I am delighted to welcome you to this short, special edition on compassion-focused therapy (CFT). One of the core principles of CFT is that it is rooted in clinical science rather than any particular approach to therapy. If we use psychological science to better understand the way the brain evolved, functions, and can create mental health problems, we can begin to target and develop therapeutic interventions based on that science. Indeed, clinical psychology is at a point where it can begin to be less focused on allegiance to particular schools of therapy and root itself in basic science. We can distinguish the science of process from the science of intervention because they have not developed in tandem. There is considerable evidence now that a whole range of interventions that involve: developing an appropriate and supportive therapeutic relationship, creating opportunities for guided discovery and behavioural experiments, gradual exposure for avoided situations and emotions, practising imagery, learning behavioural and emotional regulation skills – to name a few – play a central role in the personal change and recovery journey. However, CFT suggests that how individuals engage in these processes can play a big role in their willingness to engage with them and how effective they are.

Compassion-focused therapy highlights the fact that if we look at the evolution of our minds then one thing stands out above all else – the human brain evolved for social processing (Cozolino, 2007, 2008; Siegel, 2012). Over 100 millions years ago, the advent of the mammalian ‘caring for offspring’ and group living introduced a whole range of emotion regulation processes that work through relationships – one of which was obviously the attachment system and capacity for affiliation and caring (Carter, 1998; Porges, 2007). Much of our evolution of intelligence was driven by social challenges and our cognitive architecture is adapted for social processing (Dunbar, 2010). Social relationships matter immensely to our well-being in many ways. For example, the extent and degree of affiliation that we experience from the day we are born to the day that we die has a huge impact on the quality of our lives (Cozolino, 2007, 2008). Affiliative processes influence the architecture of our motivational and emotional systems and even influence genetic expression (Belsky & Pluess, 2009; Siegel, 2012).

So, if we put the capacity for affiliation central to the regulation of mind this directs attention to how people can experience kindness and affiliation from others, show kindness, empathy and affiliation to others and relate to oneself in those ways. Problems in any of these areas can spell trouble. Indeed, it was problems with being open and
responsive to affiliation from others, and self-affiliation, that began the journey into CFT. While working with traditional cognitive behavioural interventions I encountered people (commonly from traumatic backgrounds) who did not experience emotion change from cognitive change. They could understand the logic of changing how they thought about and judged things (and did do that), but this was ineffective at changing deeply felt experiences of the self, especially shame and a long-lived inner sense of worthlessness or badness (Gilbert, 1998a). There was a cognitive emotion mismatch, a well-known difficulty within CBT (Stott, 2007). Now, feeling better, obviously, is about feeling. So, the exploration of what gives us feelings of reassurance safeness, connectedness, contentedness and calming or being lovable, especially when one has had a sense of badness or unlovableness and disconnectedness all one’s life, became an important concern of therapy and research.

This led to a focus on the evolutionary origins of, and mechanisms for, experiencing reassurance, connectedness and calming via social relationships. Of particular interest is the way a parent calms a distressed infant by providing certain inputs such as stroking, holding, rocking and calm voice; and later consoling and validating. Signals of affection, helpfulness and supportiveness evolved to have physiological (often calming) effects, so these signal/stimuli must produce changes in their targets. For example, a mother’s affection must stimulate processes inside the infant (Cozolino, 2007, 2013). When I explored with individuals how they actually beard and emotionally experienced their ‘alternative coping thoughts’ (did they ‘bear’ them in kind, reassuring and helpful tones?) it turned out that they did not. Rather, they often experienced them as cold, logical and at times aggressive. For example, when generating alternative thoughts to the idea that one is a failure, a person might come up with alternatives like: ‘this is an unfair global statement, there are a number of things I succeeded at (and list them), and I have a good family, I am not as black-and-white as that’. But the emotional tone could be contemptuous as in: ‘come on (you idiot) this is an unfair global statement…; look at the evidence of your successes (stupid)…’. Therapists rarely checked on the emotional tone of alternative thoughts and I found that the emotional tone of self-to-self relating is often hostile and shaming – even when trying to be helpful!

Another area where feeling supported and cared about was difficult was when individuals acknowledged ‘intellectually’ that others cared about them, but had a real difficulty in feeling cared for. Some of them were experiencing a long-lived, deep sense of a shamed self which seemed to block any openness to affection and sense of connection to others (‘if you really knew me and what goes inside me, you would not like or care for me’; Gilbert, 1998b, 2007). Some talked in terms of a separation between self and others, ‘as if there is barrier between me and others’ and of their feelings of inner loneliness or difference from others; of their sense of disconnection (Cacioppo & Patrick, 2008). There seemed to be problems in a very particular evolved emotion system that underpins affiliation (Depue & Morrone-Strupinsky, 2005).

When I suggested to my clients to try to generate and practise an emotional tone of kindness, warmth and support (that has a real understanding for the pain of say depression), many point blank refused or found it very difficult. Indeed, Pauley and McPherson (2010) confirmed that depressed people find self-kindness almost impossible. They can be soaked in self-criticism, shame and at times contempt. Recent studies have explored this and found that indeed fears of compassion are highly associated with depression and anxiety (Gilbert, McEwan, Matos, & Rivis, 2011). It also became clear that the experiencing of affiliation was complicated and linked to other processes such as empathy and distress tolerance as well as being motivated to care.
These qualities of caring motivation, sympathy and empathy together are well captured in the concept of compassion (Gilbert, 2010; Gilbert & Choden, 2013). As of now the science of compassion is growing quickly (www.compassion-training.org) and the development and cultivation of compassionate as part of therapeutic interventions is now recognized as an important innovation requiring further research and development (Hoffmann, Grossman, & Hinton, 2011). CFT uses a range of interventions pioneered by other therapies but focusing on patients’ capacity to experience these with affiliative emotion. This is because it is the affiliative emotion system that creates the capacity for feeling better, regulates negative emotion and creates feelings of connectedness rather than aloneness and isolation.

This special edition therefore has brought together four articles to explore this. The first article provides an overview of the basic psychological science that underpins the CFT model, including an exploration of social mentality theory and the significance of different evolved emotion regulation systems, especially those underpinning affiliation (Gilbert, 2014). The second article is by Gumley, Braehler, and Macbeth (2014) who explore the roles of affiliation in psychosis. People with these experiences can be especially vulnerable to feelings of isolation and internal states of hostility. Increasing interest is focused on one of the core hormones that underpin affiliation (oxytocin), and they offer an extensive review of this work. The article highlights the importance of thinking about and promoting affiliative processes in people with these difficulties.

People with eating disorders can be difficult to help and they, like many other groups, can be highly self-critical and struggle with developing affiliative feelings to themselves and others. They can also have difficulties in emotion processing and tolerating certain emotions. In the third article, Goss and Allan (2014) explore how CFT concepts and interventions have been integrated into a standard CBT programme for eating disorders, over a number of years. They outline the positive impact this has had on the therapeutic process and outcomes, and point to areas for future development.

Last but not least we know that many of our inpatients receive little in the way of psychological interventions. So, one question is: could the introduction of a few (4) sessions of CFT that covers areas such as helping people consider why our brains can give us so much trouble (and that is not our fault), the nature of mindfulness and attention, understanding and cultivating compassion, and the development of specific imaging practices, be helpful for this troubled and heterogeneous group? Heriot-Maitland, Vidal, Ball and Irons (2014) set out to explore a short CFT informed intervention in terms of feasibility in the busy ward context, patient acceptability and effectiveness. Importantly, they found that clients on acute units, who could be in high states of distress, could nonetheless understand the model and gain benefit from the insights it offered and some of the compassion practices. They also found that nursing staff saw it as useful and were interested to participate too. Having established these important first steps they point out that this is just the beginning of a process of identifying how to develop the CFT approach for this setting.

Although clinical psychologists can feel their roles have been rather eroded in the competitive arena of faster, cheaper therapies, clinical psychologists will always be central to the scientific developments in our understanding of mental health problems and their recovery. The human brain is complex, and recent research has shown it is highly influenced by affiliative processes, even our genetic expressions. So as a science and profession we must continue to develop and work out the implications of what we are finding out about the nature of the human mind. CFT is a scientist practitioner model with a focus on affiliative psychology which has potential implications for a range of human
activities. Only with careful research can we build on our knowledge base for the benefit of all.

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References


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