

Compassionate Mind Training for People with High Shame and Self-Criticism: Overview and Pilot Study of a Group Therapy Approach

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Compassionate mind training (CMT) was developed for people with high shame and self-criticism, whose problems tend to be chronic, and who find self-warmth and self-acceptance difficult and/or frightening. This paper offers a short overview of the role of shame and self-criticism in psychological difficulties, the importance of considering different types of affect system (activating versus soothing) and the theory and therapy process of CMT. The paper explores patient acceptability, understanding, abilities to utilize and practice compassion focused processes and the effectiveness of CMT from an uncontrolled trial. Six patients attending a cognitive-behavioural-based day centre for chronic difficulties completed 12 two-hour sessions in compassionate mind training. They were advised that this was part of a research programme to look at the process and effectiveness of CMT and to become active collaborators, advising the researchers on what was helpful and what was not. Results showed significant reductions in depression, anxiety, self-criticism, shame, inferiority and submissive behaviour. There was also a significant increase in the participants' ability to be self-soothing and focus on feelings of warmth and reassurance for the self. Compassionate mind training may be a useful addition for some patients with chronic difficulties, especially those from traumatic backgrounds, who may lack a sense of inner warmth or abilities to be self-soothing. Copyright © 2006 John Wiley & Sons, Ltd.

Shame has recently been recognized as a major component of a range of mental health problems and proneness to aggression (Gilbert, 1997, 2003; Gilligan, 2003; Tangney & Dearing, 2002). People can even risk death and serious injury in order to avoid shame and 'loss of face'. Not only can shame influence vulnerability to mental health problems

but also it affects expression of symptoms, abilities to reveal painful information, various forms of avoidance (e.g., dissociation and denial) and problems in help seeking. Moreover, shame triggered in either therapist or patient can be a source of therapeutic ruptures (Gilbert & Leahy, in press). Although there is no commonly agreed definition of shame, it is often seen to involve two key components. The first is related to thoughts and feelings about how one exists in the minds of others (called external shame; Gilbert, 1997, 1998). *External* shame is marked by thoughts and feelings that

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others view the self negatively with feelings of anger or contempt and/or that the self is seen as having characteristics that make one unattractive and thus rejectable or vulnerable to attacks from others. To experience 'self' as 'living in the minds of others' as a rejectable person can make the social world unsafe and activates a range of defences such as wanting to hide, conceal and 'not be seen', and can have a powerful inhibitory effect on information processing such that a person can feel his or her mind become blank or confused (Gilbert, 1998). In external shame the focus of attention is on what is in the mind of others about the self. *Internal* shame emerges with the development of self-awareness and how one exists for others (Lewis, 1992, 2003). The focus of attention is on the self, with self-directed attention, feelings and evaluations of self as inadequate, flawed or bad. A key component of internal shame is thus self-devaluation and self-criticism. External and internal shame can be fused together (which Lewis (1992, 2003) refers to as the 'exposed self'). The consequence is that in an episode of shame the person experiences the outside world turning against him or her, and his or her own self-evaluations and sense of self (internal world) also become critical, hostile and persecuting. Under this type of threat the self can feel overwhelmed, easily fragmented and simply closes down—there is no safe place either inside or outside the self to help soothe or calm the self. It was recognizing the felt intensity of the hostility of the external and internal world that raised questions of whether it might be possible to help shame-prone and self-critical people create, within themselves, a focus for self-soothing and compassion that would reduce the sense of threat, increase a sense of safeness and thus work with shame material. Hence, this paper outlines the thinking behind efforts to help people develop self-compassion and the outcome of an uncontrolled study of a group therapy based on developing self-compassion.

THE PROBLEMS OF SHAME AND SELF-CRITICISM

Stuewig and McCloskey (2005) explored various self-conscious emotions during children's transition to adolescence and found that, over an eight year period, shame was mediated by parental humiliation and rejection. Feiring, Taska, and Lewis (2002) found that in both children and adolescents the ability to adjust to sexual abuse was significantly related to attributional style and the

person's experience of shame. Cheung, Gilbert, and Irons (2004) found that feelings of shame and inferiority can be a focus for rumination and are associated with depressive rumination. Shame therefore seems to have a certain 'stickiness' about it, which can easily pull individuals into a ruminative self-critical style, increasing vulnerability to a range of difficulties. Self-criticism is significantly associated with shame-proneness (Gilbert & Miles, 2000) and both are trans-diagnostic, permeate many disorders, increase vulnerability, effect expression of symptoms and elevate risk of relapse (Gilbert & Irons, 2005; Tangney & Dearing, 2002; Zuroff, Santor, & Mongrain, 2005). Zuroff, Koestner, and Powers (1994) found that self-criticism in childhood is a predictor of later adjustment. Self-criticism is associated with lifetime risk of depression (Murphy et al., 2002). Some forms of shame-proneness are linked to early abuse and underpin forms of self-criticism (Andrews, 1998).

Heimpel, Wood, Marshall, and Brown (2002) found that, following a setback, low self-esteem people appeared less motivated to improve their moods than high self-esteem people. They suggest two key processes may be involved. First, low self-esteem people experience a greater loss of energy to a mood lowering setback than high self-esteem people. Second, low self-esteem people struggle with *far more self-criticism* than high self-esteem people, setting up a vicious circle of a dip in mood triggering self-criticism that triggers a further dip in mood. Whelton and Greenberg (2005) have shown that the pathological aspects of self-criticism are not just related to the content of thoughts but to the effects of self-directed anger and contempt in the criticism.

High self-critics can find it hard to feel reassured by cognitive tasks and behavioural experiments (Lee, 2005) and dips in mood can trigger self-criticism in recovered depressed people (Teasdale & Cox, 2001). Rector, Bagby, Segal, Joffe and Levitt (2000) suggest that highly self-critical people may do less well with standard CBT, although the degree to which self-critical thinking can be modified is important to outcome. Psychodynamic therapists also recognize that self-criticism and self-persecution can be hard to treat (Scharffee & Tsignouis, 2003). Given the prevalence of shame and self-criticism, therapies that specifically focus on this element may be especially useful for some patients. Compassionate mind training (CMT) evolved from working with high shame and self-critical people (Gilbert, 1992, 1997, 2000; Gilbert & Irons, 2005).

THE IMPORTANCE OF A LACK OF WARMTH, SOOTHING AND AFFECTION IN SELF-CRITICISM

The pathogenic qualities of shame and self-criticism have been linked to two key processes. The first quality is the degree of self-directed hostility, contempt and self-loathing that permeates self-criticism (Gilbert, 2000; Whelton & Greenberg, 2005; Zuroff et al., 2005). Second is the relative inability to generate feelings of self-directed warmth, soothing, reassurance and self-liking (Gilbert, 2000; Gilbert, Clarke, Kempel, Miles, & Irons, 2004; Linehan, 1993; Neff, 2003a; Whelton & Greenberg, 2005). Although reducing self-directed hostility is important to help high shame self-critics, CMT has also focused on developing abilities to generate feelings of self-reassurance, warmth and self-soothing that can act as an antidote to the sense of threat. The potential importance of developing inner warmth came from observations that some high self-critics could understand the logic of CBT and generate alternative thoughts to self-criticism but rarely *felt* reassured by such efforts (Lee, 2005). As noted above, such individuals often come from neglectful or traumatic backgrounds and have rarely felt safe or reassured. Indeed, we have found that feelings of warmth or gentle reassurance were often *frightening* for them. It seemed therefore as if these individuals could not access soothing-affect systems in their self-to-self processing (Gilbert, 2000). This raised two questions: (1) how might early backgrounds influence the balance between self-criticism and self-soothing? and (2) could we teach some high self-critics to stimulate a particular type of affect system that underpins soothing? To understand the value of such efforts requires a short detour into consideration of how 'warmth and soothing systems' have evolved as salient affect regulation systems, and why some self-critics may struggle with accessing these processing systems (Brewin, 2006).

The Human Warmth System

It is now generally agreed that one of the key evolutionary changes that emerged with the mammals was attachment and care provision for infants (Bell, 2001; Bowlby, 1969; Mikulincer & Shaver, 2004). In fact, many mammals (and especially humans) need, and are responsive to, signals of care and affection and have evolved attachment mechanisms that are sensitive and responsive to such signals (although some theorists distinguish

warmth/affection from attachment/security/protection (MacDonald, 1992)). Not only do these signals of care/warmth create experiences of safety (Gilbert, 1989, 2005a), they may do so by impacting on a specific kind of affect and affect regulation system. Recent research has indicated that there are two different, but interactive, positive affect (PA) systems. One PA system is focused on doing/achieving and anticipating rewards/successes. This system may be dopaminergic and is arousing and activating (Panksepp, 1998). The second system, however, is particularly linked to social signals of affiliation and care and involves neurohormones such as oxytocin and opiates (Carter, 1998; Depue & Morrone-Strupinsky, 2005; Panksepp, 1998; Uv ns-Morberg, 1998). Signals and stimuli such as stroking, holding, voice tone, facial expressions and social support are natural stimuli that activate this system (Uv ns-Morberg, 1998; Wang, 2005).

Depue and Morrone-Strupinsky (2005) also link these two affect regulating systems to different types of social behaviour. They distinguish affiliation from agency and sociability. Agency and sociability are linked to control and achievement seeking, social dominance and the (threat focused) avoidance of rejection and isolation. Affiliation and affiliative interactions, however, have a calming effect on participants, alter pain thresholds and the immune and digestive systems and operate via an oxytocin-opiate system. There is increasing evidence that oxytocin is linked to social support, regulates stress hormones and buffers stress, those with lower oxytocin having higher stress responsiveness (Heinrichs, Baumgartner, Kirschbaum, & Ehler, 2003). Such evidence points to the possibility that this oxytocin-opiate system is particularly linked to soothing and calming (Carter, 1998; Depue & Morrone-Strupinsky, 2005; Field, 2000; Wang, 2005), and can be regarded as part of a safety system (Gilbert, 1989, 1993, 2005a).

Activation and maturation of this system are especially important in the first years of life, where a parent acts as a reassuring and soothing agent (Gerhardt, 2004). In doing so the caregiver creates experiences and emotional memories of safety, and enables infants (and later children) to understand and feel safe with their own emotions (Leahy, 2005; Schore, 1994). Such emotional memories, with their neurophysiological mediators, may then become available in times of stress (Brewin, 2006). It is now believed that parental neglect and abuse may fail to help this system mature, and indeed abuse and neglect can cause

problems in brain maturation (Gerhardt, 2004; Schore, 2001). The threat systems for these children may be over-stimulated (Perry et al., 1995), making them more sensitive to threat and less emotionally regulated—in part because they may not have soothing experiences/memories that form the foundation for self-soothing. While soothing and affiliation lowers stress and cortisol, shame, negative evaluation and criticism by others is now known to be one of the most powerful elicitors of cortisol stress responses (Dickerson & Kemeny, 2004). The key aspect is thus that there appears to be a specific affect processing system that may underpin soothing/safeness that matures in the contexts of affectionate care. How might low activation of this system, together with high threat, influence self-criticism?

Insecure Attachment and Self-Criticism

Secure attachments give rise to internal working models of others as safe, helpful and supportive and these provide a source for self-evaluation and self-soothing (Baldwin, 2005; Mikulincer & Shaver, 2004, 2005). Insecure children, however, become more focused on others as sources of threat. In that context they become highly, social rank focused, especially on the power of others to control, hurt or reject them (Gilbert, 2005a; Irons & Gilbert, 2005; Sloman, Gilbert, & Hasey, 2003). A series of studies by Dunkley and colleagues (e.g., Dunkley, Zuroff, & Blankstein, 2006) have explored various measures of perfectionism and suggest two underlying factors: the first is setting and striving for personal standards; the other is striving to avoid criticism/rejection from others and was labelled 'evaluative concerns'. Dunkley et al. (2006) found that it is the evaluative concerns dimension that is linked to various psychopathological indicators. Moreover, evaluative concerns are significantly linked to self-criticism, and it is the self-critical aspect of evaluative concerns that is particularly pathogenic. Sachs-Ericsson, Verona, Joiner, and Preacher (2006) found that children who are shamed by their parents (they use the term 'verbally abused') by being called stupid or bad may be especially vulnerable to develop self-criticism by easily internalizing these labels. They found that self-criticism fully mediated the relationship between parental shaming (verbal abuse) and depression and anxiety; a finding replicated by Irons et al. (2006).

Another way to conceptualize the relationship between self-evaluation/criticism and the treat-

ment of powerful and harmful others is from a conditioning paradigm (Gilbert, 1992, pp. 421–426). Ferster (1973) suggested that if children express anger or seek care, but these expressions elicit anger or withdrawal of love from the parent, a child's anger or care eliciting feelings/efforts can become conditioned to anxiety. Over time the child may become unaware of their anger or desires to seek care and only aware of the anxiety. In contexts of conflict they are more likely to adopt submissive and self-blaming behaviours for another's aggression or lack of care towards them. Forrest and Hokanson (1975) found that, compared with non-depressed people, depressed people switch to self-blaming and self-punitive responses in the face of conflict, whereas non-depressed people were more likely to express anger or assertive behaviour. They suggest that self-blame is a well learnt *defensive* response in the face of conflict with others, and that depressed people can have problems processing anger and dealing with conflicts. Thus some forms of self-criticism can be seen as a defensive submissive response to threats from others (Gilbert, 1992; Gilbert & Irons, 2005). Buchbinder and Eisikovits (2003) found that women often feel shame and self-blame in the context of a powerful, hostile spouse, and this is one reason women do not leave violent and abusive relationships. Andrews and Brewin (1990) found that when women were in an abusive relationship they tended to self-blame for the violence but once they had escaped (and were safe) they blamed the abuser. Sharhabani-Arzy, Amir, and Swisa (2005) found that, in the context of domestic violence, self-criticism significantly increases the risk of posttraumatic stress disorder.

Thus, research suggests that when people feel insecure, because others are seen as threatening and more powerful than the self, heightened self-monitoring, self-blaming, self-criticism and striving to meet other people's expectations of the self (evaluative concerns) can emerge as *safety* behaviours/strategies, especially where blaming powerful others for their punitive/neglectful behaviour would accentuate risk from them (Bowlby, 1980; Gilbert, 1984; Gilbert & Irons, 2005). Conceptualizing self-criticisms as forms of *safety behaviours/strategies* has important implications for formulation. Rather than see these in terms of maladaptive schema or cognitive distortion, they are linked to safety and self-protection. Paradoxically, however, they can also increase the sense of internal threat. We will explore this more fully shortly.

In regard to the lack of warmth from others, Baldwin and his colleagues found that the ability

to cope with setbacks and failures is related to the accessibility of schema and memories of others as helpful and soothing (see Baldwin & Dandeneau, 2005; Mikulincer & Shaver, 2004, 2005). For example, Baldwin and Holmes (1987) found that people who were primed with a highly evaluative relationship, and who then failed at a laboratory task, showed depressive-like responses of self-critically blaming themselves for their failure and drawing broad negative conclusions about their personalities. Conversely, individuals who were instead primed with a warm, supportive relationship were much less upset by the failure and attributed the negative outcome to situational factors rather than personal shortcomings. In another study, students were asked to generate research ideas and were then subliminally primed (outside conscious awareness) with either the approving or disapproving face of the department professor. Those primed with the disapproving face rated their ideas more unfavourably than those primed with the approval face. Negative *self-evaluation* was *non-consciously* linked to approval/disapproval of another (see Baldwin, 2005, for reviews of this work). In a review and study on self-critical forms of perfectionism Dunkley, Zuroff, and Blankstein (2003) suggest that self-critical perfectionists experience chronic dysphoria 'because they experience minor hassles in catastrophic terms and perceive others as condemning, unwilling or unavailable to help them in times of stress' (p. 235).

Taken together then, self-criticism can emerge from many sources, e.g. from modelling (treating self as others have treated self), safety strategies/behaviours with hostile others, shame (Andrews, 1998; Gilbert, 1998), inability to process anger (Ferster, 1973), lack of internal schema of others as safe/supportive (Mikulincer & Shaver, 2004) and/or as a fear-anger/frustration response that acts as a warning in the face of threat (e.g., if you don't work harder, lose weight, control your emotions no-one will love you). Although the threat-safety seeking aspects of self-criticism can vary, a common theme that links them may be the inability to self-soothe and be compassionate to self when under shame-focused threat.

CONCEPTUALIZING INNER COMPASSION FOR SELF

CMT starts from the premise that when things go wrong for people or they fail at certain tasks they may fear the consequences (e.g., being shamed and

rejected by others), become self-critical and are unable to access self-soothing and self-reassurance for the self. Both internal (self-to-self) and external (other-to-self) worlds are experienced as turning hostile. Gilbert et al. (2004) found a strong inverse relationship of self-criticism with abilities to focus on self-reassuring thoughts, and self-reassurance was associated with lower depression scores. Neff (2003a, 2003b) found that a lack of self-compassion was associated with increased vulnerability to a number of indicators of psychopathology. Gilbert, Baldwin, Irons, Baccus, and Clark (2006) found that self-criticism was associated with difficulties in generating images and feelings of self-compassion. Lehman and Rodin (1989) found that bulimic and non-bulimic people did not differ in regard to using food for nurturing, but bulimics were significantly less able to self-nurture in non-food ways. They note that their study highlights 'the usefulness of the self-nurturance construct in understanding the eating disorders' (p. 121).

A number of therapies are now focusing on the importance of helping people develop inner compassion and self-soothing abilities; especially noted in Dialectical Behaviour Therapy (Linehan, 1993; Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006). The cognitive therapists McKay and Fanning (1992), who have developed a self-esteem program, see self-compassion as a key antidote to self-criticism. Although directly teaching compassion is not part of mindfulness training for depression relapse (Segal, Williams, & Teasdale, 2002), compassion is believed to emerge naturally from its practice (Kabat Zinn, personal communication, June 2003). In some forms of mindfulness training, loving-kindness meditations are added to standard procedures (see, e.g., Shapiro, Astin, Bishop, & Cordova, 2005). In Buddhism, compassion is seen as central to well-being (Davidson & Harrington, 2002) and there are a variety of meditation exercises to promote it (Leighton, 2003; Ringu Tulku Rinpoche & Mullen, 2005). Allen and Knight (2005) note possible advantages of explicitly combining mindfulness training and compassion work in treating some depressions and other disorders. According to our view presented here, self-compassion can help reduce the sense of threat and create feelings of safeness.

Components of Self-Compassion

Most theorists see compassion as a multifarious process. For example, McKay and Fanning (1992) view compassion as made up of understanding,

acceptance and forgiveness. Neff (2003a, 2003b), from a social psychology and Buddhist tradition, has developed a self-compassion scale that sees 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 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 mindful awareness and acceptance of painful thoughts and feelings, rather than over-identifying with them. Neff, Kirkpatrick, and Rude (in press) have shown that self-compassion is different to self-esteem and is conducive to many indicators of well-being.

Our approach to compassion is rooted in the evolutionary model of social mentality theory (Gilbert, 1989, 2000, 2005a, 2005b). This approach suggests that animals and humans co-create different role relationships (e.g., attachment, sexual, dominate-subordinate). Different role relationships are created via the exchange of different signals, and different social signals activate different brain and physiological systems (e.g., affection signals can activate oxytocin, while aggressive signals activate stress-cortisol (Carter, 1998; Depue & Morrone-Strupinsky, 2005)). Importantly, however, we can respond to externally or internally generated cues/stimuli as if they are the same. An external sexual image may stimulate pituitary systems to give rise to sexual arousal but a sexual fantasy may do likewise. Whether the signal/stimulus is externally or internally generated, the response (an activation of sexual arousal) can be very similar. In regard to the thought-emotion processes involved in self-criticism, this external and internal equivalence is important. Thus, CMT views self-criticisms as internal stimuli that act like *social* stimuli, that the brain can treat *like real (threat-focused) interactions*. Thus one part of the self (processing systems) may deliver a string of criticisms (you failed again, you are no good, nobody will love you) and another part of the self (processing systems) responds to these putdowns as it might to external putdowns, with stress, anxious or depressive responses. The social mentality that is active is thus related to a dominate (hostile attack) and subordinate (submissive, anxious/depressed) response. These self-criticisms can be seen as a form of internal self-harassment, which can regularly stimulate submissive, anxious and depressive defences, especially if a person cannot defend

him- or herself against them (Whelton & Greenberg, 2005). We suspect that over time, with repeated use, these become highly sensitized and conditioned pathways and probably develop a retrieval advantage (Brewin, 2006).

This type of self-to-self-relating can come in the form of self-talk and patients can often identify inner hostile or helpful voice(s). Critical inner voices can come with suggestions, commands, condemnations and with emotions (e.g. contempt; Gilbert, 2000; Whelton & Greenberg, 2005). Patients can learn to interact with these aspects of self, such as writing them down as automatic thoughts and clarifying their meaning, or directly talking with them by (say) acting them out, as in the Gestalt technique of two chairs (Whelton & Greenberg, 2005). In essence, however, they can be analysed as 'inner conversations' and relationships (Gilbert, 2000; Gilbert & Irons, 2005; Watkins, 1986).

Compassion abilities in contrast are linked to evolved motivational, emotional and cognitive-behavioural competencies to be caring of others and increase the chances of their survival and prosperity (Gilbert, 2005a). As such it involves a number of key abilities that include a motivational aspect on the *desire to care for the well-being of another*, *distress sensitivity/recognition* related to the ability to detect and process distress rather than denial or dissociation, *sympathy* related to being emotionally moved by distress, *distress tolerance* related to the ability to tolerate distress and painful feelings 'in another' rather than avoidance or seeking to control the emotions of the other, *empathy* related to intuitive and cognitive abilities (e.g., 'theory of mind skills') to understand the source of distress and what is necessary to help the one distressed, and *non-judgment* related to the ability to be non-critical of the other's situation or behaviours. All these require the emotional tone of *warmth*. Problems in any one element can make compassion difficult. *Self-compassion* arises from the utilization of these competencies for self-to-self relating: that is, we develop genuine concern for our well-being; learn to be sensitive, sympathetic and tolerant of our distress; develop deep understanding (empathy) of its roots and causes; become non-judgemental/critical and develop self-warmth. These qualities are also viewed as important in DBT (Linehan, 1993; Lynch et al., 2006). In addition, we can learn to identify with compassion as a self-desirable quality, build it into self-identity (I would like to be...) and seek to take *action* to promote compassion.

We refer to our approach as compassionate *mind* training because we are not targeting specific core beliefs or schema *per se*, but (like mindfulness) seek to alter a person's whole orientation to self and relationships. We seek to change an internalized dominating-attacking style, that activates a submissive defensive response when dealing with setbacks and failures, and replace it with a caring, compassionate way of being with one's distress. To put this another way, we seek to give compassion processes a retrieval advantage (Brewin, 2006; Lee, 2005). Thus, to a setback or failure, we acknowledge, and are compassionate to, the disappointment and fear associated with it, the 'heart sink feeling' and learn to accept, tolerate and work with that fear (e.g., by being empathic and tolerant of one's distress), rather than activating the attack-self-criticism and submissive defence pathways. The therapist's compassionate stance to patients' fear and heart sink feelings as understandable (not their fault) reactions in the contexts of their lives (Lynch et al., 2006), helps the patients begin to form new self-to-self relationships that are accepting and understanding of distress and may have major physiological organizing effects (Wang, 2005).

CMT builds from CBT and DBT approaches of psycho-education, Socratic discussion, guided discovery, learning thought and affect monitoring, recognizing their source, de-centring, acceptance, testing out ideas and behavioural practice. The therapist relationship building skills of DBT (Lynch et al., 2006) and CBT (Gilbert & Leahy, in press) are also key to CMT. Although CBT focuses on automatic thoughts, they are part of our automatic *reactions* to events that become fused with emotions, behavioural tendencies and thoughts. So, for example, a phone call from the police that a loved one has been injured would activate a flush of anxious emotions, behaviours 'to rush to find' and be with one's loved one and thoughts of the possible seriousness and consequences of their injury. This focus on reactions is important, because in CMT we stress that such reactions to threat are often rapid responses from our defence and safety systems, linked to emotional memories, and can flush through us before we can consciously influence them. It is important to help people realize, and be compassionate to the fact, that automatic reactions *are not their fault*, or easily controlled, but arise as a result of evolved defences, genes, learning and conditioning. This can help reduce people's beliefs that they should be able to control their automatic reactions, that their feelings and reactions are wrong or shameful and that there

is something 'wrong with them' if they are unable to control them (Leahy, 2002, 2005). Helping people accept their automatic reactions without being self-critical involves meta-cognitive processes (Lynch et al., 2006; Wells, 2000), while helping people change them often requires various forms of normalizing, forms of exposure and new emotional learning (Brewin, 2006; Gilbert & Irons, 2005).

The basic idea behind CMT is thus that some people have not had opportunities to develop their abilities to understand the sources of their distress, be gentle and self-soothing in the context of setbacks and disappointments but are highly (internally and externally) threat focused and sensitive. When a setback, failure or conflict occurs they rapidly access internal schema of others as hostile/rejecting (Baldwin, 2005) with (well practiced) self-focused self-attacking. The key question was then: is it possible to directly teach people how to be self-soothing, and to *train* people to generate feelings of compassion and warmth when they are feeling threatened, experiencing defensive emotions (of anger, anxiety or disgust) and being self-critical/condemning? Can we teach people to have different, affect-related inner conversations, to activate a care-giving mentality in self-to-self relating? Given that some people are *frightened* or even contemptuous of inner warmth, is it possible to desensitize them to such fears, teach them to value compassion and help them practice being compassionate with themselves?

STEPS IN COMPASSIONATE MIND TRAINING (CMT)

Safety Strategies/Behaviours and the Functional Analysis of Self-Criticism

A number of therapists have pointed out that self-criticism can serve a number of functions (Driscoll, 1988). Gilbert et al. (2004) found that self-criticism was a complex process with different *forms and functions*. One function focuses on self-correction, such as stopping oneself from making mistakes or keeping oneself on one's toes, alert to errors and striving to achieve. Another function was to harm the self and take revenge on the self because of anger and contempt with the self, and trying to rid the self of bad aspects. Both forms of self-criticism were highly associated with shame and low mood. As noted above, for high shame-prone people, self-monitoring, self-blaming and self-criticism/attacking could be forms of safety and self-regulation strategies, which require careful assessment of

their origins and functions before trying to alter them (Gilbert & Irons, 2005).

Rather than trying to identify these processes as distorted cognitions/behaviours or maladaptive, we frame them in the language of safety behaviours (Kim, 2005; Salkovskis, 1996; Thwaites & Freeston, 2005); that is, people are doing the best they can to regulate painful situations, memories and emotions. We stress the fact that powerful feelings and thoughts (automatic reactions) can emerge in us as a result of our evolved emotion systems and past conditioning and in this sense 'are not our fault'. Shame-prone patients can be so riddled with ideas that there is something fundamentally bad or incompetent about them that we see this ability to 'stand back' and see safety behaviours as automatic defences (rather than as distortions or maladaptations) as essential and helpful to a de-centring process, which aids empathy and understanding of one's distress and self-criticisms. *Compassion can then be extended to one's self-critical thoughts and behaviours as often automatic safety strategies/behaviours.* This avoids people becoming critical of their self-criticism or trying to aggressively rid themselves of, or subdue, their self-criticism. Without this formulation CMT can be difficult, because people can fail to see their efforts as safety behaviours—that they developed to deal with fears of others (e.g., their rejection or contemptuous anger). If the underlying fear is not addressed, people can be very reluctant to give up self-criticism. For example, one person from a rejecting background thought that her self-criticism made her work hard and kept her negative emotions in check and in this way she could 'earn her place in the world'. If she gave up self-criticism she might not work so hard, not spot her mistakes and never find a place where others loved or valued her. Directly working on self-criticism was less helpful than working on her fear of rejection and of 'never finding a place of acceptance or belonging'. She learnt to recognize her self-criticism as fear based and to be compassionate to that fear.

We thus discuss self-criticism by formulating it as arising from the following.

- *Early trauma*, such as abuse and neglect, bullying or parental/peer criticism. Such traumas are commonly associated with powerful sensory-based autobiographical memories and the therapist may explore these in some detail because they have qualities that are like trauma memories (Lee, 2005). Unaddressed, these can make it
- difficult for the patient to feel safe. For example, one patient could vividly recall the 'look of hatred' on her mother's face and her own terror when Mother had one of her rages. These experiences lay down the emotional memories that form the basis for carrying key fears through life.
- *Basic fears* are of two types, externally focused and internally focused. Externally focused fears relate to what the outside world can do to the self, e.g., 'others have the power to reject and hurt me; they can turn nasty at any moment'. Internally focused fears relate to (a return of) anxiety, panic, shame, depression or rage that one feels one cannot control.
- *Basic safety strategies/behaviours/beliefs* are the ways that people have learnt to try to avoid or defend themselves against external attacks and the internal emergence of unwanted emotions that can feel overwhelming or shaming. People may try to avoid harm from others by being overly submissive and non-assertive, blaming self, silencing the self, always putting the needs of others first, not trusting others and keeping them at a distance, or working excessively hard to make themselves desirable to others. Alternatively, they may use avoidant strategies, bully others or keep others at a distance and avoid intimacies. Control of internally aversive experiences can be via dissociation, substance misuse, cutting oneself, reminding oneself of one's faults and weaknesses or trying to rid oneself of 'bad things inside me'.
- *Unintended consequences*. What start off as understandable efforts to defend the self from external and internal threats often have unintended consequences. Being overly submissive means others may not take you seriously; always putting the needs of others first means one does not learn what one's own needs and values are, or how to satisfy them. Criticizing oneself to try to reduce errors (and thus reduce threats from others) leads to self-harassment and exhaustion, and rarely being able to be at peace and content with oneself. Keeping one's distance from others, being highly self-reliant or being a self-concealer can lead to feelings of emotional isolation and never really feeling part of relationships—always the outsider.
- *Self-attacking for unintended consequences*. While self-criticism can be part of a safety strategy it can also arise because of the unintended consequences. For example, one submissive woman said that she hated herself for always being so submissive and letting fear overwhelm her. A

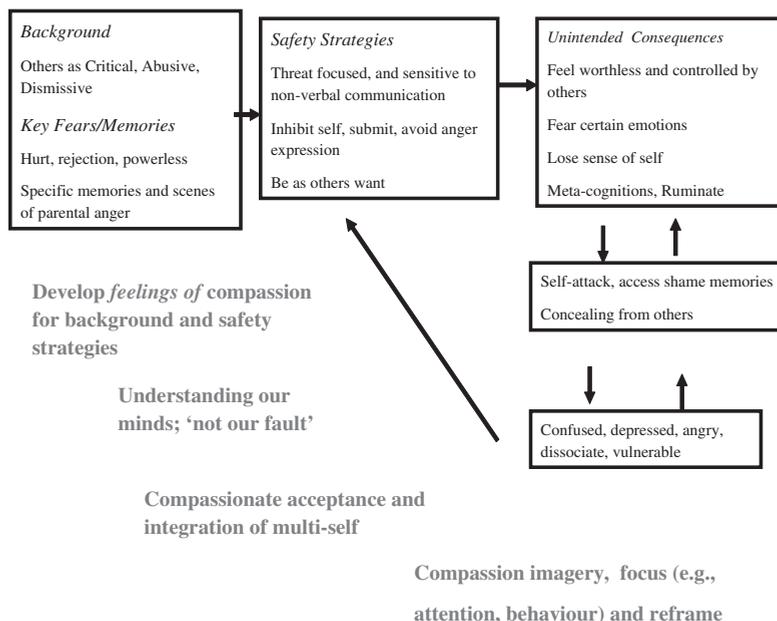


Figure 1. Threat/safety strategy formulation for shame and self-criticism, with 'compassion focus' below the boxes

man who abused alcohol said that at times when he stood back and saw what his addiction had done to him he hated himself for his weakness, got depressed and drank more. In such cases, one starts with compassion for the submissiveness and fear that underpins it, and for the need to use alcohol to soothe the self. Rather than hating the 'alcoholic self', we develop compassion for it. Key then is to always seek out the fear or sense of threat that underpins safety strategies.

It is very useful to help people see these links and stand back from them by diagramming them out. An example of these, with the compassionate focus, is given in Figure 1.

This aids a number of processes, including functional analysis. Over time the therapist helps the patient to do the following: (1) Be in tune with the feelings associated with memories, which can have trauma-like and sensory qualities (e.g., being able to recall facial expressions of angry others (Lee, 2005)). (2) Understand the development of the safety strategies as both conditioned emotional responses and planned strategies (and meta-cognitive beliefs) to cope with and avoid external threats (from others) and also the internal threats of the (re)activation of feelings that can seem overwhelming and automatic—we stress the 'not one's fault'

concept. (3) Learn compassionate acceptance and empathy for the origins and use of safety strategies. (4) Recognize that we have multiple subsystems (called multi-self, e.g., to attack or flee or seek reassurance, or win approval) that can have different priorities and action tendencies and can pull us in different directions—and these 'inner conflicts' can be confusing. We might focus on the fact that 'different parts of you have been trying as best they can to defend you or help you cope. However, these parts of you never have the overall picture, nor can they see far ahead. So they can pull in opposite directions and be very confusing and feel overwhelming'. (5) Develop compassionate imagery and compassionate and mindful ways of attending to fears and safety strategies that can provide the emotional basis for new forms of attention, thinking, behaving and feeling. We try to teach how to bring compassionate images to mind and reframe self-criticisms, e.g., 'it is sad I feel frightened/worthless/confused but this is understandable given the fears I have been confronted with. However, if I am gentle and kind to myself I can focus on . . . ; and it would help to me to do . . .'. CMT focuses on how each aspect of the difficulty has some functional aspect behind it, is linked to the defence system and is usually self-defensive, and how we can be compassionate for this, and change. Thus we look at the defensive strategies, seek

to explore the fears that fuel it (e.g., of rejection or harm from others) and work with those fears compassionately.

Therefore, following elicitation and functional analysis of shame and self-attacking thoughts, the therapy seeks to develop compassionate empathy and acceptance for distress and use compassionate decentering. This seeks to help people replace avoidance or attempts to rationalize distress away, or become self-critical when distressed, and learn affect tolerance (Hayes et al., 1996; Hayes, Strosahl, & Wilson, 2004; Lynch et al., 2006). Key also is to reduce *submissive acceptance* of self-attacks, where people agree with, and submit to, their own self-attacks (Whelton & Greenberg, 2005). Acceptance of, and compassion for, a self-attack is not the same as submissive compliance. CMT tries to help people see self-attacking as a form of safety strategy/behaviour, often automatic and as a highly rehearsed set of responses to 'failures/setbacks' (Gilbert & Irons, 2005). Thus, in CMT we suggest that we are *not* going to 'take on' self-criticism directly (in the sense of trying to undermine it with counter-evidence that a patient may struggle to emotionally believe or accept) but to explore why we do it (the fears behind it) and develop new ways for thinking and feeling, and that as we switch perspectives to a compassion focus/mentality, the hostility in the self-attacks may gradually recede. The key is to develop a new self-to-self relationship based on warmth, care and compassion for self, with compassionate insight into how one arrived at one's current position unintentionally. Our abilities to be self-compassionate (we explain) may be under-developed for various reasons related to earlier experiences, and the fact that we have been mostly trying to defend ourselves in various ways. When we are highly threat focused, warmth can be difficult and even frightening. Thus, in the first instance we are less interested in *how much* a person may believe in an alternative idea or thought about themselves but more on the felt warmth and reassurance of any alternative. It is the affect generated in/with an alternative that is key, rather than logical reasoning *per se*. We offer a simple behavioural and neurophysiological rationale (Gilbert, 2000). This is given in the 'training' section in Appendix 1 (Developing qualities of inner compassion, part 9).

We spend a lot of time developing what we call *empathy for one's own distress*, both in the past (e.g., empathy for distress as a threatened child), and in the current life context. We discuss why loss of affection/approval in early life and currently can

feel so powerful and unpleasant. We give a brief outline of evolution and social mentality theory (Gilbert, 1989, 2005a), especially that derived from attachment theory (Bowlby, 1969, Cassidy & Shaver, 1999; Leahy, 2005; Mikulincer & Shaver, 2004, 2005), group belonging (Baumeister & Leary, 1995) and shame (Gilbert, 1998, 2003) to explain why humans are so dependent on the good feelings of others towards them. With them we feel safe; without them we can feel vulnerable and threatened (Gilbert, 1998, 2003). We stress that 'all humans want/need to feel loved and accepted, because in our evolved past our very survival may have depended on it. So when this does not happen for us the brain can register this as a major threat—and then our emotional minds try to develop some kind of protection strategies, which can become automatic. Although very understandable these can become unhelpful and prevent us from changing'. All of our participants found this brief psycho-education aspect helpful. Patients can then be invited to explore (brainstorm) all the possible ways protection—safety strategies might work, such as avoidance, anger, emotional numbing or denial. We also explore how much of our time is spent trying to either elicit other people's approval or avoid being controlled/threatened by them.

In a group format, patients often identify with each other and support each other on these themes as they tell their stories of the origins of their self-criticisms. This standing back and developing empathy for oneself, 'it is understandable why I feel like this and attack myself because . . . ; my basic fear has always been that . . .' often alters the affect from anger or contempt to sadness and grief. Although some patients can find this emotional awareness of inner sadness and longing very threatening at first, it can be the beginning of developing sympathy for one's own distress and tolerating feelings of vulnerability and sadness. The therapists and group acknowledge, and give strong validation to this process (Bates, 2005; Leahy, 2005). With this validation the patients may begin to more fully appreciate that many of their efforts (including self-attacking) have been safety behaviours—to try to protect themselves and regulate their emotions because they have felt so unsafe with others and their external and internal worlds.

We continually stress therefore that it not so much distortions in reasoning that are key but automatic safety strategies/behaviours and conditioned responses, and not having had opportuni-

ties to develop alternatives based on genuine care. For example, a patient may come to the view 'I used to hate myself for getting anxious or angry because those feelings made me feel so vulnerable, but now I realize these feelings are painful and part of my protection system; they are understandable and not reflections of me being bad or weak'. Patients may also be invited to reflect that sadistic fantasies of revenge to others can be common (evolved) and understandable defensive reactions to being hurt—unpleasant, frightening and undesirable as they may be nonetheless. Even animals can engage in revenge. Our evolved brains can simply generate these thoughts and feelings at times of threat and injury, and while we can learn to recognize and cope with them and not act them out they are not a mark of personal badness. Thus a de-shaming process is key here (Leahy, 2002; Lynch et al., 2006), but this does not diminish the value of also re-evaluating basic beliefs, as in standard CBT and DBT, where this is helpful.

Empathy for one's distress and self-criticism can also arise when people reflect that these ways of treating the self may have their origins in childhood: 'I learnt to judge and relate to myself as others related to me'. Moreover, the themes and nature of the attack may actually be modelled from someone else (e.g. a critical parent, a school bully (Sachs-Ericsson et al., 2006))—we are not born self-critical (Lee, 2005). Self-attacking can sometimes be a way of coping with hostility to others because feeling angry with others (e.g. a powerful parent) can be frightening or feel like a betrayal (Gilbert & Irons, 2005). One patient noted that her mother had been very depressed and 'not there for her', but she could not be angry with her because that would be very bad and uncaring. The group helped her acknowledge how hard it is to allow anger as an understandable response to the loss of a caring mother and not evidence of personal badness (see also Hackmann (2005) for working on this theme using imagery). The patient was able to reflect that anger with others who let her down had always 'been hard for her' and made her feel 'bad as a person'.

With the developing of empathy for one's own distress and self-attacking, and being able to place it in a historical context, they are then invited to note their self-attacks but to refocus with compassionate attention, compassionate thinking and compassionate behaviour, and practice generating warmth. To start this process the patient is invited to focus briefly on their breathing (to shift attention) and then to engage in compassionate

re-focusing. In regard to behaviour change they are invited to think about how they could bring 'compassion into action': to act out a compassionate response to a difficulty. 'Homework' or as we prefer 'independent practice' is also constructed in terms of a compassionate practice, to help with 'these difficulties', and the focus is on encouragement and *warmth* when doing the 'homework', not self-bullying.

DEVELOPING COMPASSIONATE IMAGES AND WARMTH

As an aid to generating warmth we have hypothesized that feelings of warmth normally begin via experiencing warmth from others towards the self (noted above). These become internalized to act as internal schema or self-objects that act as referents for self-soothing (Baldwin, 2005). Although many therapies rely on the therapeutic relationship as being a source for such internalization (Holmes, 2001) and of articulating, mirroring and validating patient's emotional experiences (Leahy, 2005; Linehan, 1993), CMT invites people to create their own images of warmth. Thus patients are invited to imagine their ideal of caring and compassion (Gilbert & Irons, 2004, 2005). This can be done in two key ways. The first is by thinking or recalling one's own compassionate motives and feelings flowing *outwards* to others (e.g., imagine compassion and warmth for a child or someone one cares about). This approach is used to help with unpleasant ruminations where a person recalls outward-directed compassion feelings and then how to generate and direct those feelings to the self (E. Watkins, personal communication, Oct. 2005). This imagining of compassion flowing to others and from others to self (e.g., via imagining a universal, compassion Buddha) is the basis for Buddhist forms of compassion meditation (Ringu Tulku Rinpoche & Mullen, 2005).

Rather than provide people with a culturally located image, such as a Buddha image, for generating feelings of compassion *flowing into* the self, we ask patients to imagine their own ideal of caring, where ideal is defined as the best for you (e.g. no different in principle than thinking about one's ideal meal or house—it has all that you want and desire; Lee, personal communication, July 2005). However, this ideal image has to have the qualities of *wisdom, strength, warmth and non-judgement/acceptance that is given to the person* (i.e. to experience the image coming with warmth for and directing it at, the self). Time is spent focusing

on the sensory qualities of these images (e.g., physical appearance and sound/voice tone). Some patients can take time to be able to do this and others can find their first efforts painful to do (see Appendix 1 for the guided imagery exercise).

Imagery

The use of imagery as a therapy aid is now used in many therapies (Hackman, 1998, 2005; Holmes & Hackmann, 2004). The use of images that direct warmth, understanding and compassion towards the self has been used in Buddhism for hundreds of years (Leighton, 2003). Whilst we have focused on an ideal of compassion with the above qualities, Lee (2005) has labelled such images the 'perfect (as an ideal) nurturer'. While some patients will generate human-like images, other patients find this difficult and may at first have a compassionate image of a tree, a sea, sun or an animal. They may also choose to embed their images in an image of a safe 'place'. The key to the image, however, is that the image has a 'mind' that can understand them, can communicate with them and has the qualities noted above. Thus if the compassionate and soothing image is of the sea then the image of the sea is of being very old with qualities of *wisdom, strength, warmth and non-judgement/acceptance that is given to the person*. The more unique and personal the person feels their image to be, the better it may work for them.

When patients find it difficult to generate alternative thoughts or feelings to their self-attacking they can focus on their compassionate image and consider 'what would my compassionate image/perfect nurturer say to me?' This is called the compassionate reframe (Lee, 2005). When working with sensory memories (of say abuse) we invite people to also focus on a compassion image and imagine what that compassion part of them would feel, say and act towards them (Gilbert & Irons, 2005; Lee, 2005). We switch attention back and forth between threat images and soothing images/affect systems focusing on compassion qualities.

We suggest that in order to bring a compassion system on line the person may need to switch to different neurophysiological and psychological processing systems. There is good evidence that directed imagining and recall affects neurophysiological processes (George et al., 1995). Mindfulness training has been found to alter immune system functioning and brain lateralization (Davidson et

al., 2003). Rein, Atkinson, and McCraty (1995) found directed compassion imagery had a positive effect on an indicator of immune functioning (S-IgA), while anger imagery had a negative effect. Imagery may have various recall advantages and be more affect related than 'logical thinking' alone (Lee, 2005). Although in this study many found generating compassionate images and practice difficult to do, by the end of the therapy they were able to generate some kind of image that they felt soothed them. At the end of each session we ended with a compassionate imagery meditation.

The psycho-education aspect of the power of thoughts and images to stimulate physiological processes was conducted by drawing an outline of a brain on a flip chart. We then explained that if one is hungry, seeing a meal will make our brain respond by stimulating our stomach acids and saliva. If we see something sexy then this 'signal' can stimulate our brain and give us arousal. However the key aspect of these examples is to note that our brains *will also* respond to internally generated images of a meal or something sexy. We can just think about a meal or something sexy and notice an effect in our bodies. Then we point out that if someone is criticizing us this stimulates our stress system. However, if we generate criticism from the inside then those 'inner critical voices' can also stimulate stress and make us feel beaten down. Finally, if people are kind, understanding, accepting and supportive of us this can stimulate a soothing system. So it makes sense that if can learn to create soothing images and experiences *from within* then we might be able to stimulate this system in our brains in times of stress. We found that our participants found this simple approach very helpful and generated much discussion. A number of patients said, they could now see how their thoughts affected their bodies and physical states and that 'oh I can now see why you want to help us develop compassion'. We also used analogies of a kind of physiotherapy for the mind where we are practicing developing new 'emotional muscles' (Gilbert & Irons, 2005).

Once our participants had some kind of image, and a sense of what compassion feelings were, they were invited to bring this image to mind and spend time focusing on what it felt like to feel warmth from the image, acceptance from the image and strength from the image. In another exercise they were invited to generate their images and then bring to mind their shame or self-attacking thoughts and just 'feel the presence' of the compassionate images with them and look together at

the thoughts in a detached way. A number of participants reported that their negative thoughts seemed to change. One person who had the image of the sea saw the sea gradually dissolve away his negative thoughts and became tearful, with the thought 'I don't have to think this, I can let it all go. It really wasn't my fault'.

As part of a compassionate reframe and process, patients can be asked to write themselves compassionate letters. They may bring to mind their compassionate images and imagine them writing a letter to self. For example, it might start with 'Dear Sally, I was sad to hear you have been feeling . . . and beating yourself up again. However, I want you to know that . . .'. The therapist helps the patient focus on empathy for his or her distress and then compassionately re-frame difficulties with compassionate attention, thinking, behaviour and warmth. Trying to generate compassionate warmth in the writing is important so as to avoid a detached form of writing. Patients may begin writing letters that are somewhat cold and dismissive or telling them what they should or should not do. Thus the therapist gradually guides their writing to become more compassionate. Some patients prefer this form of writing down to that of traditional thought forms, partly because they are more narrative and partly because, by imaging an inner conversation with a compassionate other, this cues them into a different style of thinking and feeling (which we would suggest is based in a different social mentality; Gilbert, 2005b).

In summary, CMT involves the elements of a specific psycho-educational focus on the qualities of self-compassion, locating self-criticisms as forms of safety strategies/behaviour, recognizing the fears behind it, developing empathy for one's own distress and safety efforts and refocusing on compassionate images, thoughts, emotions and behaviours—with warmth.

THIS STUDY

CMT has developed over a number of years in collaboration with patients. Although there are a number of anecdotal reports of the value of CMT and we have tested certain elements of this approach (Gilbert & Irons, 2004), we wanted to explore a more systematic group format. Bates (2005) has suggested that compassion, expressed and shared in a group setting, can be an important source of change. Because CMT evolved from work with people who had long-term problems, com-

monly diagnosed as having personality disorders, we chose to run a small pilot CMT group for day hospital patients with such difficulties.

METHODS AND PROCEDURE

This study involved patients with major/severe long-term and complex difficulties, currently in treatment in a day centre of the Derbyshire Mental Health services NHS Trust, UK. The centre uses cognitive-behavioural group programmes and works along day hospital therapeutic community lines, where a sense of belonging, safeness, consistency and community are important. Participants attend all day, two to three days a week within two distinct programmes, Mondays and Wednesday or Tuesdays and Thursdays, with more open ended meetings on Fridays. Patients attend one programme or the other but not both. Treatment can last for up to two years, with an average of 15 months.

Ethical approval was obtained from the Local Research Ethics Committee. Following this, Sue Procter, team manager/cognitive therapist at the day centre, advised all patients about a research project into compassionate mind training for people who are very self-critical, and invited volunteers. The research was discussed regularly at community meetings, so that all patients had an opportunity to volunteer, should they so wish. Acceptance into the group was based on the following.

1. They had to be in current therapy within the centre and not due for discharge within the next three months.
2. They had to agree to regular attendance each Friday morning for two hours for 12 weeks of the trial.
3. They had to have clear problems with shame and with self-criticism and self-devaluation.

Nine patients volunteered, four men and five women. Of the nine who began CMT, three dropped out (two men and one woman). One of these was related to the difficulties of attending due to a number of crises in her life and feeling 'too upset' in sessions. Another became physically unwell and could not attend the day centre. The third participant dropped out after ten weeks saying he felt much better and wanted to 'move on'. He choose not to engage further so it is difficult to know his exact reasons, but family pressure to leave the day centre might have been a factor. Hence, the data given below is based on the six

participants going through the full course of training. For the six completing the CMT sessions the age range was 39–51 years (mean 45.2, SD 5.54).

In the week preceding the start of CMT, participants were asked to complete a series of self-report questionnaires, covering forms and functions of self-criticism, depression, anxiety and shame. Research assistants from the local mental health research unit helped them in this. It was then agreed to meet on a weekly basis, Friday mornings 9.30–11.30, for 12 weeks.

We did not seek to give formal psychiatric diagnoses to our participants, although all of them had previously been diagnosed by local psychiatrists as suffering from personality disorders and/or chronic mood disorders. Many had engaged in serious self-harming behaviour and all described histories of emotional difficulties since childhood with histories of early, physical or sexual abuse and/or severe neglect. Four of the women had been in abusive relationships with partners. All participants had had a variety of previous psychological and drug treatments. They were all familiar with the basic CBT approach and had made some progress, although continued to struggle with an intense sense of shame and self-criticism.

The group-based format of CMT is highly task focused and unfolds in a series of steps. At our first few meetings we explored the nature of self-criticism, outlined the rationale behind the therapy and introduced the idea of compassion and self-compassion as the intention of the therapy. After group discussion and brainstorming on what compassion may entail, participants were provided with a single written sheet of the qualities of self-compassion we were trying to help them develop (see Appendix 1). We then began to explore the fears of developing self-compassion (e.g., it is a weakness, will make me vulnerable, cannot be trusted, feels strange, is overwhelming or frightening). In subsequent sessions we explored the nature of self-attacking using examples provided by the participants.

MEASURES

The Hospital Anxiety and Depression Scale (HADS)

The HADS is a well known 14-item questionnaire developed by Zigmond and Snaith (1983) to measure patients' self-reported anxiety and depression scores. Patients rate the severity or frequency of current depressive and anxious

symptoms. This scale has been found to have sound psychometric properties (Savard, Laberge, Gauthier, Ivers, & Bergeron, 1998). The depression scale focuses primarily on anhedonia and does not contain any self-evaluative items.

Weekly Diary Measuring Self-Attacking and Self-Soothing

We constructed a weekly monitoring diary to record people's experiences of their self-critical and self-soothing thoughts and feelings. This was constructed from previous studies exploring hostile and compassionate self-imagery (Gilbert et al., 2006; Gilbert & Irons, 2004). The diary is given in Appendix 2. We chose an *interval contingent* format (Wheeler & Reis, 1991), which required respondents to record their self-critical and self-soothing thoughts and images over a set period of time. In the first session of the study participants were taken through the diaries and we explained how to complete them. Subsequently, a diary was completed in each session, giving weekly records. Previous work had suggested to us that daily dairies of this form were not well kept (Gilbert & Irons, 2004). Although this method is open to retrospective bias, Ferguson (2005) points out that interval contingent diaries are useful when the subject being recorded is frequent, may not have fixed start/end points and may be continuous or sporadic. For analysis we used the sum of each domain to give an overall score for self-critical thoughts and self-soothing thoughts (see Appendix 3).

The Functions of the Self-Criticizing/Attacking Scale (FSCS)

Gilbert et al. (2004) developed this 21-item self-report measure to examine the *reasons* people might be critical of themselves. The items were derived from clinical work with depressed patients. The scale begins with a probe statement, 'I get critical and angry with myself', followed by 21 possible reasons for self-attacking, such as 'to remind me of my responsibilities'. Participants rate the items on a five-point scale, from 0 = not at all like me to 4 = extremely like me.

Factor analysis suggested two separate factors: self-correction and self-persecution. Self-correction items are concerned with improving performance and keeping up one's standards. This factor includes items such as 'to make me concentrate', 'to prevent future embarrassments' and 'to keep

me from making minor mistakes'. Self-persecution items are concerned with dislike and contempt for the self and include items such as 'to take revenge on part of myself', 'because if I punish myself I feel better' and 'to cope with feelings of disgust with myself'. The scale has good internal reliability with Cronbach alphas of 0.92 for both subscales.

The Forms of the Self-Criticizing/Attacking and Self-Reassuring Scale (FSCRS)

Gilbert et al. (2004) developed this 22-item scale to measure the forms and styles of people's critical and reassuring self-evaluative responses to a setback or disappointment. Participants respond to a probe statement 'when things go wrong for me . . .' on a five-point Likert scale (ranging from 0 = not at all like me to 4 = extremely like me) to a series of questions designed to tap self-criticism and self-reassurance. Self-critical items include 'I am easily disappointed with myself'; 'there is a part of me that puts me down'; 'I have become so angry with myself that I want to hurt myself'. Factor analysis suggested that the self-critical factor could be separated into two sub-factors; one that focuses on feeling inadequate and defeated, called 'inadequate self' (nine items; Cronbach alpha = 0.90), while the other focuses more on a sense of disgust and anger with the self and was called 'hated self' (five items; Cronbach alpha = 0.86).

Self-reassurance items of this scale focus on thoughts of self-reassurance that include 'I am able to remind myself of positive things about myself'; 'I encourage myself for the future'. This is an eight-item, one-factor scale referred to in this study as self-reassurance (Cronbach alpha = 0.86).

Social Rank Variables

Social rank variables are those that measure a person's sense of relative rank and social position. There are three key measures of this: social comparison, tendencies for submissive behaviour and beliefs in the degree to which others see the self as low rank and 'look down and negatively evaluate the self'—called external shame (see Gilbert, 2004, for a review).

External Shame (the Other as Shamer Scale; OAS)

Negative feelings about the self that originate from experiencing others as critical and rejecting (i.e. others as 'shamers' or shaming) has been referred

to as external shame (Gilbert, 1998). The OAS is an 18-item scale developed by Goss, Gilbert, and Allan (1994) and Allan, Gilbert, and Goss (1994). It was developed from the Internal Shame Scale (ISS) developed by Cook (1993, 1996). Participants respond to statements such as 'I think that other people look down on me' and 'Other people look for my faults' on a five-point Likert scale ranging from 0 (never) to 4 (almost always). The scale has good internal consistency, with a Cronbach alpha of 0.92 (Goss et al., 1994), and has been used in a number of studies.

Social Comparison Scale

A person's sense of relative rank in relation to others can be derived from how people compare themselves to others. Allan and Gilbert (1995) developed the social comparison scale for this purpose. It has been used in a number of studies and has been found to be highly correlated with depression (Allan & Gilbert, 1995; 1997). Subjects make a global social comparison of themselves in relation to others on 11 bipolar constructs, rated 1–10. Hence, to the probe question 'in relation to others I feel . . .' one domain is:

Inferior 1 2 3 4 5 6 7 8 9 10 Superior.

Thus, *low* scores indicate relative *inferiority* compared with others, while *high* scores indicate relative *superiority*. Negative correlations with depression thus indicate that higher depression is associated with increasing inferiority (lower scores). There are 11 items, measuring constructs of inferior–superior, attractive–unattractive, and insider–outsider.

Submissive Behaviour Scale (SBS)

This scale was originally developed from the work of Buss and Craik (1986), who asked subjects to identify typical submissive behaviors. The most highly agreed upon items (16 items) were chosen to construct the Submissive Behaviour Scale (Allan & Gilbert, 1997). It includes items such as 'I agreed I was wrong even though I knew I wasn't'. Subjects respond by giving their estimated frequency of these behaviors on a five-point scale. This scale has satisfactory internal consistency and test–retest reliability; the Cronbach's alpha was 0.85 in both a student and a depressed group (Allan & Gilbert, 1997) and is highly correlated ($r = 0.73$) with the 'sub-assertive' measure of the inventory of interpersonal problems (Gilbert, Allan, & Goss, 1996).

RESULTS

The data was analysed with SPSS 10 using the Wilcoxon signed-rank test. This test is recommended for small subject numbers and repeated measures (Field, 2005). The results are given in Table 1, with histograms in Figure 2.

Depression and Anxiety

As can be seen in Table 1 and Figure 2, the results show a clear pattern of change for this group. There was a significant reduction in both HADS, Anxiety and Depression, scales. The group moved out of a 'caseness' band for the HADS. This does hide some individual variation, with some doing very well and others less well, but all participants reported feeling less depressed and anxious.

Self-Monitoring Diaries

These data indicate that over the 12 weeks various elements of self-attacking and self-soothing (as captured in the diaries) significantly changed. Many participants found their self-critical thoughts became less frequent, less powerful and less intrusive, while their self-soothing thoughts became more powerful and accessible. We note that the self-criticism variable at week one was negatively skewed (-2.10), which reflects the very high levels of self-criticism of some people.

Self-Critical and Self-Reassuring Self-Report Scales

These scales were completed at the beginning and end of therapy and not weekly. In terms of the functions of self-criticism, there was a significant drop in self-persecution but not self-correction. This is interesting, and as discussed later, may relate to the functions of this form of self-criticism or the numbers involved in this study. In regard to the forms of self-criticism (what people actually do and focus on in their thinking), there were significant drops in criticism focused on inadequacy and criticism focused on self-hatred. In addition, there was a significant rise in self-reassurance.

Social Rank Variables

This training also had a significant impact on helping to reduce people's sense of external shame; that is, they were less likely to endorse beliefs that others looked down on them. In regard to social comparison, there was a major reduction of feelings of inferiority, with social comparison scores moving into a non-clinical range.

Of interest also is the reduction in submissive behaviour. We did not specifically target assertiveness as a task, although there were times when issues of dealing with conflicts with others in a compassionate way were discussed. As the group progressed, participants spontaneously talked

Table 1. Changes in the seven measures over the 12-week therapy ($n = 6$)

Scale	Subscale	Mean score at week 1	Mean score at week 12	T	Z-score	Associated P value
HADS	Anxiety	14.67 (SD = 3.78)	6.83 (SD = 2.93)	0	-2.20	0.03
	Depression	10.33 (SD = 2.67)	4.3 (SD = 2.73)	0	-2.21	0.03
Diary	Self-Criticism	54.20 (SD = 8.80)	18.80 (SD = 18.00)	0	-2.20	0.03
	Self-Compassion	10.20 (SD = 5.53)	56.40 (SD = 13.46)	0	-2.21	0.03
Functions of self-criticism	Self-Correction	28 (SD = 15.79)	21.67 (SD = 11.74)	2.75	-1.05	NS
	Self-Persecution	17.5 (SD = 8.62)	9.6 (SD = 8.45)	0	-1.83	0.05
Forms of self-criticism and self-reassurance	Inadequate Self	31.33 (SD = 5.16)	14.5 (SD = 7.01)	0	-2.02	0.07*
	Hated Self	15.17 (SD = 3.76)	5.67 (SD = 5.40)	0	-2.20	0.03
	Reassure Self	6.17 (SD = 6.40)	19.83 (SD = 8.21)	0	-2.20	0.03
Others as Shamer	Others as Shamer	48.5 (SD = 17.27)	36.33 (SD = 12.13)	0	-2.20	0.03
Social Comparison	Social Comparison	34.83 (SD = 21.50)	58.67 (SD = 26.00)	0	-2.21	0.03
Submissive Behaviour	Submissive Behaviour	42.67 (SD = 11.52)	30 (16.95)	1	-2.00	0.05

*sig at 10% level for small numbers.

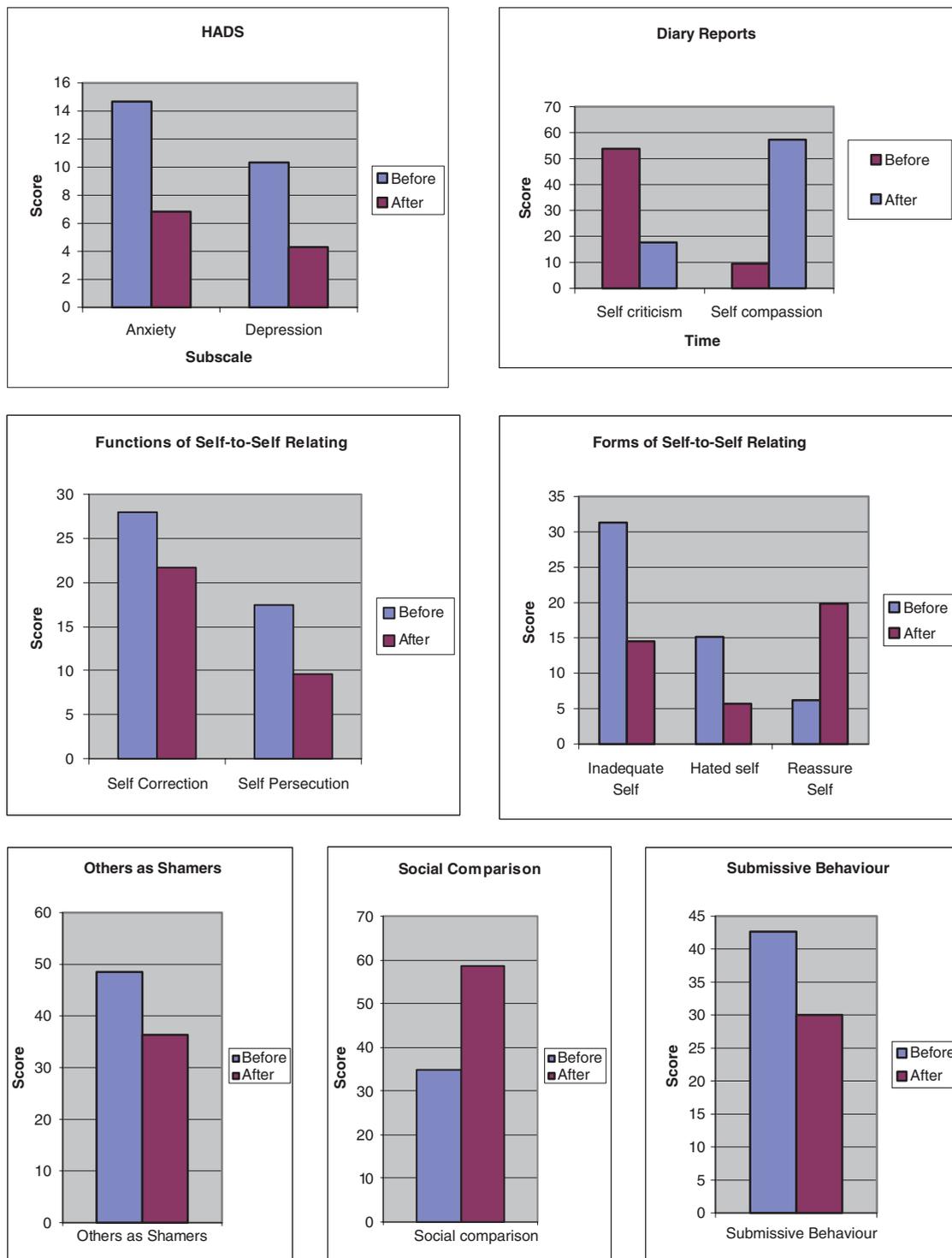


Figure 2. Histograms of study variables 1-7

about how they were able to be more assertive as they began to become more compassionate and value themselves. Interestingly, some reflected on the fact that they felt less isolated and alone in the world as a result.

Two Months Follow-Up

We had arranged for a follow-up of all participants but due to personal difficulties only four participants returned for a two-month follow-up. For two of them there had been severe life-events, involving hospitalization and the near death of a son from alcohol abuse. However, they both felt that being able to generate compassionate images when they were distressed had significantly contributed to their abilities to get through these crises. All participants had continued to practice using their image and efforts at developing compassionate thinking, behaviours and feelings and felt that they had taken their images and compassionate focus further with this practice. We were unable to obtain sufficiently reliable data for analysis.

CONCLUSION

This study is a 'pre-trial study' and did not seek to offer a control group. As this was the first time CMT had been used in a group-based format its primary concerns were to explore patient acceptability, how the various elements would work together, the effectiveness of CMT for patients with chronic mental health difficulties and to learn from the participants. All these aspects are necessary before engaging in comparing CMT with other interventions and further research work on the processes underpinning change (Brewin, 2006).

To prepare to work with imagery we taught a brief relaxation exercise that involved being mindful of breathing. The idea was to watch the breath enter and leave the body and notice how thoughts and other sensations often intrude. When this occurs (as it naturally will), the idea is to just notice them and *gently* bring the focus back to breathing. The idea is practicing attention focusing and not to 'clear the mind' or 'make oneself relax'. This idea is also key to imagery work, where one gently brings the attention to the task, noting but not reacting to 'attention wandering'. Participants learn not to try to force images or get caught up in frustration with slow progress. However, even after 15 seconds or so of 'mindful breathing', some patients found this deeply alarming, with the pos-

sibility that some would not continue if they had to do this. We discussed with the group that the aim of the exercise is to help us refocus our attention and thoughts when they wander; i.e., we focus on the process of attention rather than results. It was then decided that SP would buy the group tennis balls and the following week practice sensory attention focusing on the tennis ball—its texture and feel. This worked extremely well for some people, who felt that 'holding their ball' (and yes there was amusement in the group on this) helped them 'feel more relaxed than they had done in years'. For some it became a transitional or conditioned object that they carried with them and felt soothed when holding it. One participant took to the idea and bought herself some coloured socks that she took to wearing to the group and put on when she felt distressed. This alerted us to the potential value of grounding sensory based processes (e.g., use of objects) by linking them to a compassion focus. Lee (2005) has raised a similar issue and suggests the use of certain smells that can link/cue to compassion feelings. These sensory based cues may aid retrieval of compassion focused thoughts and feelings. Although some patients appeared to become dependent on their tennis ball for a while, all agreed that this was a better way to try to soothe the self than self-cutting, drinking alcohol or taking drugs. We think this is an important area for future research in regard to how such stimuli, that have sensory qualities, can be used to help people connect to a compassion and soothing focus. It is known, for example, that people under stress (e.g., men at war) use letters and pictures of loved ones to self-soothe (Mikulincer & Shaver, 2004).

During the early training, participants had trouble in identifying specific negative thoughts and using the diaries, partly because, as one said, 'when you feel black inside it is difficult to see black against it'. They also had difficulty thinking about self-soothing or what a 'compassionate thought and image' would be like. This became a focus for work and non-judgmental practice.

In the early sessions many participants had a real fear of becoming self-compassionate. For example, one participant felt that when she tried to generate feelings of warmth for herself there was only a 'black hole' inside of her and became very anxious and tearful. A number of participants could not generate any images and these took some time to emerge. Some started by thinking of soothing places (e.g., a summer meadow or the sea) and then gradually brought in the qualities of compassion—

wisdom, strength, warmth and non-judgement. Some participants believed that compassion was a weakness and 'letting oneself off the hook', or that it was dangerous because one would 'let one's guard down'. Some participants seemed to have a conditioned emotional response of anxiety to warmth—when in the past they had allowed themselves to feel cared for by another, this other person had turned abusive or rejecting.

We approached this 'fusing and conditioning' of feelings of warmth from others with rejection and abuse (and thus intense anxiety when trying to generate a compassionate image) by explaining the conditioning process using a flip chart. In fact, throughout the sessions we had a flip chart and coloured pens on hand to write up key ideas or work with their thoughts, feelings and dilemmas.

We tried to help participants focus on the fact that their compassionate images were being created from their own minds. Hence, it was one's own inner compassion that one was trying to develop. Even so, these experiences of warmth were very difficult, and at times frightening for some people. A number of participants had times of sharing grief and sadness and being fearful of being overwhelmed with grief and losing control. Indeed, grief and sadness may be an affect that high shame-prone people particularly struggle with (Gilbert & Irons, 2005). At the end of the therapy a number of participants reported that the validation of their grief, as they became more sensitive and acknowledged their distress (e.g., how alone and frightened they had felt during abuse or through much of their lives), and sharing such experiences with others who had similar feelings, was very important for them. Unresolved anger at others was also another reason people found it hard to be able to trust anyone, even their own compassionate images. Again we approached this as an understandable response, and that anger can be a safety strategy that keeps others at a 'safe distance', or we seek to gain power and control by punishing others. Some patients found the issue of revenge (and revenge fantasies) to be shaming, counter to their self-identities, but listening to others talk of such, learning that it is a normal response that one can acknowledge, work on and not act out or lose control of, was helpful to them. The difficulties of forgiveness were also discussed. Especially important was the notion that forgiveness requires recognition of hurt, differs from submissiveness and does not mean 'letting one's guard down' or necessarily liking the other or having to be close to them. We focused on letting

go of anger and the fears and blocks to doing this. For some people this seemed to free up their abilities to become more self-compassionate.

Working with these difficulties, by the end of the 12th session the group were able to sit for 20 minutes just focusing on their compassionate images, observing negative thoughts and 'letting them go' and generating self-warmth. In discussion, some participants thought that when they felt threatened and stressed they had learned to refocus their attention by first trying to put themselves in an empathic and compassionate frame of mind (or bring to mind a compassionate image)—and then consider (non-self-hostile) alternative thoughts. The group liked the focus on generating warmth and reassurance in their alternatives, rather than focus on their 'evidential accuracy'. Many felt this took pressure off them of trying to 'change their thinking' or trying to convince themselves to believe in alternatives because they could now just 'be' with their thoughts/feelings and switch to self-compassion. They recognized that if they could focus on compassion they were trying to activate a different mentality in themselves. While acceptance is increasingly being used in a variety of therapies (Hayes et al., 2004; Linehan, 1993; Lynch et al., 2006), we focus on *compassionate acceptance*.

The data suggests CMT had a significant impact on depression, anxiety, self-attacking, feelings of inferiority, submissive behaviour and shame. We note that we did not produce a significant change in self-correcting self-attacking. It is unclear why this was the case, but many participants still endorsed this as a positive (to keep me on my toes, to stop me making mistakes, drive me on). The low number of participants might also be a factor, because for some people it did clearly reduce. However, there was discussion around the implications of reducing this form of self-attacking, with anxieties of becoming lazy and not 'keeping up'. Gilbert (1992, p. 111) discussed this as the good-bad self-paradox. 'I must be (a little) good because I know what my faults are; not to see (or criticize myself for) my faults would make me bad.' We think we could have done a better job in working with these ideas with behavioural tasks that ask people to do certain things (the washing up or cooking a meal) but not engage with any self-criticism, and see if that makes a difference to their behaviours. The data suggest more thought on this aspect is needed. We also considered that this type of self-attacking can be linked to an identity, as one participant noted he could feel quite 'weird' in

giving it up. One person thought it was a bit like being 'naked'.

Subsequent to the end of this group, five patients felt ready for discharge from the main day hospital programme. In addition to reported improved interpersonal relationships, one person has gained full-time employment (having not worked for many years) and one person is in voluntary work seeking employment. Two patients are living on their own and coping, in their view, 'much better with this'. One person has not been in further contact with the hospital. One person, who is still attending the programme, is coping with a major health problem in her child, a divorce and a malpractice court case.

For this group, patients were invited to be active participants in the exploration of possible advantages of CMT. As Goodare and Lockwood (1999) note, once patients understand what knowledge is sought they can offer insights from 'the inside'. In this spirit of research we also sought reflections on how they thought things had gone for them. Some participants felt this had been 'a revolutionary experience' and had never realized just how hostile they were with themselves and what inner compassion and acceptance felt like. Many noted that they had never felt self-compassion or soothing before and had few memories of others soothing them or feeling safe and protected by others. All thought it had been a very helpful experience. One patient wrote down her thoughts, shared them in the follow-up session and agreed that we could present them here.

I would just like to tell you all here today what (CMT) means to me. It seemed to awaken a part of my brain that I was not aware existed.

1. The feeling of only ever having compassion for other people and never ever contemplating having any for myself.
2. Suddenly realizing that it's always been there, just that I never knew how to use it towards myself.
3. It was such a beautiful, calming feeling to know it was OK to feel like this towards myself without feeling guilty or bad about it.
4. Being able to draw on this when I was frightened and confused, to calm myself down and to put things in perspective and say to myself 'IT'S OK TO FEEL LIKE THIS'.

Having compassion for myself means I feel so much more at peace with myself. Knowing that it is a normal way of life to

have compassion for myself and it's not an abnormal way of thinking, but a very healthy way of thinking. It felt like I was training my mind to switch to this mode when I start to feel bad about myself or life situations were starting to get on top of me.

What is striking about this, and what other participants thought, was how much they had (previously) felt that being self-compassionate and empathic to one's distress was a self-indulgence or weakness and definitely not something to cultivate. Someone who had had previous CBT felt that CBT was more initially acceptable in some ways because it smacked of being reasonable, sensible, being mature and in control and making oneself work hard. For them CMT, with its focus on allowing, tuning into distress, developing self-focused empathy and sympathy, and cultivating warmth, felt quite different and risky.

Although there is no control group we suggest it is unlikely that these changes would have occurred by natural time progression—given the length of time our participants had had their difficulties and that all of them had had various forms of drug and psychotherapy in the past. Importantly, however, they were well supported within the CBT based day programme and this would have significantly added to the effectiveness. We were able to build and blend in many of the CBT aspects they had already learnt, such as use of Socratic questioning, thought monitoring, re-evaluation and 'homework'. A downside was that, for those who had not taken part, seeing this group prosper had generated some envy, which was acknowledged and worked with by SP and her colleagues.

CMT should be conducted compassionately and the therapist models compassion and is non-defensive when problems arise (e.g., when patients become upset or angry because they feel the therapy is not helping). At times the therapists may use their own examples (Lynch et al., 2006). However, we have found that because the whole group is very explicitly focused on developing compassion (and not on 'challenging' negative thoughts as such, or interpreting behaviour or feelings) the whole atmosphere of the group helps to contain these issues and patients quickly switch to trying to be compassionate with each other, whilst at the same acknowledging possible conflicts (Bates, 2005). In addition, because the group is task focused they share difficulties, solutions and insights in trying to engage in certain of the tasks (e.g., developing self-empathy and generating

compassionate images, engaging in compassionate practice).

We have tried to indicate that in many respects CMT is clearly a hybrid of other therapies. However, CMT is rooted in an evolutionary approach to human psychology with a special focus on the neurophysiological and maturation processes of warmth and attachment systems. It fits with the increasing desire to understand both psychological and (neuro)physiological processes, and targeting therapies at not just psychological mechanisms but also key physiological systems (Cozolino, 2002; Gilbert & Irons, 2005). Our research group is currently trying to develop research in exploring possible physiological changes that may be associated with compassion training, for example effects on cortisol and oxytocin. We are still in the process of refining our approach and deepening our understanding. It is for example clear that many patients have various fears of compassion, see it as a weakness or have very little to guide them at first. Anger and hatred of self and others is often a key block. Therefore, working with these elements takes time. Although this is an early study, we hope that we have indicated the value of making self-compassion a specific focus for therapy, especially for those with long-term difficulties from harsh backgrounds. More research is needed to replicate these findings in better controlled studies and to explore the mechanisms of change (Brewin, 2006). However, for this group they found it a moving and 'deeply helpful' experience.

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REFERENCES

- Allan, S., & Gilbert, P. (1995). A social comparison scale: Psychometric properties and relationship to psychopathology. *Personality and Individual Differences*, *19*, 293–299.

- Allan, S., & Gilbert, P. (1997). Submissive behaviour and psychopathology. *British Journal of Clinical Psychology*, *36*, 467–488.
- Allan, S., Gilbert, P., & Goss, K. (1994). An exploration of shame measures: II: Psychopathology. *Personality and Individual Differences*, *17*, 719–722.
- Allen, N.B., & Knight, W.E.J. (2005). Mindfulness, compassion for self, and compassion for others. Implications for understanding the psychopathology and treatment of depression. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 239–262). London: Routledge.
- Andrews, B. (1998). Shame and childhood abuse. In P. Gilbert, & B. Andrews (Eds), *Shame: Interpersonal behavior, psychopathology and culture* (pp. 176–190). New York: Oxford University Press.
- Andrews, B., & Brewin, C.R. (1990). Attributions of blame for marital violence: A study of antecedents and consequences. *Journal of Family and Marriage*, *52*, 757–767.
- Baldwin, M.W. (ed.) (2005). *Interpersonal cognition*. New York: Guilford.
- Baldwin, M.W., & Dandeneau, S.D. (2005). Understanding and modifying the relational schemas underlying insecurity. In M.W. Baldwin (Ed.), *Interpersonal cognition* (pp. 33–61). New York: Guilford.
- Baldwin, M.W., & Holmes, J.G. (1987). Salient private audiences and awareness of the self. *Journal of Personality and Social Psychology*, *52*, 1087–1098.
- Bates, T. (2005). The expression of compassion in group psychotherapy. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 369–386). London: Routledge.
- Baumeister, R.F., & Leary, M.R. (1995). The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin*, *117*, 497–529.
- Bell, D.C. (2001). Evolution of care giving behavior. *Personality and Social Psychology Review*, *5*, 216–229.
- Bowlby, J. (1969). *Attachment: Attachment and loss*, Vol. 1. London: Hogarth.
- Bowlby, J. (1980). *Loss: Sadness and depression. Attachment and loss*, Vol. 3. London: Hogarth.
- Brewin, C.R. (2006). Understanding cognitive behaviour therapy: A retrieval competition account. *Behaviour Research and Therapy*, *44*, 765–784.
- Buchbinder, E., & Eisikovits, Z. (2003). Battered women's entrapment in shame: A phenomenological study. *American Journal of Orthopsychiatry*, *73*, 355–366.
- Buss, D.M., & Craik, K.H. (1986). Acts, dispositions and clinical assessment: The psychopathology of everyday conduct. *Clinical Psychology Review*, *6*, 387–406.
- Carter, C.S. (1998). Neuroendocrine perspectives on social attachment and love. *Psychoneuroendocrinology*, *23*, 779–818.
- Cassidy, J., & Shaver, P.R. (Eds). (1999). *Handbook of attachment: Theory, research and clinical applications* (pp. 115–140). New York: Guilford.
- Cheung, M.S.P., Gilbert, P., & Irons, C. (2004). An exploration of shame, social rank and rumination in relation to depression. *Personality and Individual Differences*, *36*, 1143–1153.

- Cook, D.R. (1993). *The Internalized Shame Scale manual*. Menomonie, WI: Channel (available from Author; Rt. 7, Box 270a, Menomonie, WI, 54751).
- Cook, D.R. (1996). Empirical studies of shame and guilt: The internalized shame scale. In D.L. Nathanson (Ed.), *Knowing feeling: Affect, script and psychotherapy* (pp. 132–165). New York: Norton.
- Cozolino, L. (2002). *The neuroscience of psychotherapy. Building and rebuilding the human brain*. New York: Norton.
- Davidson, R., & Harrington, A. (Eds). (2002). *Visions of compassion: Western scientists and Tibetan Buddhists examine human nature*. New York: Oxford University Press.
- Davidson, R.J., Kabat-Zinn, J., Schumacher, J., Rosenkranz, M., Muller, D. et al. (2003). Alterations in brain and immune function produced by mindfulness meditation. *Psychosomatic Medicine*, 65, 564–570.
- Depue, R.A., & Morrone-Strupinsky, J.V. (2005). A neurobehavioral model of affiliative bonding. *Behavioral and Brain Sciences*, 28, 313–395.
- Dickerson, S.S., & Kemeny, M.E. (2004). Acute stressors and cortisol response: A theoretical integration and synthesis of laboratory research. *Psychological Bulletin*, 130, 335–391.
- Driscoll, R. (1988). Self-condemnation: A conceptual framework for assessment and treatment. *Psychotherapy*, 26, 104–111.
- Dunkley, D.M., Zuroff, D.C., & Blankstein, K.R. (2003). Self-critical perfectionism and daily affect: Dispositional and situational influences on stress and coping. *Journal of Personality and Social Psychology*, 84, 234–252.
- Dunkley, D.M., Zuroff, D.C., & Blankstein, K.R. (2006). Specific perfectionism components versus self-criticism in predicting maladjustment. *Personality and Individual Differences*, 40, 665–676.
- Feiring, C., Taska, L., & Lewis, M. (2002). Adjustment following sexual abuse discovery: The role of shame and attributional style. *Developmental Psychology*, 38, 79–92.
- Ferguson, E. (2005). The use of diary methodologies in health and clinical psychology. In J.N.V. Miles, & P. Gilbert (Eds), *A handbook of research methods in clinical and health psychology* (pp. 111–124). Oxford: Oxford University Press.
- Ferster, C.B. (1973). A functional analysis of depression. *American Psychologist*, 28, 857–870.
- Field, A. (2005). *Discovering statistics using SPSS: Second edition*. London: Sage.
- Field, T. (2000). *Touch therapy*. New York: Churchill Livingstone.
- Forrest, M.S., & Hokanson, J.E. (1975). Depression and autonomic arousal reduction accompanying self-punitive behavior. *Journal of Abnormal Psychology*, 84, 346–357.
- George, M.S., Ketter, T.A., Parekh, P.I., Horwitz, B., Herscovitch, P., & Post, R.M. (1995). Brain activity during transient sadness and happiness in healthy women. *American Journal of Psychiatry*, 152, 341–351.
- 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: Erlbaum.
- Gilbert, P. (1992). *Depression: The evolution of powerlessness*. Hove: Erlbaum–New York: Guilford.
- Gilbert, P. (1993). Defence and safety: Their function in social behaviour and psychopathology. *British Journal of Clinical Psychology*, 32, 131–153.
- Gilbert, P. (1997). The evolution of social attractiveness and its role in shame, humiliation, guilt and therapy. *British Journal of Medical Psychology*, 70, 113–147.
- Gilbert, P. (1998). What is shame? Some core issues and controversies. In P. Gilbert, & B. Andrews (Eds), *Shame: Interpersonal behavior, psychopathology and culture* (pp. 3–36). New York: Oxford University Press.
- 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: Brunner-Routledge.
- Gilbert, P. (2003). Evolution, social roles, and differences in shame and guilt. *Social Research*, 70, 1205–1230.
- Gilbert, P. (2004). Depression: A biopsychosocial, integrative and evolutionary approach. In M. Power (Ed.), *Mood disorders: A handbook of science and practice* (pp. 99–142). Chichester: Wiley.
- 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.W. Baldwin (Ed.), *Interpersonal cognition*. (pp. 299–335). New York: Guilford.
- Gilbert, P. (in press). *Psychotherapy and counselling for depression*. London: Sage.
- Gilbert, P., Allan, S., & Goss, K. (1996). Parental representations, shame interpersonal problems and vulnerability to psychopathology. *Clinical Psychology and Psychotherapy*, 3, 23–34.
- Gilbert, P., Baldwin, M., Irons, C., Baccus, J., & Clark, M. (2006). Self-criticism and self-warmth: An imagery study exploring their relation to depression. *Journal of Cognitive Psychotherapy*, 20, 183–200.
- Gilbert, P., Clarke, M., Kempel, S., Miles, J.N.V., & Irons, C. (2004). Criticizing and reassuring oneself: An exploration of forms style and reasons in female students. *British Journal of Clinical Psychology*, 43, 31–50.
- Gilbert, P., & Irons, C. (2004). A pilot exploration of the use of compassionate images in a group of self-critical people. *Memory*, 12, 507–516.
- 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., & Leahy, R. (in press). *The therapeutic relationship in the cognitive behavioural psychotherapies*. London: Routledge.
- Gilbert, P., & Miles, J.N.V. (2000). Sensitivity to put-down: Its relationship to perceptions of shame, social anxiety, depression, anger and self–other blame. *Personality and Individual Differences*, 29, 757–774.

- Gilligan, J. (2003). Shame, guilt and violence. *Social Research*, 70, 1149–1180.
- Goodare, H., & Lockwood, S. (1999). Involving patients in clinical research: Editorial. *British Medical Journal*, 319, 724–725.
- Goss, K., Gilbert, P., & Allan, S. (1994). An exploration of shame measures: I: The 'other as shamer' scale. *Personality and Individual Differences*, 17, 713–717.
- Hackmann, A. (1998). Working with images in clinical psychology. In A. Bellack, & M. Hersen (Eds), *Comprehensive clinical psychology* (pp. 301–317). London: Pergamon.
- 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.
- Hayes, S.C., Strosahl, K.D., & Wilson, K.G. (2004). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford.
- Hayes, S.C., Wilson, K.G., Gifford, E.V., Follette, V.M., & Strosahl, K. (1996). Experiential avoidance and behavioral disorders: A functional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology*, 64, 1152–1168.
- Heimpel, S.A., Wood, J.A., Marshall, M.A., & Brown, J.D. (2002). Do people with low self-esteem really want to feel better? Self-esteem differences in motivation to repair negative moods. *Journal of Personality and Social Psychology*, 82, 128–147.
- Heinrichs, M., Baumgartner, T., Kirschbaum, C., & Ehlert, U. (2003). Social support and oxytocin interact to suppress cortisol and subjective response to psychosocial stress. *Biological Psychiatry*, 54, 1389–1398.
- Holmes, E.A., & Hackmann, A. (Eds). (2004). *Mental imagery and memory in psychopathology* (Special Edition: Memory Volume 12, No. 4). Hove: Psychology Press.
- Holmes, J. (2001). *The search for the secure base: Attachment theory and psychotherapy*. London: Brunner-Routledge.
- Irons, C., & Gilbert, P. (2005). Evolved mechanisms in adolescent anxiety and depression. The role of attachment and social rank systems. *Journal of Adolescents*, 28, 325–341.
- Irons, C., Gilbert, P., Baldwin, M.W., Baccus, J.R., & Palmes, M. (2006). Parental recall attachment relating and self-attacking/self-reassurance: Their relationship with depression. *British Journal of Clinical Psychology*, 45, 297–308.
- Kim, E.J. (2005). The effect of the decreased safety behaviors on anxiety and negative thought in social phobics. *Anxiety Disorders*, 19, 69–86.
- Leahy, R.L. (2002). A model of emotional schemas. *Cognitive and Behavioral Practice*, 9, 177–171.
- Leahy, R.L. (2005). A social-cognitive model of validation. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy*. (pp. 195–217). London: Brunner-Routledge.
- 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.
- Lehman, A.K., & Rodin, J. (1989). Styles of self-nurturance and disordered eating. *Journal of Consulting and Clinical Psychology*, 57, 117–122.
- Leighton, T.D. (2003). *Faces of compassion: Classic Bodhisattva archetypes and their modern expression*. Boston: Wisdom.
- Lewis, M. (1992). *Shame: The exposed self*. New York: Free Press.
- Lewis, M. (2003). The role of the self in shame. *Social Research*, 70, 1181–1204.
- Linehan, M. (1993). *Cognitive behavioral treatment of borderline personality disorder*. New York: Guilford.
- Lynch, T.R., Chapman, A.L., Rosenthal, M.Z., Kuo, J.R., & Linehan, M. (2006). Mechanisms of change in Dialectical Behaviour Therapy: Theoretical and empirical observations. *Journal of Clinical Psychology*, 62, 459–480.
- MacDonald, K. (1992). Warmth as a developmental construct: An evolutionary analysis. *Child Development*, 63, 753–773.
- McKay, M., & Fanning, P. (1992). *Self-esteem: A proven program of cognitive techniques for assessing, improving, and maintaining your self-esteem* (2nd ed.). Oakland, CA: New Harbinger.
- 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. (2005). Mental representations of attachment security: Theoretical foundations for a positive social psychology. In M.W. Baldwin (Ed.), *Interpersonal cognition* (pp. 233–266). New York: Guilford.
- Murphy, J.M., Nierenberg, A.A., Monson, R.R., Laird, N.M., Sobol, A.M., & Leighton, A.H. (2002). Self-disparagement as a feature and forerunner of depression: Findings from the Stirling County study. *Comprehensive Psychiatry*, 43, 13–21.
- 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.
- Neff, K.D., Kirkpatrick, K.L., & Rude, S.S. (in press). Accepting the human condition: Self-compassion and its links to adaptive psychological functioning. *Journal of Personality*.
- Panksepp, J. (1998). *Affective neuroscience*. New York: Oxford University Press.
- Perry, B.D., Pollard, R.A., Blakley, T.L., Baker, W.L., & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation and 'use-dependent' development of the brain: How 'states' become 'traits'. *Infant Mental Health Journal*, 16, 271–291.
- Rector, N.A., Bagby, R.M., Segal, Z.V., Joffe, R.T., & Levitt, A. (2000). Self-criticism and dependency in depressed patients treated with cognitive therapy or pharmacotherapy. *Cognitive Therapy and Research*, 24, 571–584.
- Rein, G., Atkinson, M., & McCraty, R. (1995). The physiological and psychological effects of compassion and anger. *Journal for the Advancement of Medicine*, 8, 87–105.

- Ringu Tilku Rinpoche & Mullen, K. (2005). The Buddhist use of compassionate imagery in Buddhist mediation. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 218–238). London: Brunner-Routledge.
- Sachs-Ericsson, N., Verona, E., Joiner, T., & Preacher, J.K. (2006). Parental verbal abuse and the mediating role of self-criticism in adult internalizing disorders. *Journal of Affective Disorders*, 93, 71–78.
- Salkovskis, P.M. (1996). The cognitive approach to anxiety: Threat beliefs, safety-seeking behavior, and the special case of health anxiety and obsessions. In P.M. Salkovskis (Ed.), *Frontiers of cognitive therapy* (pp. 48–74). New York: Guilford.
- Savard, J., Laberge, B., Gauthier, J.G., Ivers, H., & Bergeron, M.G. (1998). Evaluating anxiety and depression in HIV-infected patients. *Journal of Personality Assessment*, 7, 349–367.
- Scharffee, J.S., & Tsignouis, S.A. (2003). *Self hatred in psychoanalysis: Detoxifying the persecutory object*. London: Brunner-Routledge.
- Schore, A.N. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development*. Hillsdale, NJ: Erlbaum.
- Schore, A.N. (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal*, 22, 201–269.
- Segal, Z., Williams, J.M.G., & Teasdale, J. (2002). *Mindfulness-based cognitive therapy for depression. A new approach to preventing relapse*. New York: Guilford.
- Shapiro, S.L., Astin, J.A., Bishop, S.R., & Cordova, M. (2005). Mindfulness-based stress reduction for health care professionals: Results from a randomised control trial. *International Journal of Stress Management*, 12, 164–176.
- Sharhabani-Arzy, R., Amir, M., & Swisa, A. (2005). Self-criticism, dependency and posttraumatic stress disorder among a female group of help seeking victims of domestic violence. *Personality and Individual Differences*, 38, 1231–1240.
- Slovan, L., Gilbert, P., & Hasey, G. (2003). Evolved mechanisms in depression: The role and interaction of attachment and social rank in depression. *Journal of Affective Disorders*, 74, 107–121.
- Stuewig, J., & McCloskey, L.A. (2005). The relation of child maltreatment to shame and guilt among adolescents: Psychological routes to depression and delinquency. *Child Maltreatment*, 10, 324–336.
- Tangney, J.P., & Dearing, R.L. (2002). *Shame and guilt*. New York: Guilford.
- Teasdale, J.D., & Cox, S.G. (2001). Dysphoria: Self-devaluative and affective components in recovered depressed and never depressed controls. *Psychological Medicine*, 31, 1311–1316.
- Thwaites, R., & Freeston, M.H. (2005). Safety-seeking behaviours: Fact or fiction: How can we clinically differentiate between safety behaviours and additive coping strategies across anxiety disorders. *Behavioural and Cognitive Psychotherapy*, 33, 177–188.
- Uv ns-Morberg, K. (1998). Oxytocin may mediate the benefits of positive social interaction and emotions. *Psychoneuroendocrinology*, 23, 819–835.
- 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.
- Watkins, E. (2005, Oct.). *Rumination*, Workshop for Derbyshire Mental Health Trust.
- Watkins, M. (1986). *Invisible guests: The development of imaginal dialogues*. Hillsdale, NJ: Analytic-Erlbaum.
- Wells, A. (2000). *Emotional disorders and metacognition: Innovative cognitive therapy*. Chichester: Wiley.
- Wheeler, L., & Reis, H.T. (1991). Self-recording of everyday life events: Origins, types and uses. *Journal of Personality*, 59, 339–354.
- Whelton, W.J., & Greenberg, L.S. (2005). Emotion in self-criticism. *Personality and Individual Differences*, 38, 1583–1595.
- Zigmond, A.S., & Snaith, R.P. (1983). The Hospital Anxiety and Depression Scale. *Acta Psychiatrica Scandinavica*, 67, 361–370.
- Zuroff, D.C., Koestner, R., & Powers, T.A. (1994). Self-criticism at age 12: A longitudinal study of adjustment. *Cognitive Therapy and Research*, 18, 367–385.
- Zuroff, D.C., Santor, D., & Mongrain, M. (2005). Dependency, self-criticism, and maladjustment. In J.S. Auerbach, K.N. Levy, & C.E. Schaffer (Eds), *Relatedness, self-definition and mental representation. Essays in honour of Sidney J. Blatt*. (pp. 75–90). London: New York.

APPENDIX 1. DEVELOPING QUALITIES OF INNER COMPASSION

As we have seen from our work together, being self-critical can be very stressful and make us feel worse. One way of coping with disappointment and our ‘inner bully’ is to learn to be compassionate to the self. This requires a number of things of us:

1. **Valuing compassion.** Some people are worried that if they are compassionate with themselves they may somehow be weak or lack the drive to succeed. Thus, they don’t really value compassion. However, if we think about people who are renowned for their compassion, such as Buddha, Jesus, Ghandi, Florence Nightingale and Nelson Mandela, they can hardly be regarded as weak or ‘unsuccessful’. Learning to be compassionate can actually make us stronger and feel more confident.
2. **Empathy.** Empathy means that we can understand how people feel and think, see things from their point of view. Similarly, when we have empathy for ourselves we can develop a better understanding for some of our painful

- feelings of disappointment, anxiety, anger or sadness. This can mean we may need to learn when to be *gently sensitive to our feelings and distress*—rather than try not to notice them or avoid them. Sometimes we tell ourselves that we shouldn't feel or think as we do, and try to deny our feelings rather than working with them. The problem with this is that we don't explore them to understand them and then they can be frightening to us. We can learn to understand how and why we became self-critical, often because we feel threatened in some way. Becoming empathic means coming to see the threats that lay behind self-criticism.
3. **Sympathy.** Sympathy is less about our understanding and more about feeling and wanting to care, help and heal. When we feel sympathy for someone, we can feel sad or distressed with them. Learning to have sympathy for *ourselves* means that we can learn to be sad, without being depressed, e.g., without telling ourselves that there is something wrong or bad about feeling sad. We can also focus on feelings of *kindness in our sympathy*.
 4. **Forgiveness.** Our self-critical part is often very unforgiving, and will usually see any opportunity to attack or condemn as an opportunity not to be missed. Learning the art of forgiveness, however, can be important. Forgiveness allows us to learn how to change; we are open to our mistakes and learn from them.
 5. **Acceptance/tolerance.** There can be many things about ourselves that we might like to change, and sometimes it is helpful to do that. However, it is also important to develop acceptance of ourselves as human beings 'as we are' with a full range of positive and negative emotions. Acceptance isn't passive resignation, such as feelings of being defeated, or not bothering with oneself. It is an *open-heartedness* to all our fallibilities and efforts. It is like having the flu and accepting that you have to go to bed perhaps but also doing all you can to help your recovery.
 6. **Developing feelings of warmth.** This requires us to begin to experience and practice generating *feelings* of warmth for the self. To do this we can use images and practice feeling warmth coming into us. When we are depressed this feeling may be very toned down and hard to generate—so we will have to practice. It can seem strange and sometimes even frightening—so we can go step at a time.
 7. **Growth.** Compassion is focused on helping people grow, change and develop. It is life enhancing in a way that bullying often is not. When we learn to be compassionate with ourselves, we are learning to deal with our fallible selves, such that we can grow and change. Compassion can also help us face some of the painful feelings we wish to avoid.
 8. **Taking responsibility.** One element of compassionate mind work is taking responsibility for one's self-critical thinking. To do this we can learn to recognize when it's happening and then use our compassionate side to provide alternative views and feelings.
 9. **Training.** When we attack ourselves we stimulate certain pathways in our brain but when we learn to be compassionate and supportive to our efforts we stimulate different pathways. Sometimes we are so well practiced at stimulating inner attacks/criticisms that our ability to stimulate inner support and warmth is rather under-developed. Hence, now that we have seen how we can generate alternatives to our self-attacking thoughts, we can explore ways to help them have more emotional impact. It does not take away painful realities but it can help us to cope in a different way. The training part can be like going to a physiotherapist, where you learn to do exercises and build up certain strengths. The compassion systems in your brain are the ones we are trying to strengthen with our exercises.

APPENDIX 2. BUILDING A COMPASSIONATE IMAGE

This exercise is to help you *build* up a compassionate image for you to work with and develop (you can have more than one if you wish, and they can change over time). Whatever image comes to mind, or you choose to work with, note that it *is your* creation and therefore your own personal ideal—what you would really like from feeling cared for and cared about. However, in this practice it is important that you try to give your image certain qualities. These will include:

Wisdom, Strength, Warmth and Non-judgement

So in each box below think of these qualities (wisdom, strength, warmth and non-judgement) and imagine what they would look, sound and feel like.

If possible we begin by focusing on our breathing, finding our calming rhythm and making a half smile. Then we can let images emerge in the mind—as best we can—do not too try to hard—if nothing comes to the mind, or the mind wanders, just *gently* bring it back to the breathing and practice compassionately accepting.

Here are some questions that might help you build an image: would you want your caring/nurturing image to feel/look/seem old or young; male or female (or non-human looking, e.g., an animal, sea or light)? What colours and sounds are associated with the qualities of wisdom, strength, warmth and non-judgement? Remember your image brings compassion to you and for you.

How would you like your ideal caring-compassionate image to look—visual qualities?	
How would you like your ideal caring-compassionate image to sound (e.g., voice tone)?	
What other sensory qualities can you give to it?	
How would you like your ideal caring-compassionate image to relate to you?	
How would like to relate to your ideal caring-compassionate image?	

