing up to something" then again we focus on feelings of warmth, support and encouragement. Over time, people gradually get a sense of introducing the concept of warmth, kindness and encouragement as basic compassion tasks into many aspects of their lives and interactions.

Fear of compassion

Many clients, who come from harsh or complex backgrounds, are actually quite frightened of and resistant to compassion. In fact, most of the skills of CFT are precisely to work with people's fears and resistances to compassion. In CFT the assumption is that clients will often be unable to be self-compassionate because they do not have access to their soothing system at the best of times. Moreover, their soothing system can be seriously compromised. Bowlby (1969, 1973) noted this many years ago when he reflected that at times, when a therapist is kind to clients, that actually seemed to make them more angry or anxious. He reasoned that this was because kindness activates the attachment system; once the attachment system is activated various unresolved feelings and unmet needs are also activated. Hence, individuals who have a lot of unprocessed anger or anxiety to their attachment objects will re-experience that in the therapeutic relationship.

The behaviour therapist Ferster (1973) explained it in a different way. He suggested that clients can have secondary, emotional, conditioned reaction to their emotions. For example, if a child's care eliciting behaviour has constantly been punished or intimacy has been a source of abuse, then feelings of warmth, closeness and kindness can reactivate those primary emotions of fear and disgust. Until recently there was little evidence for these views. However, Rockliff, Gilbert, McEwan, Lightman, and Glover (2008) studied people's physiological reactions to compassionate imagery using cortisol and heart rate variability measures. Some individuals showed a threat response to compassion imagery and this was associated with measures of being self-critical and also of anxious attachment. One of our ongoing fMRI studies appears to also confirm that some people have a threat response to compassion imagery. This new data highlights the fact that for some people one has to work through the threat response to compassion, in order to facilitate a smooth functioning of the soothing system.

For some people compassionate images can be "contaminated", that is, difficult to imagine loving non-critical carers. It is important, therefore, that these are discussed openly with clients, that their soothing system may be linked into other threat systems that need (re)working on (de-toxifying). One then brainstorms and collaborates on how to do that, and reclaim one's soothing system so that it too functions as it was designed to. Behaviour experiments and exercises are planned. This can take time.

People can also have various meta-cognitions that are linked to the fear of becoming compassionate and gentle. These have to do with feelings that one would become weak, lazy, not achieve anything, or that one does not deserve compassion, etc. In all of these cases, the therapist works hard to understand the fear in them. In other words, what is the fear of becoming weak, and the fear of not deserving? These fears are then addressed as understandable but also to explore and generate alternatives to them. A common cognitive intervention might be to think of the Buddha, Christ, Florence Nightingale, Nelson Mandela, or whoever the client can think of as being highly compassionate and to wonder if they are weak or inadequate. On the issue of deserve, the fear of compassion is usually that the person will be criticised for having something they feel they do not deserve, or it will be taken away, or they will drop their guard and something bad will creep up on them unnoticed.

In more complex cases, where individuals harbour a lot of anger, they can be ambivalent about compassion because part of them actually wants to be aggressive and angry, even violent (e.g., confronting abusers). There can be a struggle to understand that sometimes compassion is not about soothing but developing the courage to feel and act in appropriate ways to defend and assert oneself. These

assertive behaviours may be developed for real-life situations or worked through in imagery (Hackmann, 2005). One person recognised that going to Karate was actually a compassion thing to do for herself—on a number of fronts.

Fear of giving up self-criticism

The fear of compassion can be linked to the fear of giving up self-criticism. So, as we engage in any change process, there is a full functional analysis around self-critical thinking. One way to facilitate this is to ask the client to close their eyes and to imagine that they no longer feel critical or angry with themselves and that they have given up self-critical tendencies. One then asks "What are the blocks or resistances that came up for you while you were doing this exercise; imaging you would never be self-critical again?", "What is your greatest fear in becoming more self-compassionate or reducing the self-criticism?", "What might you lose?", "What might you have to face?", "What risks are there?". Sometimes, it may seem that even a self-identity is threatened: A client may worry about "who would I be if I stopped criticising myself." Generally, helping clients to see the value of developing compassion, and understanding that it is fear that holds them back from developing self-compassion, is more helpful than simply trying to generate evidence or why they deserve compassion.

Research

In CFT the therapist operates in the relationships the various attributes and skills of compassionate as possible (Gilbert, 2007b). However, as indicated compassion focused therapy may enhance and contribute a new dimension to many other therapies. For example, the treatment of obsessive compulsive disorder (and other anxiety disorders) requires exposure. However, helping clients to engage with this in a very compassionate way, and learning to focus on internal warmth and support to help them face the feared stimuli, may reduce the chances of drop out and increase their readiness and tolerance for exposure.

Most or all of the evidence for CFT is based on process research. Research is just beginning with outcome research. There is some evidence that it can be helpful to people who have had long-term personality problems (Gilbert & Procter, 2006) and it has also been used in some case studies of paranoid psychotic voices hearers (Mayhew & Gilbert, 2008). Developing self-compassionate letter writing in students has been shown to help them cope with negative life events (Leary, Tate, Adams, Allen, & Hancock, 2007). Compassion focused therapy was designed for people who have complex and chronic difficulties and for whom developing an internal

sense of safeness, security, contentment and soothing is very difficult. The training aspects that focus on imagery, reframing, letter writing and other activities are called Compassionate Mind Training because we suggest to clients that literally they are training their minds in different ways, an aspect of it being like a neuro-physiotherapy approach (Gilbert & Irons, 2005). So we also suspect that we are developing new physiological pathways in the brain through this training (Begley, 2006; Lutz et al., 2008).

CONCLUSION

CFT is in line with a number of other new therapy developments that seek to link psychotherapy to what we know about the brain (Begley, 2006; Cozolino, 2002; Ogden et al., 2006; Van der Hart et al., 2006). One of the new findings from psychological and neuroscience studies of emotion is that there are two very different positive affect systems. One is related to drive and the other is related to contentment and soothing (Depue & Morrone-Strupinsky, 2005). The soothing system has been adapted by the evolution of attachment and is triggered through signals of warmth and caring. People who are not able to stimulate this system may have few internalised memories of caring others and, therefore, it is something of a challenge for the therapist to help them to start to generate interventions to stimulate this system. Sometimes they cannot even imagine what feeling self-care and compassion would be like.

CFT has a specific orientation to therapy and may enhance other therapies (Gilbert, in press-a; Gilbert & Irons, 2005). For example, Socratic dialogues, guide discovery, inference chaining, exposure, behavioural experiments, acceptance and mindfulness are clearly not originated in CFT. And of course the very idea of focusing on compassion as a therapeutic approach is many thousands of years old. New research in attachment and neuroscience are offering new ways to conceptualise and develop this focus. As the years unfold it will need to be sculptured by research evidence but so far the results are promising.

REFERENCES

Begley, S. (2007). *Train your mind. Change your brain.* New York: Ballantine.

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment.* London: Hogarth.

Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation, anxiety and anger.* London: Hogarth.

Buss, D. M. (2003). *Evolutionary psychology: The new science of mind* (2nd Ed). Boston: Allyn and Bacon.

Carter, C. S. (1998). Neuroendocrine perspectives on social attachment and love. *Psychoneuroendocrinology, 23,* 779-818.

Caspi, A., & Moffits, T. E. (2006). Gene-environment interactions in psychiatry: Joining forces with neuroscience. *Nature Reviews: Neuroscience, 7,* 583-590.

Cozolino, L. (2002). *The neuroscience of psychotherapy: Building and rebuilding the human brain.* New York: Norton.

Cozolino, L. (2007). *The neuroscience of human relationships: Attachment and the developing brain.* New York: Norton.

Dalai Lama. (1995). *The power of compassion.* Delhi, India: Harper Collins.

Dalai Lama. (2001). *An open heart: Practising compassion in everyday life.* London: Hodder & Stoughton.

Decety, J., & Jackson, P. L (2004). The functional architecture of human empathy. *Behavioral and Cognitive Neuroscience Reviews, 3,* 71-100.

Davidson, R., & Harrington, A. (Eds.). (2002). *Visions of compassion: Western scientists and Tibetan Buddhists examine human nature.* New York: Oxford University Press.

Depue, R. A., & Morrone-Strupinsky, J. V. (2005). A neurobehavioral model of affiliative bonding. *Behavioral and Brain Sciences, 28,* 313-395.

Ellenberger, H. F. (1970). *The discovery of the unconscious: The history and evolution of dynamic psychiatry.* New York: Basic Books.

Ferster, C. B. (1973). A functional analysis of depression. *American Psychologist, 28,* 857-870.

Fonagy, P., & Target, M. (2006). The mentalization-focused approach to self pathology. *Journal of Personality Disorders, 20,* 544-576.

Gerhardt, S. (2004). *Why love matters: How affection shapes a baby's brain.* London: Brunner-Routledge.

Gilbert, P. (1984). *Depression: From psychology to brain state.* London: Erlbaum.

Gilbert, P. (1989). *Human nature and suffering.* Hove, UK: Erlbaum.

Gilbert, P. (1992). *Depression: The evolution of powerlessness.* Hove, UK: Erlbaum.

Gilbert, P. (2000). Social mentalities: Internal "social" conflicts and the role of inner warmth and compassion in cognitive therapy. In P. Gilbert & K. G. Bailey (Eds.), *Genes on the couch: Explorations in evolutionary psychotherapy* (pp. 118-150). Hove, UK: Brunner-Routledge.

Gilbert, P. (2005a). Compassion and cruelty: A biopsychosocial approach. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 9-74). London: Routledge.

Gilbert, P. (2005b). Social mentalities: A biopsychosocial and evolutionary reflection on social relationships. In M. Baldwin (Ed.), *Interpersonal cognition* (pp. 299-335). New York: Guilford.

Gilbert, P. (2007a). *Psychotherapy and counselling for depression* (3rd ed.). London: Sage.

Gilbert, P. (2007b). Evolved minds and compassion in the therapeutic relationship. In P. Gilbert & R. Leahy (Eds.), *The therapeutic relationship in the cognitive behavioural psychotherapies* (pp. 106-142). London: Routledge.

Gilbert, P. (in press-a). *An introduction to the theory and practice of compassion focused therapy.* London: Routledge.

Gilbert, P. (in press-b). *The compassionate mind: Facing the challenges of life.* London: Constable Robinson.

Gilbert, P., & Irons, C. (2005). Focused therapies and compassionate mind training for shame and self-attacking. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 263-325). London: Routledge.

Gilbert, P., McEwan, K., Mitra, R., Franks, L., Richter, A., & Rockliff, H. (2008). Feeling safe and content: A specific affect regulation system? Relationship to depression, anxiety, stress and self-criticism. *Journal of Positive Psychology, 3,* 182-191.

Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: A pilot study of a group therapy approach. *Clinical Psychology and Psychotherapy, 13,* 353-379.

Hackmann, A. (2005). Compassionate imagery in the treatment of early memories in axis I anxiety disorders. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 352-368). London: Brunner-Routledge.

Hofer, M. A. (1994). Early relationships as regulators of infant physiology and behaviour. *Acta Paediatirica Supplement, 397,* 9-18.

Holmes, J. (2001). *The search for the secure base: Attachment theory and psychotherapy.* London: Brunner-Routledge.

Irons, C., Gilbert, P., Baldwin, M. W., Baccus, J., & Palmer, M. (2006). Parental recall, attachment relating and self-attacking/self-reassurance: Their relationship with depression. *British Journal of Clinical Psychology, 45,* 297-308.

Leary, M. R., Tate, E. B., Adams, C. E., Allen, A. B., & Hancock, J. (2007). Self-compassion and reactions to unpleasant self-relevant events: The implications of treating oneself kindly. *Journal of Personality and Social Psychology, 92,* 887-904.

Lee, D. A. (2005). The perfect nurturer: A model to develop a compassionate mind within the context of cognitive therapy. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 326-351). London: Brunner-Routledge.

Leighton, T. D. (2003). *Faces of compassion: Classic Bodhisattva archetypes and their modern expression.* Boston: Boston Wisdom Publications.

Linehan, M. (1993). *Cognitive behavioral treatment of borderline personality disorder.* New York: Guilford.

Lutz, A., Brefczynski-Lewis, J., Johnstone, T., & Davidson, R. J (2008). Regulation of the neural circuitry of emotion by compassion meditation: Effects of the meditative expertise. *Public Library of Science, 3,* 1-5.

Mayhew, S., & Gilbert, P. (2008). Compassionate mind training with people who hear malevolent voices: A case series report. *Clinical Psychology and Psychotherapy, 15,* 113-138.

Mikulincer, M., & Shaver, P. R. (2004). Security-based self-representations in adulthood: Contents and processes. In N. S. Rholes & J. A. Simpson (Eds.), *Adult attachment: Theory, research, and clinical implications* (pp. 159-195). New York: Guilford.

Mikulincer, M., & Shaver, P. R. (2007). *Attachment in adulthood: Structure, dynamics, and change.* New York: Guilford.

Neff, K. D. (2003a). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity, 2,* 85-102.

Neff, K. D. (2003b). The development and validation of a scale to measure self-compassion. *Self and Identity, 2,* 223-250.

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy.* New York: Norton.

Rockliff, H., Gilbert, P., McEwan, K., Lightman S., & Glover, D. (2008). A pilot exploration of heart rate variability and salivary cortisol responses to compassion-focused imagery. *Journal of Clinical Neuropsychiatry, 5,* 132-139.

Porges, S. W. (2007). The polyvagal perspective. *Biological Psychology, 74,* 116-143.

Uväns-Morberg, K. (1998). Oxytocin may mediate the benefits of positive social interaction and emotions. *Psychoneuroendocrinology, 23,* 819-835.

Schore, A. N. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development.* Hillsdale, NJ: Erlbaum.

Singer, J. L. (2006). *Imagery in psychotherapy.* Washington, DC: American Psychological Association.

Smyth, J. M., & Pennebaker, J. W. (Eds.). (2008). Boundary conditions of expressive writing: Health psychology [Special section]. *British Journal of Health Psychology, 13,* 1-95.

Van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization.* New York: Norton.

Vessantara (1993). *Meeting the Buddhas: A guide to Buddhas, Bodhisattvas and tantric Deities.* New York: Winhorse.

Wang, S. (2005). A conceptual framework for integrating research related to the physiology of compassion and the wisdom of Buddhist teachings. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 75-120). London: Brunner-Routledge.