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Compassion Focused Group Therapy for Recovery after Psychosis

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This chapter outlines the application of an evolutionary model of emotion regulation, Compassion Focused Therapy (CFT),[1] in a group therapy that aims to promote emotional recovery from psychosis. CFT was specifically developed for people with high shame and self-criticism (Gilbert, 2000, 2010a, 2010b). We will describe the theoretical principles of CFT and suggest that the regulation of threat processing through stimulation of soothing and affiliation is a valid and promising therapeutic focus in the treatment of psychosis.

Theoretical Background

Emotional recovery from psychosis

Emotional recovery is a key dimension of overall recovery from psychosis (Birchwood, 2003). Problematic emotional recovery is characterized by depression, hopelessness and suicidal thinking (Birchwood *et al.*, 2000a), social anxiety (Gumley *et al.*, 2004; Birchwood *et al.*, 2006) and trauma (Morrison *et al.*, 2003). In addition, shame and stigma (Iqbal *et al.*, 2000; Rooke and Birchwood, 1998), feeling trapped in one's illness (Karatzias *et al.*, 2007) and the fear of recurrence (White and Gumley, 2009) significantly

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undermine emotional recovery. Although CBT for psychosis has demonstrated effectiveness in alleviating distressing persisting positive psychotic symptoms, there is less evidence for its effectiveness on key aspects of emotional recovery (Wykes *et al.*, 2008). The roles of affect regulation, attachment, mentalizing and self-organization in the development and recovery from psychosis are increasingly recognized (Garfield, 1995; Gumley and Schwannauer, 2006).

Threat and psychosis

Many psychopathologies are linked to threat processing focusing on the external world (e.g. the action of others) or the internal world (e.g. one's own feelings, thoughts or intrusive memories) (Gilbert, 1993). Psychosis is also strongly linked to negative affect and threat appraisal (Freeman and Garety, 2003).

There are many reasons why people can become highly sensitized to threat. The high rates of psychosocial stressors in early life such as losing a parent before the age of 16 (Morgan *et al.*, 2007), childhood abuse and neglect (Read *et al.*, 2005), parenting marked by control in the absence of warmth (Read and Gumley, 2008), bullying, witnessing violence at home, homelessness, being in care, assault (Bebbington *et al.*, 2004), poverty (Harrison *et al.*, 2001) and racial discrimination (Bhugra *et al.*, 1997) might partly account for the pronounced threat sensitivity seen in people with psychosis (Myin-Germeys and van Os, 2007). High rates of insecure, especially dismissive, and disorganized attachment styles have been identified in this population (Dozier, 1990; Tyrrell and Dozier, 1997; Berry *et al.*, 2008). Central to these findings is that they seem to reflect a lack of individuals' experience of safeness in early relationships and in their ability to self-soothe (Liotti and Gumley, 2009).

Following a psychotic episode people experience major internal threats. Bullying voices, traumatic memories, low self-worth, shame and self-attacking (often related to delusional beliefs) maintain a high level of internal threat, conflict, distress and entrapment (Birchwood *et al.* 2000; Gilbert *et al.*, 2001; Longe *et al.*, 2010). The generation of voices is associated with voice hearers misidentifying critical internal signals/speech as critical external signals/speech (McGuire *et al.*, 1996). This external attribution in turn increases threat and entrapment by reducing the sense of control individuals perceive to have over their mental state (Birchwood *et al.*, 2000).

They way in which the individual experiences the external world relating to them and to their psychotic experience determine the level of social threat. The trauma of the psychosis itself and its often devastating impact may further dysregulate affect (Gumley and Schwannauer, 2006). Relapses

and being (re)traumatized by coercive service responses (Frame and Morrison, 2001) pose actual threats, which can interfere with people's willingness to engage with services and to disclose distress. Fears of being victimized, physically harmed, stigmatized and excluded also foster submission, social withdrawal and isolation. Hypervigilance of social threats followed by active avoidance is thought to contribute to paranoia and social anxiety, which in turn increase the perception of social threat (Green and Phillips, 2004). Shame and stigma are common in psychosis and block affiliative connections to others, promote avoidance and increase social anxiety (Gilbert and Andrews, 1998; Birchwood *et al.*, 2006).

Avoidant coping strategies such as submitting to voices or to others by complying or appeasing (Birchwood *et al.*, 2000), thought suppression (Spinhoven and van der Does, 1999), or 'sealing over' (McGlashan, 1987) are common and understandable attempts to cope. Unfortunately, sealing over strategies such as down-regulating threats by minimizing the impact of the psychosis, being reluctant to talk about the psychosis or to explore its underlying emotional issues are linked to worse engagement (Tait *et al.*, 2003), impaired mentalizing (Braehler and Schwannauer, 2011) and worse outcome (Thompson *et al.*, 2003).

In summary, the data suggest that people with psychosis suffer from major difficulties in regulating threat.

The role of affiliation in the regulation of threat

The evolution of attachment as a protective and provisioning relationship for the infant has had profound effects on subsequent evolution and on affect regulation and social cognition in particular (Gilbert, 1989, 2005; Porges, 2007). Research over the past 20 years has shown just how powerful – especially early – attachment relationships are in shaping physiological and phenotypic development (Belsky *et al.*, 2007; Cozolino, 2007; Porges, 2007). Specialized neurophysiological systems underpinning our capacity to process affiliation (Depue and Morrone-Strupinsky, 2005) have been found to down-regulate fear (Kirsch *et al.*, 2005). Affiliation and affection play major roles in the maturation of the brain, in particular of areas involved in social cognition and empathy (Schore, 1996). Feelings of safeness and security as provided by experiences of affiliation and attachment have profound effects on abilities to process social information, mentalize and regulate affect (Fonagy *et al.*, 2002). Some people with psychosis might become fearful of others due to a heightened threat sensitivity and due to difficulties in affect recognition, mentalizing and theory of mind skills – rendering the 'minds of others' strange and unfathomable (Penn *et al.*, 1997; Russell *et al.*, 2000). Therefore, poor affiliation skills to self and to others

may reduce mentalizing (MacBeth *et al*., 2011) and may increase distress, avoidance, social withdrawal and risk of relapse (Gumley *et al*., 2010).

Given that individuals with psychosis may have increased threat sensitivity and decreased affiliative capacity, it follows that one therapeutic target would be to increase the abilities for affiliation both with self and with others.

Definition of compassion

Compassion can be defined in different ways (Gilbert, 2010). In CFT compassion is related to a number of attributes that include – developing the *motivation* to be caring in order to address distress and suffering; capacities to be *attentive* to suffering within the self or others; to be emotionally engaged (in sympathy and in tune with) and moved by suffering of self and others; to be *tolerant* of emotions of distress that can be aroused; abilities to develop *empathic* insights into the causes and sources of suffering of self and others; capacities to take a non-condemning, open and mindful orientation to the process. Common misunderstandings about compassion are that it involves a striving to attain a state of serene bliss or 'niceness' free from negative emotions. In keeping with attachment theory, CFT helps build an internal secure base and trains us in capacities for soothing and courage, which allow us to descend into, turn towards and contain our emotional pain.

Evidence-base of compassion-based interventions in psychosis

Research on the application of CFT in psychosis is at an early stage. Questions about the understandability, relevance, effectiveness and common difficulties of using this approach with people with psychosis require further attention. In a first attempt to address these questions Mayhew and Gilbert (2008) used a single case design with three individuals who heard distressing malevolent voices, but who were not actively psychotic. Following 12 individual sessions of CFT, two did very well and one less so. The clients who significantly improved found the compassion focus a new way of relating to themselves and others. The individual who did less well felt he 'didn't deserve compassion' and was dominated by intrusive fantasies that he felt too ashamed to discuss. This is not an uncommon problem and speaks of the complex relationship between self-compassion and shame (Gilbert, 2010). Johnson and colleagues evaluated the effects of Loving Kindness Meditation in 18 outpatients with persistent negative symptoms (Johnson *et al*., 2011). After six sessions participants reported a significant increase in positive

emotions, self-acceptance, mastery, life satisfaction and a significant decrease in negative symptoms mainly in anhedonia. In a study of 20 sessions of group CFT for 19 clients with psychosis in a high security psychiatric setting, Laithwaite and colleagues (2009) found a large magnitude of change for levels of depression and self-esteem. In addition moderate effects were found for social comparison and general psychopathology, with a small magnitude of change for feelings of shame. These changes were maintained at 6-week follow-up. Braehler and colleagues (in press) assessed the feasibility of randomization and the acceptability of group CFT in a community setting. Twenty-two clients with psychosis received 16 sessions of group CFT and treatment as usual. Relative to TAU, CFT was associated with greater clinical improvement and an increase of compassion of large magnitude. In the CFT group increases in compassion were associated with reductions in depression and social marginalization. The evidence, albeit limited at this stage, suggests that CFT is safe and acceptable to use with this population.

Compassion focused group therapy for recovery after psychosis

The present protocol further developed a forensic group manual (Laithwaite *et al*., 2009) by running groups in a community setting (Braehler *et al*., in press). A compassion-focused formulation of recovery stresses the adverse emotional and interpersonal consequences that psychotic experiences typically have on a person's life (Gumley *et al*., 2010). At the heart of group CFT for psychosis (CFTgp) is the development of compassionate relating to threats experienced in psychosis. Emotional resilience is developed through the gradual desensitization to self-compassion using psychoeducation, mindfulness and compassion practices, reframing, interpersonal learning, building of peer attachments and narrative tasks. Recommendations for interpersonal group therapy in psychosis (Kanas, 1996; Yalom, 1983) and aspects of mindfulness training (Nairn, 1999; Segal *et al*., 2002) were also taken into account.

Practical Considerations

Selecting group participants

Case studies and feasibility data suggest that the majority of people recovering from psychosis may be able to engage with and benefit from CFT (Mayhew and Gilbert, 2008; Laithwaite *et al*., 2009; Braehler *et al*., in press). Group CFT targets transdiagnostic processes (e.g. shame,

stigma, self-criticism, social avoidance). It has benefited clients with a primary diagnosis of chronic treatment-resistant schizophrenia – including those with mild cognitive impairment and limited literacy skills – as well as clients within the first 3 to 5 years following their first episode and those with other psychotic disorders. Clients with severe negative symptoms, little insight into the fact that they have a mental health problem, severe impairment through co-morbidities or severe preoccupation with delusions were not found to benefit (Braehler *et al.*, in press; Laithwaite *et al.*, 2009). These client groups also show limited benefit from traditional Cognitive Behaviour Therapy for Psychosis (Tai and Turkington, 2009). An earlier study (Laithwaite *et al.*, 2009) found that individuals who were severely psychotic and who were struggling to cope with their psychotic experiences were unlikely to benefit or sustain inclusion in CFTgp. Based on our experience, suitable participants are usually in a post-acute phase of their illness when psychotic symptoms are less severe and they are able to function at a reasonable level. It may be that further adaptations for individuals more debilitated by their symptoms could be successful.

During individual sessions therapists engage clients and conduct a standard psychological assessment including psychotic symptoms (intensity, frequency, content, distress, coping, personal meaning), background (including trauma) and their impact on emotional and interpersonal functioning including any attempts to cope and unintended consequences thereof (see examples in Figure 12.1). People who do not accept the label of psychosis for their experiences (e.g. because they attribute spiritual meaning) are eligible as long as they are able to begin to consider a psychological understanding of their emotional difficulties and have some motivation to work on those. People who experience paranoia and social anxiety need to be sufficiently motivated to work through the initial threat of participating in a group.

Engagement in CFT happens throughout by focusing away from the psychosis onto its adverse impacts and by repeatedly validating clients' coping strategies as their best effort to deal with difficult situations. Although members might vary with regards to their illness models, CFT fosters mutual respect of different ways of making sense by focusing members' attention on their joint goal, their common emotional difficulties and the universality of emotional suffering.

While some clients were able to benefit without having had therapy previously, we would recommend combining the group with individual therapy prior to the group starting in order to make sense of and cope with psychotic symptoms. In some cases we would also recommend individual therapy after the group in order to integrate any emotional issues (grief, trauma) activated through compassion work.

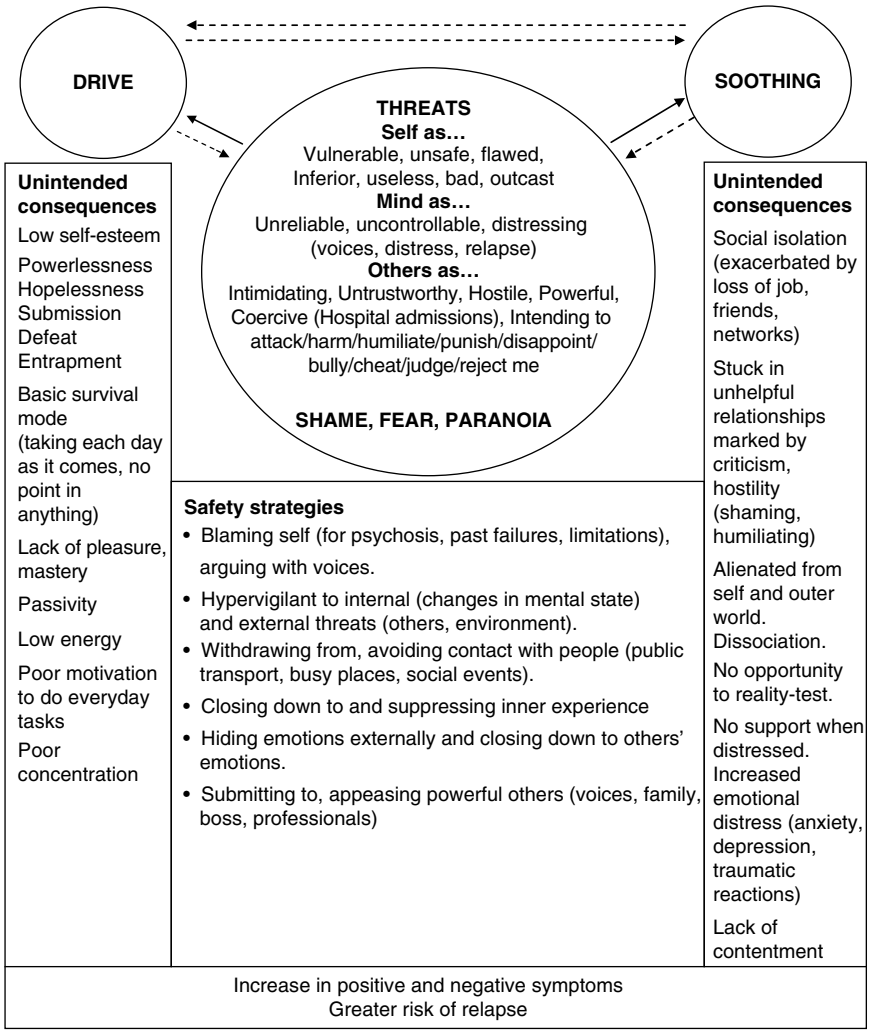

Figure 12.1 A compassion focused formulation of challenges in recovery from psychosis.
Note: ------ dashed lines indicates reduced feedback mechanism

Structural issues

Setting up the group
Further research is needed to determine the ideal format (number of sessions, structure) for running groups with this client group. The present recommendations are based on feedback from our study and on general guidelines for group therapy for psychosis (Yalom, 1983; Kanas, 1996). We recommend delivering the protocol over at least 20 sessions (2 hours per

week). A closed format simplifies the key task of developing trust to engage with others. A therapeutic group should consist of at least five and a maximum of eight members since any more would render the setting too complex and intimidating (Bateman and Fonagy, 2007).

A first step towards creating a safe and relaxed environment is to hold meetings in a private, protected room with easy access to smoking areas, refreshments and toilets. Offering informal breaks with refreshments helps initiate informal conversations between members and allows them to take a break from 'hot' topics thereby helping to maintain a therapeutic level of arousal. Members have welcomed a call from therapists prior to the session to deal with barriers to attending such as poor memory, increased distress, low mood or poor motivation.

Structure of sessions

To further reduce anxiety sessions follow the same structure. As members arrive therapists check in with everybody informally. To cue clients' memories, which are often impaired, the session begins by therapists providing a written summary of the previous session, talking through key points and answering any questions. After a brief mindfulness exercise members are invited to feed back on their mental state and their experiences of trying out homework tasks over the past week. Therapists then introduce a particular focus and exercise for each session, which draws on members' current concerns and offers sufficient space for exploration of experiences, exchange and supportive interactions; the latter making up at least half the session. Sessions end with a summary, introduction of homework and final feedback on how members are feeling.

Support outside of sessions

In an outpatient setting, a group format does not always allow for identification of significant deterioration in mental health or risk issues and members are advised to make use of their usual professional and personal supports when necessary. Contact with therapists between sessions is restricted to issues that might affect their group participation.

Role and qualities of the therapist

The therapist's key task is to create a safe and sensitive interpersonal environment (Gilbert, 2010). Through conveying warmth, openness and patience, therapists create a relaxed atmosphere of playfulness, collaboration and mutual acceptance. Therapists require the ability to hold the safe space by maintaining the agreed structure, setting boundaries and allowing sufficient opportunity for sharing and exploration. Personal practice of mindfulness and compassion has shown to improve both

therapists' attunement to clients' needs and clients' outcomes (Grepmair *et al.*, 2007; Siegel, 2010). In addition to receiving supervision, having one's own practice to draw on helps therapists to feel confident in flexibly guiding members in working with the compassion/attachment system.

Groups should be conducted with a co-therapist. This helps with monitoring and supporting distressed individuals during and after sessions. In our experience derogatory voices, traumatic memories or blocked grief can be activated during compassion practices. Individual attention and support is critical to help the person refocus on the feeling of safeness, kindness and wisdom, from which they are able to contain the affect. Having a co-therapist also offers an opportunity to model compassionate relating, reframing and reflexivity. The interactions between therapists make transparent their caring intentions towards members, which reduces the possibility of paranoid interpretations and foster a sense of existing positively in the mind of the therapists.

Therapeutic skills and interventions

To deliver CFTgp, therapists need to draw on a host of skills. First, experience of applying a psychological therapy for psychosis such as CBT is essential (Steel, this volume). Second, therapists require training and supervised experience in applying CFT which includes experiential training in mindfulness and compassion (www.compassionatemind.co.uk). Third, experience of facilitating group therapy is helpful (Yalom, 1995).

The therapeutic process itself is rooted in CBT rather than a psychodynamic approach, which would focus on unconscious processing. The format involves guided discovery and guided self-practice using an array of CBT skills such as Socratic questioning, functional analysis, graded exposure and behavioural experiments. Therapists' non-verbal behaviour (slowing down, calm, warm tone of voice, etc.) is a key medium for conveying interpersonal safeness (Gilbert, 2010). While mentalizing abilities in people with psychosis vary, they generally tend to be low (Braehler and Schwannauer, 2011; MacBeth *et al.*, 2011). Interventions and communications should therefore be clear, concise, focus on the here and now and be delivered at an optimal level of arousal such as by avoiding overarousal or intellectualization (Bateman and Fonagy, 2007). Socratic questioning can be useful to encourage people to think about emotions and motives in their mind and in the minds of others (e.g. What do you think might be going through Clare's mind? What do you think she might be feeling? Why do you think she might be feeling this way? How might she deal with this feeling?*)*.

Another feature of CFT is the focus on the body as the seat of emotional experience. Therapists regularly ask members to slow down to attend to

their physical sensations to help them tune into their present-moment experience and to approach it with curiosity and kindness. Describing the body's state (sensations, posture, facial expressions, tone of voice), labelling emotions and noticing concurrent thoughts aims to develop metacognitive awareness (Teasdale *et al.*, 2002). By strengthening the capacity to kindly observe our experience we increase tolerance of distress and reduce fear of positive and negative emotions (Linehan, 1993; Gilbert, 2010).

Clinically, we observe that many clients with psychosis have difficulties connecting with affect. They either down-regulate affect or are blunted or show an incongruent expression of affect especially when talking about upsetting events. Findings on attachment (Dozier, 1990; Tyrrell and Dozier, 1997; Berry *et al.*, 2008) and coping strategies (McGlashan, 1987; Spinhoven and van der Does, 1999) suggest that these are important safety strategies. To avoid unnecessary destabilization, CFT therapists introduce compassion practices gradually with playfulness and curiosity. In this atmosphere members can experiment with different exercises and familiarize themselves with the feeling at their own pace.

Group process

Similar to traditional CBT for psychosis groups, CFT group therapy is structured and task-focused. CFT differs from traditional CBT in that it explicitly utilizes the emerging group processes to support the development of compassionate skills and attributes (Gilbert and Procter, 2006). Group therapy naturally provides a social environment where the presence of mirroring minds and group therapeutic factors such as hope, cohesion, universality, identification, interpersonal learning and altruism (Yalom, 1995; García-Cabeza and González de Chávez, 2009) can be capitalized on. If facilitated effectively, the group becomes a lived experience of the caregiving-mentality, which naturally counteracts the isolation, shame and fear members feel. In CFT the group serves as a secure base from which to explore one's inner experience through the minds of others with qualities of sympathy, distress tolerance, empathy, non-judgement, care for well-being and sensitivity (Bateman and Fonagy, 2007; Liotti and Gilbert, 2011).

In our experience, the group atmosphere is at first often marked by a dominant-subordinate mentality between clients and towards therapists due to the high level of threat associated with social settings. Subordinate individuals protect themselves through silence, withdrawing or appeasing other. This hinders exploration and interaction between members and focuses attention excessively on therapists. While more therapist-client interactions in the initial sessions are acceptable, it is the therapists' task to create social safeness and to facilitate co-operative client-to-client relating

as sessions go on. This can be done by containing dominant individuals, by openly resolving any conflict and by opening up discussion to others (e.g. Can others relate to John's experience? What reactions did you notice within yourselves as you were listening to John?). Therapists need to both encourage participation while respecting the adaptive use of such safety strategies in some members.

Treatment Protocol

We present the key therapeutic tasks and processes including adaptations for working with psychosis and feedback from clients and therapists who participated in our groups. These are suggestions, which need to be adapted to your setting, to the needs and abilities of the group and the evolving group dynamics.

Formation phase

In the first phase members explore the impact psychotic experiences have had on their lives and formulate ways to overcome blocks to recovery in terms of the CFT model. Members bond over their shared experiences and the compassionate motivation is activated through the insights derived from the model and the setting of a joint recovery goal. The following three steps should be carried out over the first sessions at an appropriate pace for the group concerned.

1 Establishing the group as a secure base
The goal of the first contacts is to begin to create safeness. Prior to the first session, members are sent an invitation outlining the details of the group but also reminding them of how it is normal to feel anxious and that there will be no pressure to speak in the group. In the first session, after a meet and greet where members are given name labels, therapists introduce the goals and structure of the group and remind members that all contributions are voluntary. During an ice-breaker task members work in pairs to find out about, for example, their partner's favourite hobby/TV show/meal and introduce their partner to the group. This reduces the anxiety about introducing oneself. Members' hopes and expectations of the group are shared and ground rules agreed upon. A further task that can be carried out in pairs or triads involves using cards listing negative, positive and neutral feelings to help members share their feelings about coming to the group and how they are finding the first session. This helps to acknowledge and normalize feelings of anxiety and helps to instill hope

and excitement about future sessions. Therapists provide additional support to members who appear anxious and quiet.

2 Learning how the threat system gets in the way of recovery
Formulation involves therapists mapping the psychosis and its impact in terms of the CFT model. Therapists begin by describing common psychotic experiences in basic terms not to educate but to encourage members to share their own experiences and meanings. It is important that group members have a shared understanding of what is meant by psychotic experiences. Often individuals have not had or taken the opportunity to speak about the psychosis and its consequences. Clients often avoid talking about their experiences as staff may respond in an alarming way (admission, increase of medication). The fears surrounding the psychosis prevent clients from making sense of and integrating their experiences. This systematic avoidance also reinforces individuals' fear of relapse, sense of defeat, entrapment and disconnection from others.

The focus of the exploration then shifts to the impact that the psychosis – its symptoms, treatment and emotional distress – is currently having on members' lives. To facilitate this exploration in the group, therapists can use the metaphor of a pebble dropping into water and causing ripples as a way of illustrating how the psychosis has affected their sense of self, emotions, behaviour and relationships to others and society in general (Laithwaite *et al*., 2009).

Members usually express feeling shame, anxiety and vulnerability. At this early stage members often only connect with *ongoing* threatening experiences as opposed to earlier threat memories as this feels less overwhelming. Some members talk about their psychotic beliefs or behaviours in a light-hearted way while others are merely ready to listen. As members recognize that they all share difficult experiences, they feel huge relief and an initial sense of cohesion, safeness and trust develops. This shared humanity with regard to psychosis (We're all in the same boat) allows others to gradually open up and share some of their often painful experiences. For this same reason members can find this session challenging as it gets them in touch with the negative affect they tend to suppress.

Therapists teach clients about the causes of suffering being rooted in the basic design of our minds and in its evolutionary adaptations. It is emphasized that neither the design of our minds nor the forces which have shaped our mind – society, upbringing and genes - were chosen by us. This concept of 'just finding ourselves here with a brain and mind we didn't choose' is fundamental to beginning the process of de-shaming. Members often blame themselves for the psychosis and their current life situation. They are encouraged to realize that none of this is their fault. By dropping shaming, blaming and fear of stigma individuals can begin to feel less threatened and more empowered in their recovery.

Therapists teach members about how our minds have evolved with three basic types of emotion regulation systems ('3 circle model') and what their functions are (see Figure 12.2).

First, therapists explain how the threat-system is critical for our survival by triggering fast and automatic action responses to protect ourselves. Different threats and ways in which the threat system is trying to keep members safe are explored and validated as automatic safety reactions. Because self-protection is so vital to our survival, threat processing overrides positive emotions. In light of the pervasive threats from self, mind and others following a psychotic episode, it is understandable that the threat system has overruled the drive and soothing/affiliation system. To help clients reduce shame and self-blame it is critical to repeatedly validate the use of safety strategies such as avoidance as an automatic survival strategy.

> It is very understandable that you would be feeling frightened and that you would avoid others since you had such negative experiences (e.g. others threatening, bullying you). That makes sense since we all want to protect ourselves from getting hurt or from feeling bad about ourselves. We all want to be safe, so our body and brain automatically kick in to protect ourselves. We didn't design this, so it is not our fault. These safety strategies have been built into our bodies and brains to help us survive over millions of years. There is, however, a downside to avoiding others for longer periods. As you said you still feel vulnerable so that feeling you were trying to protect yourself

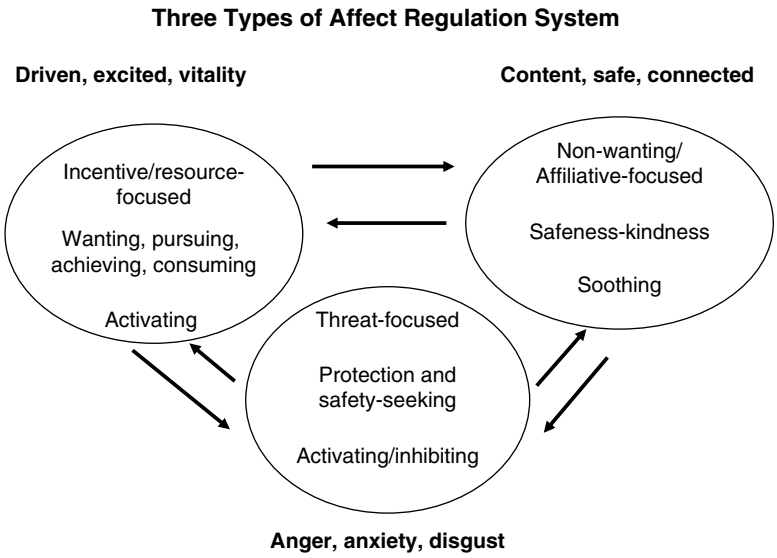

Figure 12.2 The interaction between our three major emotion-regulation systems. Reprinted with kind permission from Paul Gilbert, *The Compassionate Mind* (London: Constable, 2009)

> from is still there. On top of this you feel lonely, cut off, have no drive, feel even more afraid of others and lose confidence in building relationships.

Next therapists explain the function of the drive system. It motivates us to engage in activities and provides us with a positive feeling of pleasure and reward when we succeed in achieving our goals (e.g. on winning the lottery most of us would become restless, excited and would have racing thoughts).

Third, therapists introduce the soothing and affiliation system. This system is critical for our survival and well-being as it down regulates the threat and drive system through rest, affection, comfort, caring, joy, warmth and play. It motivates us to care for ourselves and each other and to attend to our and each others' needs.

The unintended consequences of the overactive threat system on the drive system such as anhedonia, amotivation, defeat and on the soothing/affiliation system such as lack of supportive relationships, isolation and increased distress are drawn out collaboratively (see Figure 12.1). In doing so, clients begin to formulate their difficulties as understandable yet undesired consequences of an overactive threat system. Members draw the size of their 3 circles using colours (red/threat, blue/drive, green/soothing/affiliation) and mini-formulations are drawn out with assistance from the therapists (see Figure 12.3).

It is important to instil hope and a compassionate motivation by introducing the rationale for strengthening the soothing system as a way to counterbalance the threat system ('moving from the red into the green') and to create balance among the three emotion systems. Therapists then use the formulations to validate the fears of developing kindness towards self ('I do not deserve kindness. It makes me weak and vulnerable'), for others ('Others will take advantage of me and walk all over me') and of receiving kindness from others ('People are dangerous and cannot be trusted'). The three circle formulation is revisited throughout the therapy. It evolves and provides a common language with which clients map experience. As trust increases and compassionate skills develop, some disclose and formulate the impact of *earlier* threat memories.

3 Building a shared compassionate motivation to recover

To strengthen the compassionate motivation, a joint recovery goal is developed. The pervasive feeling of vulnerability following a psychotic episode usually hinders people from looking into their future. To avoid dealing with the possibility of one's plans being thwarted by an unpredictable recurrence of symptoms, many adopt the safety strategy of 'taking each day as it comes' (Barnett and Lapsley, 2006; Gumley and Park, 2010). Therapists anticipate barriers to setting a goal – such as hopelessness,

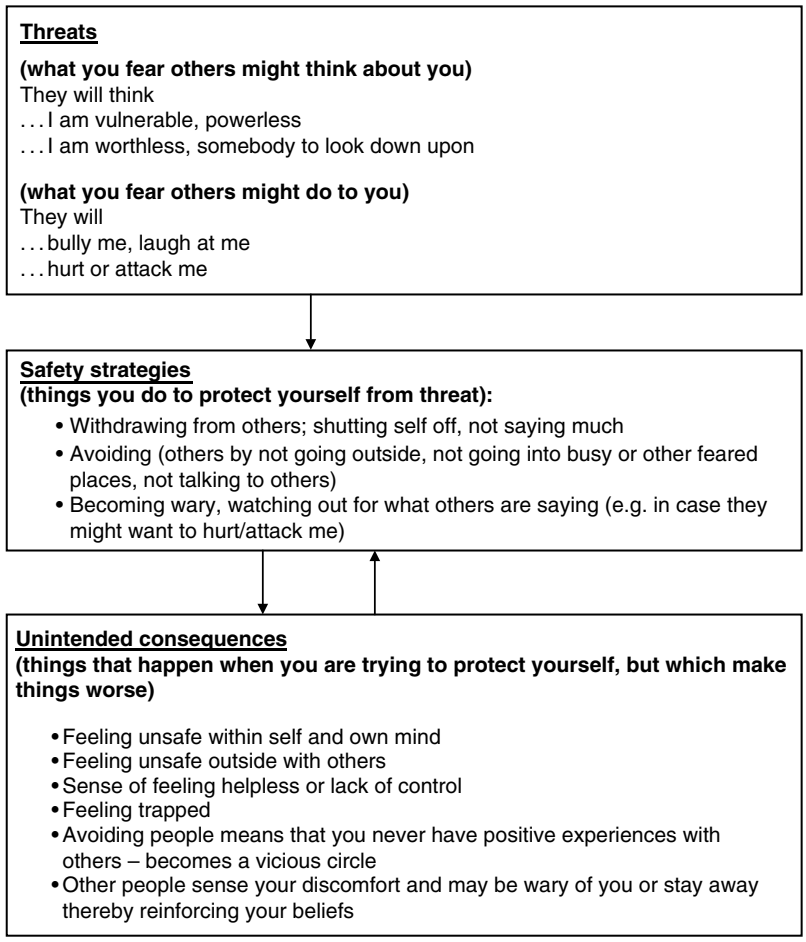

Figure 12.3 Mini-formulation of overactive threat mind

defeat, entrapment, vulnerability – as examples of how the threat system gets in the way of the recovery process. Members are asked to share what recovery means to them; where they are at in their recovery process and what they have already recovered from; and where they want to go. Typical goals reflect the wish for a stronger *drive system* – to be more motivated; to have more energy; to manage everyday tasks better; to live more independently and a stronger *soothing/affiliative system* – to like oneself more; to look after oneself better; to be more accepting and understanding of self and others; to be more comfortable in company; to be more confident in relationships; to socialize more; to develop more peace of mind; to be less frightened of relapse; to be less frustrated by others' stigmatizing views; to think in a 'saner' way.

When asked what they need to achieve their individual recovery goals, members usually become aware of their past barriers at which point fears of compassion are normalized as a sign of an overactive threat system that can be gradually overcome. This naturally leads on to the agreement of a joint recovery goal to develop a stronger soothing/affiliation system. To strengthen self-efficacy, therapists remind them of the progress they have made to date and elicit activities or relationships that have promoted recovery – possibly supporting this by watching recovery narratives on film (for example Scottish Recovery Network, 2008).

To strengthen the *compassionate motivation*, therapists invite members to contemplate insights implicit in the evolutionary model: We suffer because our threat systems are highly sensitive – yet we did not design this. We recognize that the psychosis and other distress is absolutely not our fault but is partly linked to the way our brains have been built and shaped, which we did not choose. There is a potential within all of us to develop a more balanced set of feelings by choosing to cultivate compassion. This gives us an alternative to living in the threat system. Therefore we want to look after our well-being by trying out compassion practice.

As a first step towards developing compassion a basic mindfulness exercise ('How am I?' exercise) is introduced and repeated at the beginning of every session. The exercise begins with a settling of the breath until the person arrives at a personal soothing rhythm. They then ground themselves in the sensations of the body and in the contact between the body and the chair/floor. They are then guided to notice their emotions, mind state and thoughts with a curious, welcoming and kind attitude (allowing what's already there, to be there without pushing it away or getting involved with). If members notice distress or pain, they are invited to ask themselves what the kindest thing is they could do for themselves at this point.

Mindfulness is defined as 'knowing what's happening while it's happening without preference' (Nairn, 1999). Training in mindfulness therefore entails training the observing quality of our minds. The starting point of this training is the development of an embodied awareness of one's physical and emotional experience, which has been shown to be particularly helpful for clients with psychosis (Röhricht, 2009). Our basic mindfulness exercise aims to familiarize the person with their internal experience, which they are often disconnected from as it is the source of distress. Mindfulness is safe to use with people recovering from psychosis (Chadwick *et al.*, 2005; Langer *et al.*, 2011) and has been shown to improve clinical functioning when used on its own (Chadwick *et al.*, 2009) and to reduce symptom-related distress and hospitalization rates when used as part of ACT (Bach and Hayes, 2002; Gaudiano and Herbert, 2006; see Chapter 10 this volume). By sharing their internal experiences with the group, members learn to label, express and validate emotions thereby reducing the

need to close down internally. At the same time they are guided to observe the transient and immaterial nature of mental events especially of emotions, which aims to increase distress tolerance (Linehan, 1993). The exercise also allows people to relax when they arrive in the group. Those who are too anxious to close their eyes or to focus on their breathing can focus their senses on the textures and sights of an object they hold in their hand (tennis ball, semi-precious stone) (Gilbert and Procter, 2006).

Middle phase

The majority of sessions focus on the gradual development of compassion for self and others. Compassion practices progress from being grounded in the group, to experiential practices and skills training outside the group. Therapists identify and work with barriers to developing compassion throughout.

1 Grounding compassion in the group: Group mind, interaction
In addition to imagery, concrete ways of accessing compassion in the group are introduced. Members are asked to come up with personal meanings and lived or media examples of compassionate qualities such as empathy, wisdom, courage, kindness, warmth, non-judgment or calm confidence. This helps them develop a shared meaning of compassion. By asking what the strengths and in particular the weaknesses of such qualities are, members identify their personal fears of compassion (e.g. 'The weakness of being kind is that others can take advantage of me.') and therapists have an opportunity to dispel any myths ('Compassion involves strength and courage, which means asserting yourself when others are disrespecting you').

Therapists then ask members to turn their shared meaning of compassion into statements that they write on a poster to form the group's compassionate mind. They could imagine what a wise old person would tell them or what they would have found helpful to hear when they were upset. Members consult the evolving group's compassionate mind to develop compassionate reframes to their difficulties in each session. At this point, it is important to distinguish self-compassion from self-esteem (Neff and Vonk, 2009). Self-compassion has been found to be more predictive of a positive sense of self-worth and less dependent on achievement (drive system) than self-esteem (Neff and Vonk, 2009). Self-esteem in this population is low and has been the focus of specific interventions (Barrowclough *et al.*, 2003). Self-compassion involves treating ourselves with kindness in light of our failings and weaknesses irrespective of achievement (see Box 12.1).

Since members often have negative experiences of help-seeking they are asked to define how they want to support each other. Therapists introduce the idea of members pointing out to each other when they are in threat

Box 12.1 Case example

A male member had experienced a psychotic breakdown after being made redundant following a factory closure. He since maintained that he had caused the closure due to a mistake he believed he had made. Due to shame and delusional guilt he was afraid to go outside or to travel on public transport as he feared the anger of his former colleagues. In the group he mentioned guilt, worthlessness and poor motivation as issues but did not share his story with the group. Instead he was preoccupied by black and white thinking that people were either moral or corrupt. He regularly brought this belief to the group but remained closed off to taking a compassionate stance. Towards the end of the group he shared that he had come to agree with the group's compassionate mind that 'Nobody was perfect' and 'That it is ok to get things wrong'. Therefore he concluded that one was neither immoral nor moral and that a minor slip in morals did not mean that one was immoral. This new flexibility in thinking allowed him to be more accepting of himself and others. A couple of sessions later he reported that he had seen a former colleague on the bus. At first he was terrified but when he realized that this man saw him but neither recognized nor got angry with him, he felt great relief. At the end he felt more relaxed especially when outside. He ruminated less on his self-blaming thoughts and was more forgiving towards himself for having made a mistake.

mode such as being unkind to themselves (self-critical, defeatist) or suspicious of others (e.g. feeling that nobody can be trusted, others will always let them down) and to help provide compassionate reframes for that person. We thereby capitalize on the fact that it is often easier to be compassionate to others than to ourselves. During the interaction therapists guide members to look at each other in order to tune into the gaze, facial expressions of the person talking to them and to open themselves to supportive and kind intentions. This strengthens co-operation and understanding of the model.

2 Developing compassion within self: mindful appreciation, compassionate imagery

Mindful appreciation To further stimulate the soothing/affiliation system in a non-threatening way, members are taught to appreciate a pleasant everyday object by slowing down, exploring and savouring it with their

senses (e.g. imagining being an alien who has never seen a flower before; Gilbert, 2009, pp. 235–338). Most people are surprised to note that their sensory experiences are more intense and that this helps access positive affect in a gentle way. Members are encouraged to seize opportunities to appreciate everyday activities (eating, washing) and events in nature (bird-song, sunset) and to notice their sensations, thoughts and feelings at the time. This simple exercise stimulated emotional reactivity in some members with blunted affect in our groups.

Compassionate imagery To further stimulate the soothing/affiliation system we harness the power of imagery. We explain the rationale for using imagery by asking clients to visualize their favourite meal and to observe the powerful physiological effects (increased saliva, stomach rumbling) the image is having on their bodies. The goal of compassionate imagery is to develop a compassionate self, from which clients learn to engage with their problematic parts (angry, anxious, ashamed selves). For some clients an important stepping stone towards the compassionate self is experiencing interpersonal safeness by imagining another mind (real or created ideal; human or non-human) having kind and caring intentions towards them. All exercises begin with several minutes of mindful preparation by providing a sense of being grounded in the body and anchored in soothing rhythm breathing.

A useful first exercise is safe place imagery. Discussions about an actual safe place where members felt comfortable, calm and relaxed can help to activate a helpful image. Unhelpful images are often safety-seeking such as hiding away in bed as opposed to conveying a feeling of safeness free from threat. Another initial exercise invites clients to imagine a soothing colour that has qualities of warmth, kindness, wisdom and strength. They imagine this compassionate colour surrounding them and flowing through their heart centre.

The 'mindedness' of images is gradually increased so that clients familiarize themselves with the feeling of another mind wanting them to flourish. The safe place 'welcomes you and takes joy in you being there'. The compassionate colour 'intends to help and heal you'.

A subsequent exercise involves asking members to first recall a time when they had kind and caring feelings towards a person or pet (as this is typically least threatening) and then to recall receiving compassionate feelings from another. If working with memories is difficult due to lack of caring experiences, members can use fantasy to playfully visualize an image of an ideal compassionate other, which has the following qualities: 1) a deep commitment to you and to helping you to be well; 2) wisdom that comes from a deep understanding of our human condition and of the personal suffering of each of us; 3) calm confidence and strength of mind,

which is not overwhelmed by pain and radiates a sense of authority; 4) warmth conveyed by gentleness, caring, openness; and 5) an acceptance of you as you are, not how you think you should be (Gilbert, 2010; p. 188–192). Images might take human (e.g. wise man/woman, wiser older self, Jesus; Mother Theresa) or non-human form (e.g. sunlight, rainbow, old tree). Clients are guided to explore the sensory qualities of the image and in particular focus in on the facial expressions, tone of voice and gestures both of themselves and the compassionate other.

Last, the person begins to develop their compassionate self, for example, by focusing these compassionate qualities on himself and imagining them expanding. Members are encouraged to practice taking on these qualities regularly (e.g. by becoming a wise and compassionate being every morning before getting up) with the goal of being able to access a feeling of compassion flowing through them effortlessly when they are distressed (Gilbert, 2010; pp. 159–164).

All members in our groups were able to engage in imagery. A few members experienced voices or traumatic memories intruding during imagery but were able to refocus on feelings of safeness with guidance and practice. Most were amazed that they could exert control over their minds by generating images at will that induced soothing and connectedness. See Box 12.2 for a case study.

Clients' experiences during the practices are explored focusing in particular on the physical sensations such as warmth and lightness they evoke. By eliciting members' experiences of compassion, threat and drive, therapists contrast the different body states, thoughts, feelings and motivations

Box 12.2 Case example

An elderly female was largely housebound due to back problems, paranoia, stigma and fears of having panic attacks when outside. Despite great reluctance to travel to the meetings, she enjoyed the group and engaged well. She used compassionate intentions to eat more healthily and to work towards gradually exposing herself to her fears of being outside. Without any guidance of therapists, she started by going outside to hang out washing and was eventually able to travel to a bigger city by bus to go shopping with the support of a friend. When travelling alone she used her compassionate image of a lifelong friend, which provided her with inner strength, calm, a sense of being at one and greater tolerance of her back pain. Feeling more confident she decided to join a local club and travel more to see family and friends.

that characterize the different states. Attention is drawn in particular to how it feels in the body to be ashamed or defeated vs. feeling excited or driven, competitive vs. feeling safe, relaxed and connected. The shifting between states can be made more concrete by asking clients to step into red, blue and green circles.

3 Practising compassionate skills: Attention, behaviour, thinking
Another skill practice is to ask members to formulate a compassionate intention that they can bring to a routine everyday activity which they struggle to motivate themselves to do. For instance, some chose to say to themselves before and as they were performing the activity 'I'm taking a shower because *I want to* look after myself .' or 'I'm getting up because *I want to* show my family who care for me that I also care for myself'. They were invited to slow down, focus their attention on the intention and the sensory experience, for example, warm water on their skin, and to praise themselves for making an effort to engage in the activity regardless of whether they completed it or not. Members reported an increased sense of mastery, pleasure and ease when performing activities and feeling more motivated to engage in other activities. Other compassionate intentions included getting up before midday, eating breakfast as opposed to not, eating healthily, doing chores and overcoming different limitations, for example, travelling on public transport. Box 12.3 provides an example.

Box 12.3 Case example

A male client had just been discharged from hospital after a psychotic episode marked by persecutory delusions and suicidal despair when he joined the group. He reported feeling 'tormented' by his ruminations over conflicting and unprocessed feelings of anger, shame and defeat in relation to past trauma and humiliation. On the outside he appeared slowed down and flat in his affect. He lacked the motivation to get up or wash and regularly slept until midday. The first change occurred when he imagined hearing the encouraging words and well-wishes of loved ones. This helped him to consistently get up, shower and eat breakfast leading to increased mastery and energy. He experienced the calm and peace of the safe place imagery as a 'revelation' as it was the first time he had experienced relief from his inner 'torment'. Strengthened through these practices he was able to disengage from his distressing thoughts more easily leading to him feeling calmer, more content, optimistic about his future and being more emotionally reactive.

Table 12.1 Example of using compassionate reframe diary

What caused you to become upset?	*Immediate reaction?*	*Shifting to compassionate self*	*Compassionate thinking:*	*Compassionate behaviour*
Seeing neighbour in street who does not know that I have been to hospital.	*Emotion*: Nervous, upset, ashamed, vulnerable. *Body*: Tense, nauseous. *Thoughts*: He'll ask where I have been. He will know that I have been to hospital. He will think I am a loony and loser. He will look down on me and avoid me. *Behaviour*: Avoid person.	1. Ground myself in body. 3. Slow down breathing. Find my soothing rhythm breathing. 3. Place hand on heart. 4. Put on gentle half smile. 5. Imagine becoming wise and compassionate being.	I am not alone in feeling like this. People who were in hospital with me have to deal with fear of stigma, too. It is understandable to feel scared of others judging me. The psychosis is not my fault, I did not choose it. I do not actually know what he is thinking. The more I will understand my difficulties, the easier it might get to face other people. I am ok as I am.	I will speak to a trusted person about how I feel. I could take a more gradual approach to going out on my own – I could start by going with a friend next time. If I see him next time, I could smile at him to see how he reacts.

In each session therapists guide members to arrive at a compassionate way of attending, thinking, feeling and behaving when faced with difficulties. Out of sessions members practise compassionate reframing of difficulties using diaries as shown in Table 12.1 (Gilbert, 2009; pp. 423–425).

The learning of compassionate responses is 'scaffolded' through the group atmosphere, the support from therapists and members, the group's compassionate mind, the feeling developed in the experiential exercises and finally the everyday life practice of asking during a difficulty 'Imagining being this wise and compassionate being, what is the wisest and kindest thing that I can do for myself at this moment?'. In our groups we observed that the more members developed self-compassion, the more they were able to talk about personal and distressing experiences. When developing helpful responses to paranoid thinking, a distinction between the rational and compassionate mind can be helpful (see Gumley and Schwannauer, 2006).

Neuroscientific research has demonstrated that people high in self-criticism can experience self-compassion as aversive (Rockcliff *et al*., 2008; Rockliff *et al*., 2011). Therapists need to explain that stimulating the soothing system can feel unfamiliar at first and can activate negative affect such as sadness or grief, which has long been blocked off. From the start therapists anticipate barriers such as self-criticism, mistrust and lack of empathy for others and explain their function as safety strategies, which now get in the way of recovery. Acknowledging that most of the members share a fear of others and feel vulnerable within themselves helps reduce anxiety (Lincoln *et al*., 2010). Therapists might also praise them for being courageous enough to come to the group – courage being a compassionate quality. Therapists conduct compassion exercises like behavioural experiments in that they ask members to test out if the feared consequences (of being overwhelmed by distress, becoming lazy, feeling more vulnerable, others intruding, being taken advantage of) set in (see Box 12.4).

Ending phase

1 Compassionate Narratives

During the middle phase members develop safeness to express negative affects in the here and now and learn to relate to it with increasing warmth and acceptance. During the ending phase they consolidate this skill by reflecting on changes in their recovery from a compassionate stance. The construction of compassionate narratives through writing and sharing in the group aims to help members to integrate the psychosis and its impact in order to help them move on and deal with any future setbacks. Since members vary with regard to their cognitive and mentalizing capacities

Box 12.4 Case example

A male group member was apprehensive about developing compassionate responses to his lack of motivation to increase his activity levels. He grew up with a very strong work ethic and was very hard on himself about his difficulty getting things done. Since experiencing psychosis and depression he had become increasingly ashamed and self-critical. He was anxious that being compassionate towards himself would mean that he could 'let himself off' and that he and others would see him as lazy and weak. Therapists supported him to reframe his beliefs about compassion to an act of 'the wisest thing you can do for yourself', which in his case was to gently encourage himself to do a little more each day, praise himself and engage with his critical thoughts in a more understanding way. This assured him and others that compassionate responding required courage and was not an easy way out.

Box 12.5 Case example

A male member entertained a persecutory delusion and suffered from severe depressive symptoms. His affect was visibly blunted. He believed that a newsagent had been deceitful over a winning ticket claiming it for himself. He felt cheated, humiliated and had revenge fantasies with plans on how to kill him, which he felt able to resist. He engaged well with the group and the compassion work, especially with reducing his self-criticism about struggling to accomplish his everyday roles and tasks and improving his self-acceptance. He could shift from ruminating over his delusional belief to reframing it as an overactive threat mind, which had been sensitized in early life. As he shared his life story in the final exercise, he was able to get in touch with grief and sadness about the lack of soothing in childhood. This activation of the underlying grief helped this member progress in individual therapy after the group.

and with regard to the degree to which they have processed the psychosis and any underlying trauma or loss, therapists support them to develop their narratives at their own level – such as focusing on a particular difficulty they have overcome or by taking a lifetime perspective (see Box 12.5).

2 Facilitating transition

In keeping with an attachment perspective, therapists put the same attention into facilitating the ending of a group as they put into setting it up. The ending can evoke feelings of loss, which can lead members to withdraw and close down again. Members are encouraged to integrate their compassion practice into everyday life and to develop a regular practice early on in the middle phase. An individual plan is drawn up for each person to build on what has been most helpful to them. To help members connect with the feeling of compassion, they are given a CD of practices and a compassionate letter from the group mind as a transitional object. To help members build on their achievement of bonding with others in the group, further ways in which they can access social support are discussed. Participants in our groups chose to continue to meet as a group; to attend classes with a similar theme (meditation, tai chi, practical philosophy); to join a mental health club which organized weekly social activities; to engage in regular activities or to attend events with neighbours, friends or family. In the final session, the group reflects on what has been learned and how to maintain the gains. A closing ritual like tearing up a quality they want to leave behind and taking with them a quality they want to grow can reinforce the compassionate motivation.

Working with residual psychotic symptoms

In the case of individuals experiencing distress related to residual psychotic symptoms it is important for therapists to validate the distress people are feeling and for therapists and members to help the person arrive at a helpful way of making them feel safe and respected in the here and now.

In the case of paranoid thoughts the therapist neither colludes nor argues with the content of the delusion but focuses on validating and containing the affect (e.g. It is understandable that you are feeling frightened, if you are worrying about others wanting to hurt you. What might be a helpful way of dealing with this fear now? What can we do in the group to help you feel safe?). If a member feels watched or intimidated by others, they might want to sit outside the circle to observe the group and/or they might want to survey members' (usually benevolent) intentions towards them and feel them by looking at members taking in gaze, smile and posture. Members also tend to feel reassured by supportive and empathic statements from others who have learnt how to cope with paranoia. People are reminded that the threat system is designed for rapid action and will flood us with ideas that are not necessarily true. The compassionate self is interested in separating out the fears and overprotection strategies of the threat system from reality.

Delusional beliefs of a spiritual nature often serve a protective function (against shame from early abuse, trauma or loss) and should not be invalidated but formulated within the compassion model. On further exploration members often experience their spiritual figures as containing a punitive and critical aspect. Those individuals are best guided to a compassion practice which is grounded in reality such as remembering a kind interaction with a member or a pet or developing their compassionate self.

Possible therapeutic mechanisms

Taken together, participants in our groups described improvements in terms of reduced shame and self-criticism, increased self-compassion, emotional resilience, social connectedness and the activation of negative and positive affect, which are in keeping with the goal of CFT and have been observed in non-psychotic clients (Gilbert and Procter, 2006; Gilbert, 2010; Lowens, 2010). The activation of underlying grief facilitated progress in later individual therapy. While not directly targeted in therapy, members also noted improvements in motivation, drive, self-esteem and greater flexibility in their thinking. Several members decided to tackle issues of anxiety themselves, for instance, by gradually exposing themselves to feared situations (travelling on public transport, being in groups, attending events). This has also been noted in CFT for anxiety disorders (Welford, 2010).

CFT appears to help the person develop the warmth and courage needed to approach what they fear – negative affect and affiliation with others (Gilbert, 2010, p. 175). Support for this comes from our finding that clients related more compassionately to themselves and to others and were less avoidant of negative affect when talking about their psychosis and recovery following the CFT group (Braehler *et al.*, in press).

We hypothesize that compassion facilitates the resurfacing of suppressed affect and that it acts as narrative 'glue' that embeds the affect in autobiographical memory. Narratives with a meaningful and coherent sense of autobiographical self are considered indicative of good recovery from psychosis (Lysaker *et al.*, 2003; Lysaker *et al.*, 2005; Lysaker, *et al.*, 2007; Lysaker *et al.*, 2010). It has been argued that the integration of dissociated affects reduces the likelihood of these intruding and destabilizing the self (Liotti and Gumley, 2009).

The specificity of failures in mentalizing in psychosis and how these may be related to the affiliative system are as yet unclear. Mentalizing capacities evolve in the safeness experienced in early attachment and other affiliative relationships (Fonagy *et al.*, 2011; Liotti and Gilbert, 2011). CFT might create the conditions necessary for mentalizing to develop: to provide the interpersonal safeness to venture further into the exploration

of one's own mind, the minds of others and of the processes at how we arrive at understanding others' motives, beliefs and emotions.

Conclusion

Psychosis is associated with major difficulties in affect regulation and threat processing. Based on the work described we suggest that group CFT is a promising and evolving intervention for reducing problematic threat processing. CFT also offers a general framework for supporting emotional recovery from psychosis that could be implemented on an individual, group, family and mental health service level.

Note

1 This website is maintained by the Compassionate Mind Foundation headed by Professor Paul Gilbert. It provides information of training in CFT, practical resources for clinicians (e.g. material on psychoeducation, mindfulness, imagery), literature and the possibility to join special interest (e.g. for psychosis) or local supervision groups following training in CFT. www.compassionate mind.co.uk/index.html

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